Ability of Clinicians-In-Training to Recognize Vicarious Traumatization: A Multiple Case Study

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ABILITY OF CLINICIANS-IN-TRAINING TO RECOGNIZE VICARIOUS
TRAUMATIZATION: A MULTIPLE CASE STUDY

by

Amy Cavanaugh

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Doctor of Philosophy
Department of Counselor Education and Counseling Psychology
Advisor: Kelly McDonnell, Ph.D.

Western Michigan University
Kalamazoo, Michigan
December 2010
Clinicians repeated exposure to clients who have a history of traumatic experiences can lead to vicarious traumatization (VT), which is the potential for clinicians to experience negative consequences such as changes in their sense of self and worldview (McCann & Pearlman, 1990). Experiencing VT negatively impacts the clinician’s professional identity and counseling work with clients (Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996). Having an awareness of VT is a first step in protecting oneself from experiencing the potential consequences of counseling clients who have experienced trauma. Given this, it seems relevant to understand what clinicians-in-training know about VT. Therefore, the purposes of this study were to assess beginning clinicians’ awareness and understanding of VT. To address this issue the researcher posed the following two questions: (a) What is the level of awareness of VT in clinicians-in-training? and (b) What is the impact of a VT training program on the ability of clinicians-in-training to recognize VT in others? To address these research questions, a multiple case study method was used. Participants’ awareness of VT and its associated symptoms, risk factors and impact were assessed before and after they attended a psychoeducational workshop on VT. Several sources of data were collected: a demographic questionnaire, reflection questions about a clinical
case vignette, two journal exercises, and two interviews. The single case analysis results included (a) clinicians-in training having a level of awareness that ranged from no awareness to some awareness of VT and (b) they had an increased ability to recognize symptoms, risk factors, and impact of VT as well as resilience and self care after attending the VT training program. The cross case analysis resulted in the emergence of three categories of findings: (a) level of awareness of VT, (b) impact of the VT psychoeducational workshop, and (c) participants’ responses to the clinical case vignette. The discussion includes an interpretation of the findings that emerged from the analysis, implications and limitations of the study, and consideration of future areas of study.
ACKNOWLEDGMENTS

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CHAPTER I

INTRODUCTION

Mental health professionals typically see a large population of clients who have experienced traumatic events in their lifetime. A number of scholars and researchers define trauma as an existent or feared mental, emotional, or physical injury caused by an external circumstance with long-term effects (Allen, 2005; Briere & Scott, 2006; Herman, 1997; Rosenbloom, Williams, & Watkins, 1999). Examples of traumatic events include but are not limited to the following: sexual assault, domestic violence, terrorist attack, being kidnapped, and the chaos and violence experienced during and after a natural disaster. Individuals who suffer from a traumatic event may seek therapy and thus share their traumatic experiences with clinicians. When clinicians are repeatedly exposed to hearing clients’ traumatic stories they are at risk for being negatively impacted and consequently they may find themselves lacking desire to work with clients who have experienced trauma; disengaging from their clients, such as not empathizing with their clients’ traumatic experiences; or stopping any work with clients who have experienced trauma (Harrison & Westwood, 2009; Maschi & Brown, 2010; Pearlman, 1999; Pearlman & Saakvitne, 1995a, 1995b; Rasmussen, 2005; Saakvitne, 2005; Saakvitne & Pearlman, 1996). Over time clinicians may also experience symptoms that are similar to that of their clients, such as difficulties falling asleep or changes in heart rate (Harrison & Westwood,
Listening to traumatic material repeatedly, over time, can also lead to more severe and extensive symptoms within these clinicians (Dass-Brailsford, 2010; Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995a, 1995b; Rothschild & Rand, 2006; Saakvitne, 2005; Saakvitne & Pearlman, 1996). These symptoms can include difficulties interacting with colleagues, friends, and/or family. Additional symptoms may also include clinicians feeling unsafe in their work and/or home environment(s) or questioning their religious beliefs or spirituality. Prolonged exposure to hearing traumatic stories potentially leads clinicians to experience a buildup of these symptoms and wide-ranging changes, which may lead them to be vicariously traumatized (Dunning, 1994; Harrison & Westwood, 2009; Pearlman, 1999; Pearlman & Saakvitne, 1995a, 1995b; Rasmussen, 2005; Saakvitne, 2005; Saakvitne & Pearlman, 1996). Given this potential negative outcome of working with clients who have experienced trauma, it is important to assess awareness and knowledge held by clinicians-in-training of the potential impact of working with trauma populations.

Vicarious Traumatization Defined

McCann and Pearlman (1990) defined Vicarious Traumatization (VT) as “a process through which the therapist’s inner experience is negatively transformed through empathic engagement with a client’s trauma material” (p. 279). VT is not a single occurrence of experiencing a client’s traumatic material, but a collective effect of working over time with a client or many clients who have experienced trauma (McCann

Scholars and researchers have conceptualized other similar constructs to VT, including burnout, secondary traumatic stress, compassion fatigue, secondary traumatic stress disorder, and traumatic countertransference. These constructs are used to define the effects clinicians experience when being repeatedly exposed to clients’ traumatic stories (Bride & Figley, 2009; Figley, 1995; Freudenberger & North, 1985; Maschi & Brown, 2010; Osofsky, 2009; Rothschild & Rand, 2006). However, they differ from VT due to the foundational symptoms that intrinsically change clinicians when they are vicariously traumatized.

Symptomology of VT includes aspects that are (a) physiological, (b) psychological, (c) emotional, (d) interpersonal, and (e) foundational. Physiological symptoms are important warning signs for clinicians, because they physically illustrate that clinicians are experiencing consequences from listening to clients’ traumatic material (Pearlman, 1999; Pearlman & Caringi, 2009; Pearlman & Saakvitne 1995a, 1995b).

Physiological symptoms may include increased heart rate, changes in body temperature, or lack of energy (Pearlman & Saakvitne, 1995b; Rosenbloom et al., 1999). Examples of psychological symptoms of VT include flashbacks, which are visual and/or emotional memories of past traumatic events, such as soldiers believing they see enemy combatants when they return to the United States (Rosenbloom et al., 1999) or ruminations, repeated thoughts, such as questioning throughout the day if the car doors are locked (Allen,
Emotional symptoms of VT may include increased feelings of fear, sadness, or anger; a lack of feelings, such as numbness; and intense feelings, such as extreme sadness (McCann & Pearlman, 1990; Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995a, 1995b). Interpersonal symptoms may include clinicians having difficulty connecting with others, such as having problems communicating with a partner about what they are thinking/feeling, or wanting to isolate themselves from the other people in their lives (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a, 1995b).

Foundational symptoms of VT can include clinicians experiencing changes in core aspects of their being, such as their spirituality, self, or worldview (Maschi & Brown, 2010; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a, 1995b). For example, clinicians who view themselves as spiritual, such that they believe in a higher Being, may question how that higher Being could allow hundreds of people to be killed during a natural disaster. This questioning may lead clinicians to have feelings of demoralization because of changes to their spiritual beliefs and values (Pearlman & Saakvitne, 1995b). Clinicians may also question their sense of self. This questioning may lead clinicians to begin to doubt their professional competence and their ability to help their clients, which can lead clinicians to begin to experience a loss of professional identity as a competent practitioner (Horner, 1993; Pearlman & Saakvitne, 1995a, 1995b). Another foundational symptom of VT might include clinicians’ questioning the way they view the world, such that family and home may no longer be considered a safe place that offers unconditional love and support (Maschi & Brown, 2010; McCann & Pearlman, 1990; Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995a, 1995b).
Vicarious Traumatization Risk Factors

Possible risk factors for VT include (a) ongoing and repeated work with clients who have experienced trauma, (b) clinicians’ personal trauma history, (c) present personal situation, (d) lack of supervision, (e) lack of training on working with clients who have experienced trauma, and/or (f) work environment. Ongoing and repeated work with clients who have experienced trauma may put clinicians at risk to experience VT based on repeatedly being exposed to graphic material. This can include clinicians listening to the details of clients’ traumatic stories and the atrocities that human beings carry out (Maschi & Brown, 2010; McCann & Pearlman, 1990; Osofsky, 2009; Pearlman & Saakvitne, 1995a, 1995b). Talking about the traumatic event can be very therapeutic for clients and facilitate healing for those individuals. Perlman (1999) stated that clients’ being able to tell their traumatic story can be cathartic, especially if their voices were previously unheard and/or their stories were trivialized. Examples of clients talking about the details of their traumatic stories include experiences of being in the building at the time of the World Trade Center bombing (e.g., the screams that could be heard or the smells of the burning building) or being raped while jogging (e.g., being threatened or the pain that was experienced). Being able to voice the details of the traumatic event can be therapeutic for clients, yet it can also increase clinicians’ risk for experiencing VT.

Clinicians’ own trauma history can be another potential risk factor (Bober & Regehr, 2005; Bride & Figley, 2009; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996). For example, clinicians’ experiences of childhood abuse may be remembered if working with clients who are sharing details regarding their own
childhood traumatic experiences. Another potential risk of VT includes clinicians’ present personal situations, such as being pregnant, experiencing relationship difficulties, or dealing with the death of a loved one (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a, 1995b). Pearlman and Saakvitne (1995a, 1995b; Saakvitne & Pearlman, 1996) discussed that lack of supervision also increases the risk of being vicariously traumatized. For instance, clinicians may not be able to discuss client cases and/or gain feedback regarding the difficult client traumatic issues they are facing. Another risk factor for clinicians is a lack of training on working with clients who have experienced trauma. Having limited or no specific training on working with client trauma concerns can lead clinicians to feel overwhelmed with a client’s traumatic story (Bober & Regehr, 2005; Meyer & Ponton, 2006; Osofsky, 2009; Patrick, 2007; Pearlman & Saakvitne, 1995a, 1995b). Finally, clinicians’ work environments can increase their risk of being vicariously traumatized, such as being isolated from other mental health professionals and/or having to follow agency policies that require large and overwhelming client caseloads.

**Vicarious Traumatization’s Impact**

The impact of VT can include differences in the way clinicians experience themselves and/or others as well as the world around them (Maschi & Brown, 2010; McCann & Pearlman, 1990; Pearlman & Caringi, 2009; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne, 2005; Saakvitne & Pearlman, 1996). The negative consequences of VT can impact clinicians’ professional and/or personal lives. For instance, clinicians may feel unable to empathically connect with their clients
or have a difficult time interacting with their colleagues. Other negative professional implications can include experiencing feelings of decreased professional competency or choosing to limit the number of clients experiencing trauma on their caseloads (McCann & Pearlman, 1990; Osofsky, 2009; Pearlman & Saakvitne, 1995a, 1995b). Ultimately, after prolonged exposure to hearing and vicariously experiencing clients’ traumatic experiences, professionals may decide to leave the field (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a, 1995b). Negative personal implications of clinicians experiencing VT may include their own personal trauma resurfacing or mental health concerns such as experiencing depression (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a, 1995b). Other negative personal implications of VT include feeling unsafe at night or having problems communicating with family and friends (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a, 1995b). Given the severity of the potential consequences to clinicians who work with clients healing from traumatic events, it is important that clinicians have a working knowledge of VT and know how they can protect themselves from being vicariously traumatized.

To date, the research that has been conducted about VT has focused largely on understanding the impact VT has had on clinicians, risk factors of VT, and how to help mental health professionals who have already been vicariously traumatized (Adams & Riggs, 2008; Musa & Hamid, 2008; Pearlman & Mac Ian, 1995; Rothschild & Rand, 2006; Trippany, White Kress, & Wilcoxon, 2004; VanDeusen & Way, 2006; Way, VanDeusen, & Cottrell, 2007). The lack of research regarding preventing VT is problematic because of the obvious issue; the clinician has already been negatively
impacted. To promote prevention, clinicians-in-training need to be taught about VT because a first step to prevention is awareness (Pearlman & Saakvitne, 1995a, 1995b).

**Statement of the Problem**

The research that has been conducted on VT has largely focused on understanding the construct of VT and how to help clinicians who have already been vicariously traumatized rather than how to prevent VT from occurring (Adams & Riggs, 2008; Musa & Hamid, 2008; Pearlman & Mac Ian, 1995; Rothschild & Rand, 2006; Way et al., 2007). Given the risks and negative consequences of VT, more research that addresses the prevention of VT needs to be conducted. An important component of prevention includes clinicians being aware of the construct of VT because clinicians may struggle to protect themselves if they are not aware of VT. Currently, there seems to be a dearth of research on awareness of VT in clinicians-in-training, as well as specific means to prevent these negative consequences from occurring (Harrison & Westwood, 2009). Thus, research on awareness of VT in clinicians-in-training and means to prevent VT is needed.

**Purpose of the Study**

No studies could be located that have examined the awareness and knowledge of VT of clinicians-in-training. Clinicians may be at risk for experiencing VT when working with clients who have been traumatized; thus, it is important to understand beginning clinicians’ level of awareness regarding VT. The purpose of this study was to assess awareness and understanding of VT in clinicians-in-training. In addition, the researcher implemented an intervention to increase awareness and then assessed clinician’s level of
awareness of VT post intervention. The researcher proposed to answer the following research questions: (a) What is the level of awareness of VT in clinicians-in-training? and (b) What is the impact of a VT training program on the ability of clinicians-in-training to recognize VT in others?

The next chapter will include a review of the relevant literature related to this study, including a description of trauma, constructs related to working with clients experiencing trauma, a history of scholarship regarding VT, the potential risk factors of VT, resilience and self care, research on VT, and training and prevention.
CHAPTER II

LITERATURE REVIEW

While counseling invites mental health counselors to participate with their clients in the awesome process of human growth and healing, it also may threaten their well being through exposure to their client’s trauma and its painful consequences. (Meyer & Ponton, 2006, p. 189)

Meyer and Ponton (2006) capture the essence of working with trauma populations; they discuss the rewards as well as the potential consequences of repeated exposure to hearing traumatic stories that clinicians may face. A body of research exists that supports the idea that counseling clients who have experienced trauma can potentially lead clinicians to experience their clients’ trauma vicariously (Adams & Riggs, 2008; Dass-Brailsford, 2010; Pearlman, 1999; Pearlman & Caringi, 2009; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne, 2005; Saakvitne & Pearlman, 1996; Warren, Lee, & Saunders, 2003; Way et al., 2007). A body of literature also exists that addresses how to help clinicians who have experienced the negative consequence of listening to clients’ traumatic material (Bell, Kulkarni, & Dalton, 2003; Bride & Figley, 2009; Clemans, 2004; Maschi & Brown, 2010; Pearlman, 1999; Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995a, 1995b; Rothschild & Rand, 2006; Saakvitne & Pearlman, 1996; Saakvitne, Tennen, & Affleck, 1998). In order to understand the gaps that exist in the literature, it is relevant to review the following: (a) a description of trauma, (b) the constructs related to working with clients experiencing
To better understand the impact that working with violence and trauma can have on clinicians, we must first have an understanding of trauma. Scholars and researchers have defined trauma as an existent or feared emotional, mental, or physical injury that is caused by an external situation with possible long-term effects (Allen, 2005; Briere & Scott, 2006; Herman, 1997; Ulman, 2008). According to the United States Department of Justice’s 2009 census, the prevalence of trauma in the U.S. is staggering: 1.3 million violent crimes (i.e., murder, rape, robbery, and assault) were committed in 2009. In addition to the number of violent crime victims affected in the U.S., millions of people have been affected by natural disasters, such as Hurricane Katrina, or acts of terrorism, such as the September 11th attack on the world trade center buildings and the Pentagon. Other examples of trauma include being stalked; witnessing family members being tortured; or being verbally, physically, or sexually abused. All of these horrifying events can lead individuals to experience symptoms of trauma. It is possible that a large majority of these individuals may need to find help to resolve the issues that are raised during and after traumatic events. Given this, it is important for clinicians to know how to work with clients who have been traumatized so they are not vicariously traumatized by hearing their clients’ stories.

The first step for clinicians is to know the symptoms and the characteristics that people may exhibit if they have experienced trauma. According to the Diagnostic and
Statistical Manual of Mental Disorders, Fourth Edition, DSM IV-TR (American Psychiatric Association, 2000) symptoms that comprise the diagnosis Post Traumatic Stress Disorder (PTSD) are experienced by some individuals following a traumatic event. PTSD symptoms are separated into three clusters: reoccurring, avoidant, and hyperarousal (American Psychiatric Association, 2000). Symptoms in the reoccurring cluster may include nightmares, invasive and disturbing thoughts of the traumatic event or flashbacks to a traumatic event (American Psychiatric Association, 2000). Symptoms in the avoidant cluster may include avoidance of people or situations, lack of interest in important activities, or a lack of ability to remember the trauma (American Psychiatric Association, 2000). Symptoms in the hyperarousal cluster may include difficulties sleeping, episodes of anger, heightened startle response, or physical symptoms such as increased heart rate when exposed to reminders of the traumatic event (American Psychiatric Association, 2000). It is important to note that this is not an exhaustive list of symptoms; symptoms may be experienced differently or appear different for individuals after a traumatic event (Friedman & Marsella, 1996; Miller, Veltkamp, Heister, & Shirley, 1998). For example, amongst religions that promote collectivism, “perceptions, expressions, and treatment of exposure to trauma may differ” (Friedman & Marsella, p. 13) than from religions that promote individual responsibility and accountability.

The symptoms that clients can potentially face after experiencing a traumatic event may be influenced by many variables. Briere and Scott (2006) reported that there are three main types of influence: (a) individual characteristics, (b) aspects of the traumatic incident, and (c) reactions from others to an individual who has experienced the traumatic event. Below is a brief description of each of these three areas.
Individual Characteristics

Individual characteristics that influence the way a person is affected by a traumatic event may include demographic variables, past mental health concerns, previous trauma history, and life stressors (Brier & Scott, 2006; McCann, Sakheim, & Abrahamson, 1988; Saakvitne et al., 1998). Demographic variables may include gender, race, ethnicity, sexual orientation, age, or socioeconomic status (Brier & Scott, 2006; Saakvitne et al., 1998). Specifically, it is important to note that gender, race, ethnicity, and sexual orientation are found to be important demographic variables in whether an individual is traumatized as a result of societal oppression. Briere and Scott reported that individuals with certain demographic variables (e.g., female or LGBT) are more likely to be exposed to traumatic events such as rape and/or hate crimes due to societal oppression and discrimination.

Individuals’ past mental health concerns, such as depression or PTSD, may also influence how a person responds to a traumatic situation (Matsakis, 1996; McCann et al., 1988; Ulman, 2008). For instance, an individual who has not resolved previous depressive symptoms may see their depression worsen after experiencing a traumatic event, which could in part be due to the additional stress from experiencing trauma (Matsakis, 1996).

Previous trauma history such as past sexual assault or being in the government building during the Oklahoma City bombing may be another influential characteristic in the way a person is affected by a traumatic event. For instance, an individual with past trauma may be more likely to utilize previous unhealthy coping mechanisms, such as cutting behaviors, after experiencing a new trauma (Everstine & Everstine, 1993; McCann et al., 1988). In addition, researchers have illustrated that a woman who has been
raped in the past has an increased risk for PTSD after experiencing a traumatic event due to a decreased cortisol response compared with a woman who has never been raped (McFarlane & Yehuda, 1996). Moreover, people who have experienced past trauma may be more likely to dissociate during a new traumatic event (Everstine & Everstine, 1993; McCann et al., 1988; Rothschild, 2003; Shalev, 1996). Lastly, life stressors such as losing a job or experiencing the death of a loved one may influence the symptoms individuals face after a traumatic event. For instance, the stress of losing a job can compound the traumatic stress that is felt by an individual, thereby increasing the overall impact of the traumatic event (Rothschild, 2003; Shalev, 1996).

Aspects of Traumatic Events

Along with different characteristics of individuals, specific aspects of the traumatic incident can impact how people are influenced by trauma. Those aspects of the traumatic incident can potentially include perpetrators’ intent, negative consequences of the traumatic event, individuals’ perceived intensity of the trauma, and duration of the trauma (Brier & Scott, 2006; McFarlane & Girolamo, 1996). For example, deliberate and planned acts of violence, such as watching your family be tortured, may impact an individual very differently than an unintentional traumatic incident, such as losing a family member during an avalanche. A threat to one’s life can be perceived as an extremely intense aspect of a traumatic experience, thereby increasing the traumatic stress an individual feels following the incident (Shalev, 1996). Duration of trauma may also impact a person’s reaction to a traumatic event. For instance, physical and sexual abuse
that occurred over years may impact an individual very differently than a single incident of being physically assaulted (McFarlane & Girolamo, 1996).

**Societal Reactions**

The third aspect that influences individuals’ reaction to a traumatic situation are the societal reactions individuals receive from people in their support network as well as in the broader community. This may include not only the amount of social support from family, friends, and colleagues (Allen, 2005; Saakvitne et al., 1998), but also the degree of support that individuals feel from society (Briere & Scott, 2006; Saakvitne et al., 1998). For example, people whose homes are burglarized are oftentimes better able to press criminal charges than an individual who was sexually assaulted, illustrating that society affords different degrees of judicial support for survivors of different crimes. Additionally, people whose homes are burglarized may feel more supported by family and friends through offers of places to stay for the night; whereas a survivor of sexual assault may receive shameful messages from family and friends. Unfortunately, due to societal oppression and discrimination, some traumatic situations may not afford people the same type of support. For instance, persons of some sexual orientations, religions, races, and ethnicities may not receive familial or societal support after experiencing a traumatic event. For example, a man raped by another man may not believe he is able to report the crime due to sodomy laws that exist in his state. Another example of societal oppression and discrimination interfering with support for trauma survivors included the lack of aid for many survivors of Hurricane Katrina. Looking at the outcome it is apparent that aid was dependent on race and/or socioeconomic status. These survivors found
themselves homeless and/or penniless with no help from the local, state, or national authorities, while also experiencing the death or separation from their loved ones. According to McFarlane and van der Kolk (1996), another explanation for this lack of support may be that “family members and other sources of social support can be so horrified at being reminded of the fact that they, too, can be struck by tragedies beyond their control that they start shunning the victims and blame them for what has happened” (p. 27). This absence of support is also called “the second injury” (McFarlane & van der Kolk, 1996, p. 27) and can potentially be as disturbing for a person as the traumatic event.

Given all that is involved for individuals who suffer a traumatic event, many of them may seek therapy and thus share their traumatic experiences with clinicians. Clinicians who are repeatedly exposed to hearing their clients’ traumatic stories are at risk to experience negative consequences of working with trauma populations, which may lead them to be vicariously traumatized (Dass-Brailsford, 2010; Maschi & Brown, 2010; Osofsky, 2009; Pearlman, 1999; Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne, 2005; Saakvitne & Pearlman, 1996). Thus, it is important for clinicians to understand the potential negative consequences of working with clients who have experienced trauma.

**Constructs Related to Working with Clients Experiencing Trauma**

Constructs that have emerged as a result of working with clients who have experienced or are experiencing trauma include (a) burnout, (b) compassion fatigue/secondary traumatic stress/secondary traumatic stress disorder, (c) traumatic countertransference, and (d) vicarious traumatization. Below is a description of each of
these constructs, followed by a comparative analysis of how VT differs from the other constructs.

**Burnout**

Researchers and scholars define burnout as exhaustion that develops over time from internal or external demands, which drain a professional’s energy and eliminate the benefits of one’s coping mechanisms that affect behavior and attitude (Adams, Figley, & Boscarino, 2007; Bride & Figley, 2009; Brown & O’Brien, 1998; Cicognani, Pietrantoni, Palestini, & Prati, 2009; Clark, 2009; Dass-Brailsford, 2010; Elliott, Shewchuk, Hagglund, Rybarczyk, & Harkins, 1996; Raquepaw & Miller, 1989; Udipi, Veach, Kao, LeRoy, 2007). Burnout can result in feelings of seclusion and loneliness (Adams et al., 2007; Bride & Figley, 2009; Neumann & Gamble, 1995). Burnout is often an ongoing problem that is affected by both a person’s work environment, such as difficulties with colleagues, as well as external factors, such as personal relationships. Three aspects of burnout are more commonly reported by clinicians (Adams et al., 2007; Cicognani et al., 2009; Clark, 2009; Dass-Brailsford, 2010). First, clinicians experience affective fatigue, such as feeling drained and overwhelmed while working. Second, clinicians detach themselves from the people who are seeking services, such as experiencing difficulties empathizing with their clients’ presenting concerns. Third, clinicians feel a decrease in sense of work satisfaction, such as worrying about one’s professional competence.
Compassion Fatigue/Secondary Traumatic Stress/Secondary Traumatic Stress Disorder

Figley (1995) described compassion fatigue and Secondary Traumatic Stress (STS) as the strain helping professionals experience on their ability to be empathic with trauma clients as well as all other clients over time. The terms STS and compassion fatigue can be used interchangeably (Figley, 1995). Secondary Traumatic Stress Disorder (STSD) is a pathological response to being exposed to another person’s trauma (Figley, 1995; Harrison & Westwood, 2009; Udipi et al., 2007). STSD was created as “a conceptualization that accurately describes the indices of traumatic stress” (Figley, 1995, p. 7) for helping professionals that are negatively affected by working with trauma populations. Moreover, in 1995 Figley described STS and STSD as “the latest and most exact descriptions of what has been observed and labeled over hundreds of years” (p. 14) when people hear other peoples’ traumatic stories. Compassion fatigue, STS, and STSD all “parallel” (Salston & Figley, 2003, p. 169) PTSD, “except the traumatic event is the client’s traumatic experience that has been shared in the process of therapy or interaction with the survivor” (p. 169). These three constructs can potentially include physical symptoms, such as stomachaches or headaches; psychological symptoms, such as depression or nightmares; and emotional symptoms, such as feeling intense anger or sadness (Adams et al., 2007; Bride & Figley, 2009; Bride, Radey, & Figley, 2007). Furthermore, Bride and Figley (2009) argued that “the negative effects of secondary exposure to traumatic events are the same as those of primary exposure including intrusive imagery, avoidance of reminders and cues, hyperarousal, distressing emotions, and functional impairment” (p. 316).
Traumatic Countertransference

Traumatic countertransference is considered a more present day understanding of the construct of countertransference associated with psychoanalytic theory (Salston & Figley, 2003). Traumatic countertransference is the emotional, physiological, and ideological reactions clinicians have to their clients who have experienced trauma, based on their own personal experiences. Traumatic countertransference differs from the traditional construct of countertransference by specifically focusing on clinicians reactions due to hearing clients’ traumatic material (Herman, 1997; Salston & Figley, 2003). Reactions can include clinicians experiencing difficulties correctly diagnosing clients’ issues, dissociating while hearing clients’ traumatic material, questioning their clients’ stories, or feeling unable to listen to clients’ traumatic material (Berzoff & Kita, 2010; Patrick, 2007; Rasmussen, 2005; Salston & Figley, 2003; Shubs, 2008). Wilson and Lindy (1994) classified two types of reactions of countertransference, “avoidance reactions and over-identification reactions” (p. 11). Examples of avoidance reactions include not returning clients’ phone calls or empathically disconnecting from clients (Sexton, 1999; Shubs, 2008; Wilson & Lindy, 1994). Examples of over-identification reactions include clinicians’ over involvement and inappropriate boundaries with clients, such as calling to check in with a client twice a day or giving out personal information, such as a home phone number so a client can have access outside of office hours (Sexton, 1999; Shubs, 2008; Wilson & Lindy, 1994). Shubs (2008) proposed a third type of countertransference: communicative. Communicative countertransference “refers to the all-encompassing totalistic application of countertransference reactions…to further our
understanding of the patient’s experience in the trauma as well as in the therapy interaction” (pp. 162-163). This holistic perspective takes into account not only clinicians’ reactions to clients but also attends to clinicians’ reactions to the “therapeutic interaction” (Shubs, 2008, p. 163). For instance, clinicians’ reactions to how clients retell their traumatic stories are just as important as their reactions to the details of clients’ traumatic stories. For example, a clinician’s reaction of surprise and doubt when a client tells a traumatic story with no affect are just as important as a clinician’s reaction of feeling nauseous after hearing about childhood sexual abuse. All three types of countertransference reactions can impact clinicians work with their clients. Therefore, it is important that clinicians have chances to analyze and resolve the reactions they have when listening to their client’s traumatic material (Bride & Figley, 2009; Patrick, 2007; Saakvitne, 2005; Sexton, 1999; Shubs, 2008).

**Vicarious Traumatization**

Pearlman and Saakvitne (1995a, 1995b; Saakvitne & Pearlman, 1996) stated that VT is a process and not a single experience of listening to clients’ traumatic material. Furthermore, VT is a possible risk of working with clients who have experienced or are experiencing trauma, yet “it is not something clients do to us; it is a human consequence of knowing, caring, and facing the reality of trauma” (Saakvitne & Pearlman, 1996, p. 25). It is important to note that VT is potentially a normal product of working with clients experiencing trauma and does not reflect a weakness in the clinician (Campbell & Wasco, 2005; McCann & Pearlman, 1990; Patrick, 2007; Pearlman & Saakvitne, 1995a,
VT includes many symptoms that clinicians may experience when exposed to client’s traumatic material (Dass-Brailsford, 2010; Harrison & Westwood, 2009; Maschi & Brown, 2010; McCann & Pearlman, 1990; Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne, 2005; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998; Ulman, 2008). The VT symptoms that clinicians may face are similar to the symptoms that their clients may face after their traumatic event (Patrick, 2007; Pearlman & Caringi, 2009; Rasmussen, 2005). Symptoms of VT can include (a) physiological, (b) psychological, (c) emotional, (d) interpersonal, and (e) foundational. What follows is a brief description of VT symptomology.

One possible set of symptoms that clinicians may experience are physiological (McCann & Pearlman, 1990; Patrick, 2007; Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne, 2005; Saakvitne & Pearlman, 1996). Physiological symptoms may include clinicians feeling increased heart rate or body temperature as well as a lack of energy. Other physiological symptoms may include teeth grinding or increased headaches and/or stomachaches (Pearlman & Saakvitne, 1995a, 1995b; Rosenbloom et al., 1999; Saakvitne & Pearlman, 1996). Physiological symptoms are important warning signs for clinicians, because they physically illustrate that clinicians are experiencing consequences from listening to clients’ traumatic material (McCann & Pearlman, 1990; Pearlman, 1999; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996).
Another set of symptoms clinicians may face when experiencing VT include psychological symptoms (McCann & Pearlman, 1990; Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne, 2005; Saakvitne & Pearlman, 1996). One psychological symptom could possibly include flashbacks (Rosenbloom et al., 1999). For instance, a male survivor of childhood abuse experiences previous memories of his mother yelling derogatory remarks when visiting his mother’s house after she has died. Another psychological symptom could include ruminations (Allen, 2005). For example, a clinician may think repeatedly about an argument with his or her partner. Additional psychological symptoms could include increased sensitivity to seeing or hearing about violence, hyperarousal, or hypervigilence. Hyperarousal refers to clinicians’ state of increased physiological awareness, such as becoming more sensitive to the sounds around them (Allen, 2005; Rothschild, 2003). Hypervigilence refers to clinicians’ amplified awareness of their surroundings, such as a clinician always sitting with his or her back to the wall facing the door so he or she can see who is entering the room (Rosenbloom et al., 1999).

In addition to physiological and psychological symptoms, clinicians may experience emotional and/or interpersonal symptoms (Harrison & Westwood, 2009; McCann & Pearlman, 1990; Patrick, 2007; Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne, 2005; Saakvitne & Pearlman, 1996). Emotional symptoms of VT may include increased feelings of hopelessness, disappointment, or frustration (Harrison & Westwood, 2009; McCann & Pearlman, 1990). Clinicians might also experience a lack of feelings or more intense feelings. Interpersonal symptoms can potentially include clinicians experiencing difficulties connecting with others such as
having problems trusting their partner to understand the difficulties they are experiencing at work (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a, 1995b). Other examples of interpersonal symptoms can include clinicians isolating themselves from colleagues or lack of desire to participate in social activities.

Foundational symptoms are an important and unique aspect of VT that clinicians experience (Harrison & Westwood, 2009; McCann & Pearlman, 1990; Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne, 2005; Saakvitne & Pearlman, 1996). Foundational symptoms can include clinicians experiencing changes in their spirituality, self, and worldview (Harrison & Westwood, 2009; Maschi & Brown, 2010; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne, 2005; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998). Clinicians that view themselves as spiritual may question how people could hurt other people. They may also potentially feel that they are losing their spiritual connections, such as not wanting to attend their place of worship (Pearlman & Saakvitne, 1995a, 1995b). Furthermore, clinicians may find their spiritual beliefs have changed. For example, clinicians who previously did not believe that the death penalty should be administered due to the teachings of their faith may find themselves believing that the death penalty is an appropriate punishment for criminals who have sexually abused children.

Clinicians may also question their sense of self and begin to have doubts about their professional identity. For instance, clinicians may question their conceptualization skills and if their clients’ presenting concerns are problems that will ever be resolved or they may feel unable to help clients who have experienced trauma and refer all of those clients to other clinicians (Horner, 1993; McCann & Pearlman, 1990; Pearlman &
Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996). Questioning their sense of self may also occur if clinicians doubt their ability to be good parents. Clinicians may find themselves distancing themselves from their children if they believe that their children would be negatively impacted by the VT symptoms they are experiencing. Foundational symptoms may also include clinicians’ questioning the way they view the world, such that the world may no longer be considered a safe place. For example, clinicians that work with specific trauma populations, such as female rape survivors, may begin to generalize that all men may be potential rapists. Furthermore, clinicians that repeatedly hear the atrocities that people commit against one another can begin to believe that individuals do not have the ability to influence their own lives, but rather feel that all life events are random and out of their control.

**Comparative Analysis of Constructs**

There are many aspects of VT that overlap with burnout, compassion fatigue, STS, STSD, and traumatic countertransference; however, there are also differences between these constructs. A major difference between burnout and VT is the notion that burnout can occur in any profession and with all populations of clients, whereas VT occurs specifically when clinicians empathically connect with trauma populations (Patrick, 2007; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996). Udipi and colleagues (2008) stated that clinicians who experience the negative consequences of empathically working with clients who have experienced trauma feel “overwhelmed” (p. 461) versus clinicians who experience burnout feel “overworked” (p. 461).
VT differs from compassion fatigue, STS, and STSD in part because of the complexity of the symptomology. For example, compassion fatigue, STS, and STSD include physical, psychological, and emotional symptoms, whereas VT identifies not only physical, psychological, and emotional symptoms, but also interpersonal and foundational symptoms (Pearlman & Saakvitne, 1995a, 1995b; Salston & Figley, 2003; Sexton, 1999). Additionally, unique to VT is the emphasis on how clinicians’ develop their personal and professional self identities as well as their worldview due to hearing clients’ traumatic stories (Patrick, 2007; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996). VT also has other differences from STSD. STSD pathologizes clinicians’ negative responses and reactions to listening to clients’ traumatic material, while VT normalizes these reactions as a potential aspect of empathically connecting with clients who have experienced trauma.

Lastly, traumatic countertransference differs greatly from VT. Traumatic countertransference has the potential to occur during every session with every client, whereas VT has the potential to occur only with clients who have experienced trauma (Berzoff & Kita, 2010; Kanter, 2007). Another significant difference is traumatic countertransference can include clinicians’ reactions to hearing clients’ material one time and can also be based solely on clinicians’ own personal issues. This is opposed to VT, which includes the cumulative effect of an ongoing process of working with clients experiencing trauma and may not be related to anything clinicians have personally experienced (Pearlman & Saakvitne, 1995a, 1995b; Rasmussen, 2005; Saakvitne & Pearlman, 1996). Clinicians are potentially susceptible to all of these reactions when working with clients who have experienced trauma.
History of Scholarship Concerning VT

The construct of VT was first introduced and defined by McCann and Pearlman (1990) in their groundbreaking article on the possible harmful effects of clinicians repeated exposure to client’s traumatic material. Since the introduction of VT, there has been conceptual literature that has further developed and defined the construct of VT (Clemans, 2004; Dunkley & Whelan, 2006; Gillian & Steed, 2000; Maschi & Brown, 2010; Neumann & Gamble, 1995; Patrick, 2007; Pearlman, 1999; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998). Researchers have also investigated how clinicians have been affected when listening to clients’ traumatic material as well as potential risk factors of VT (Adams, Matto, & Harrington, 2001; Adams & Riggs, 2008; Pearlman & Mac Ian, 1995; Sinclair & Hamill, 2007; Steed & Bicknell, 2001; Trippany et al., 2004).

Before the 1970s, if clinicians experienced negative consequences when listening to clients’ trauma material, they were often seen as having pathology. Their experience was also frequently seen as an individual weakness (McCann & Pearlman, 1990; Pearlman, 1999; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996). Since the 1970s, scholars and researchers have illustrated that horrifying traumatic events can potentially impact all clinicians that hear about trauma (Figley, 1995, 2002; Maschi & Brown, 2010; McCann & Pearlman, 1990; Patrick, 2007; Pearlman, 1999; Pearlman & Caringi, 2009; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998). In the 1980s, McCann and Pearlman “began to see the need for a heuristic model that would
integrate the literature on trauma and individual psychological development” (p. 5). This
desire to create a common framework for working with clients experiencing trauma
derived from their clinical work and was labeled “constructivist self development theory”
(McCann & Pearlman, 1990, p. 5).

Constructivist self development theory (CSDT) has a core idea that people have
the ability to create the way they see the world as they interact with the people in their
lives and listen to their clients’ trauma stories (McCann & Pearlman, 1990; Pearlman,
1999; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne &
Pearlman, 1996; Saakvitne et al., 1998). When developing CSDT, Pearlman, Saakvitne,
and their colleagues stated that they utilized constructs from psychoanalytic theories such
as object relations along with constructs from theories regarding social cognition that
focused on how people develop and are affected with regards to the relationships in their
lives. CSDT helps to build a “developmental framework for understanding the
The theory includes understanding clinicians’ personalities, such as strategies of coping
and interpersonal styles, along with specific portions of their clients’ traumatic events to
understand how development of the self is impacted (Pearlman & Saakvitne, 1995a,
1995b; Saakvitne et al., 1998). CSDT also includes working towards understanding how
individuals’ responses to trauma are impacted by culture and the social climate. For
example, clinicians who work with torture survivors in different countries may
experience varied reactions to hearing their clients’ traumatic stories due to the social
climate related to justice and advocacy in that specific country. CSDT “is interactive—
that is, it focuses on the complex interaction between person and environment” (McCann
& Pearlman, 1990, p. 10). Even with this growing conceptual understanding of the impact of trauma work for clinicians, most clinicians are not aware of the impact counseling clients who have been traumatized potentially has on them. Thus, it is essential that clinicians are educated on working with trauma populations and develop an awareness and working knowledge of VT. Given this, we need to understand clinicians’-in-training awareness and knowledge of how working with clients who have experienced trauma can impact their professional and personal lives.

**Risk Factors of Vicarious Traumatization**

During the process of counseling clients who are experiencing trauma, clinicians may hear traumatic stories that could include “exploitation, sadism, abandonment, and betrayal” (Neumann & Gamble, 1995, p. 344). These images may confront clinicians’ beliefs and values as well as how they view the world which could ultimately impact the clinician (Maschi & Brown, 2010; Patrick, 2007; Pearlman, 1999; Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998). Thus, clinicians could start to “view the world through a trauma lens” (Neumann & Gamble, 1995, p. 344), meaning clinicians could start to relate all of their experiences, such as interactions with family and friends, to a specific aspect of their clients’ trauma stories. If clinicians have little or no awareness of the change in which they view the world, it can have far-reaching and invasive consequences, such as permanent changes in their spiritual beliefs and/or worldview (Bride & Figley, 2009; Maschi & Brown, 2010; Pearlman, 1999; Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998).
Furthermore, scholars and researchers throughout the literature suggest the impact of VT may be long-lasting or permanent if ignored (Patrick, 2007; Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995a, 1995b; Sinclair & Hamill, 2007; Trippany et al., 2004). Below are brief descriptions of the risk factors for clinicians listening to clients’ traumatic material: (a) repeated and on-going trauma work, (b) personal trauma history, (c) personal stressors, and (d) professional stressors.

**Repeated/Ongoing Trauma Work**

Clinicians who repeatedly work with clients who are experiencing trauma are potentially more likely to experience VT (Bober & Regehr, 2005; Bride & Figley, 2009; Maschi & Brown, 2010; McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998). This risk includes ongoing exposure to graphic material such as hearing about the cruelty people commit against one another (Harrison & Westwood, 2009; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a, 1995b). For example, this could include listening over many sessions to the details of a client’s traumatic experiences of growing up as a gang member and the client sharing multiple acts of gang violence. Repeated and ongoing trauma work may also lead to additive exposure to client’s graphic traumatic material, which poses a risk in part because of clinicians’ potentially experiencing difficulties empathically engaging with their clients. For example, a clinician that grew up in a home that valued children and showed healthy signs of love and respect (e.g., hugs and positive verbal affirmations) may have difficulty remaining empathically engaged with a client that shares that they were frequently physically and verbally abused as a
child. In this situation the clinician could distance himself or herself from the client, which may then impact the clinician’s ability to help the client therapeutically change and grow (Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998).

**Personal Trauma History**

Another potential risk factor for experiencing VT includes clinicians’ personal trauma history (Bober & Regehr, 2005; Bride & Figley, 2009; Pearlman & Saakvitne, 1995a, 1995b; Radey & Figley, 2007; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998). Salston and Figley (2003) stated that clinicians may have a tendency to “overgeneralize” (p. 170) their own trauma incidents with those of their clients. For example, clinicians that have experienced sexual violence may attribute their own reactions, such as difficulty in their adult romantic interpersonal relationships and feelings of guilt and shame, whether this is accurate or not, to clients who have experienced sexual violence. This projection of their own reactions onto their clients can be problematic due to their reactions being inaccurate. In addition, clinicians then may risk missing other important information shared by their clients. In addition, clinicians may also find themselves projecting their own reactions onto their clients and finding their own unresolved trauma issues being raised. Clinicians’ unresolved personal trauma history being raised may increase their risk for VT (Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998; Salston & Figley, 2003).

Clinicians’ unresolved trauma can be harmful to both clinicians and clients when it impedes the therapeutic process because it may impede clients’ ability to grow and
heal. For instance, clinicians may focus on their own trauma versus being present with their clients’ concerns (Sexton, 1999). Therefore, clinicians may find it helpful to work on resolving their own trauma, such as attending personal therapy, to help decrease or alleviate the risk of raising their own unresolved trauma while listening to their clients’ traumatic material (Patrick, 2007; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998). Given this, it seems essential that clinicians have some awareness that having a personal trauma history may be a potential risk factor of VT, thereby giving them the opportunity to reduce this risk factor before being impacted by their clients’ traumatic stories.

**Personal Stressors**

Clinicians’ present personal stressors are another risk factor for VT (Meyer & Ponton, 2006; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998; Sexton, 1999). These may be such circumstances as relationship difficulties or dealing with the death of a loved one that could increase the risk of being vicariously traumatized by compounding the stress of hearing their clients’ traumatic stories (Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998). The different stressors in clinicians’ lives can impact their ability to focus in session as well as their overall desire to be at work (Pearlman & Saakvitne 1995a, 1995b; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998). Sexton (1999) suggested that “major life stressors will make [clinicians] more vulnerable” to VT (p. 400).
**Professional Stressors**

There are many professional stressors that may increase clinicians risk for experiencing VT: lack of supervision, lack of training on VT, inadequate or no training on working with clients experiencing trauma, and challenging work environments (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne, 2005; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998; Salston & Figley, 2003). Lack of supervision, such as having a lack of opportunity to discuss difficult clients, is one possible professional stressor. The importance of regular supervision when working with trauma is a vital professional responsibility for one’s own self care (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998; Salston & Figley, 2003). Furthermore, Sexton (1999) stated that receiving supervision is not only helpful, but an ethical duty. According to Pearlman and Saakvitne (1995a, 1995b; Saakvitne & Pearlman, 1996) and Sexton, there are three integral pieces to supervision: consideration of all parts of the relationship between clinicians and clients, awareness of any possible countertransference, and a thorough knowledge and understanding of VT. It is important to note that for clinicians who are not required by their licensing boards to receive supervision, peer supervision and case consultation are both extremely helpful ways to decrease the risk of experiencing VT. Saakvitne (2005) stated that clinicians “need consultation for holding and metabolizing the intense…personal responses to trauma” (p. 142-143). Additionally, peer supervision and case consultation can help to facilitate clinicians experiencing decreased feelings of isolation as well as allow time to process the effects of listening to clients’ traumatic
material (Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998; Salston & Figley, 2003; Sexton, 1999).

Another professional stressor includes lack of training on VT and working with trauma populations (McCann & Pearlman, 1990; Neumann & Gamble, 1995; Patrick, 2007; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne, 2005; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998). Lack of training regarding VT potentially leaves clinician without tools to combat VT. Clinicians’ lack of training regarding VT can have negative consequences (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne, 2005; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998). For instance, it could result in clinicians experiencing increased emotions after hearing their clients’ traumatic stories without understanding why their emotions were heightened or knowing helpful ways they can combat or allay their increased emotions (Patrick, 2007; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998). Lack of training regarding working with trauma populations can also increase clinicians risk for VT (Bober & Regehr, 2005; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne, 2005; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998). Limited or no specific training working with client trauma concerns can lead clinicians to feel overwhelmed or confused about how to best work with a client experiencing trauma (Patrick, 2007; Pearlman & Saakvitne, 1995a, 1995b). Specifically for new clinicians, lack of experience working with clients who have experienced trauma, the fear of not meeting their clients’ needs, and the new development of their professional identity can put them at increased risk for VT (Neumann & Gamble, 1995).
Clinicians’ work environments are another possible professional stressor for VT (Cerney, 1995; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne, 2005; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998; Sinclair & Hamill, 2007). For example, clinicians who are considered experts on working with trauma populations may be assigned all of the trauma referrals an agency receives, which, in turn, creates a large caseload of clients who have experienced trauma. In addition, negative work environments can also include having inadequate space to work or being isolated from other colleagues who work with clients who have experienced trauma. Striking a healthy balance between the time spent at their work environment and their home environment is one way for clinicians to keep perspective concerning the stressors of their job (Cerney, 1995; Salston & Figley, 2003). Additionally, reducing the overall number of hours spent working and decreasing large client caseloads could help clinicians feel less overwhelmed by work pressures (Pearlman & Saakvitne, 1995a, 1995b; Saakvitne, 2005; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998; Sinclair & Hamill, 2007). Given all of the potential professional stressors for VT, it seems essential that clinicians have an awareness of them so they can possibly reduce their risk before being negatively impacted by their clients’ traumatic stories.

**Resilience/Self Care and Vicarious Traumatization**

Considering all of the possible risk factors clinicians face, it is important to understand how clinicians can help protect themselves from VT. The constructs of resilience, vicarious resilience, and self care can aid in understanding how clinicians protect themselves from experiencing the negative consequences of listening to clients’
traumatic material and even help find potential benefits of working with trauma populations. Thus, the resilience and self care literature are important components in understanding how training can aid new clinicians in protecting themselves against VT. In this section, the literature regarding resilience, vicarious resilience, and self care will be reviewed. Below are definitions and descriptions of the constructs of resilience, vicarious resilience, and self care.

**Resilience**

Resilience can be defined as a process that entails clinicians’ ability to adjust when dealing with adverse situations as well as the ability to continue to find satisfaction in their work with clients (Clark, 2009; Hernandez, Gangsei, & Engstrom, 2007; Luthar, Cicchetti, & Becker, 2000; Masten, 2007; Patrick, 2007). The history of resilience seems to be varied and has included researching factors that help protect individuals from experiencing long lasting negative consequence of difficult experiences (Luthar et al., 2000; Masten, 2007; Meyer, 2010; Patrick, 2007). For example, research on resilience has investigated how resiliency is affected by peoples’ level of self efficacy as well as how different characteristics help people to feel balance in their lives (Luthar et al., 2000; Masten, 2007; Patrick, 2007). The importance of resilience lies in how it may provide a possible way for clinicians to learn how to protect themselves from experiencing the potential negative consequences of hearing clients’ traumatic experiences. Thus, the construct of resilience is important in helping to gain a greater understanding of how training can be more inclusive of aiding clinicians in protecting themselves against VT.
Meyer and Ponton (2006) argued that “resiliency in counselors is not an accident. Rather it is the cumulative effect of counselors’ healthy decision making, time-management, positive relationships, continuing education, and maintaining a cogent theory of counseling and a spiritual awareness” (p. 189). Factors that influence clinicians’ resiliency include (a) self care, (b) fulfillment found in work, (c) mindset, (d) culture, and (e) childhood experiences (Meyer & Ponton, 2006; Patrick, 2007). Clinicians’ ability to take care of themselves, such as exercising, meditating, and/or having healthy relationships with others, helps to foster resilience (Meyer & Ponton, 2006; Wicks, 2008). Due to the risk of experiencing VT, researchers report the importance of clinicians not sacrificing their self care in a desire to help their clients (Patrick, 2007; Rothschild, 2003; Saakvitne & Pearlman, 1996). Clinicians’ fulfillment in their work is another factor that influences their resiliency. Fulfillment in work can include appreciating the benefits of therapy with clients experiencing trauma such as seeing clients’ growth toward becoming mentally healthy (Engstrom, Hernandez, & Gangsei, 2008; Hernandez, Engstrom, & Gangsei, 2010; Hernandez et al., 2007). Additionally, fulfillment in one’s work includes an ability to focus on the aspects of the profession that are more positive for clinicians such as advocating for social change (Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998). Clinicians may at times also need to disregard or overlook the aspects of the profession that are either more challenging or less satisfying such as staffing concerns or paperwork (Patrick, 2007).

Mindset is another factor that affects clinicians’ resiliency. Patrick (2007) stated that clinician’s ability to keep their “outlook positive and [their] work, fresh, relevant, and rewarding” (p. 223) enables clinicians to decrease their chances of experiencing VT. In
addition, clinicians who describe their work with clients as challenging, such as working with clients through new and unique obstacles, will also decrease their likelihood of experiencing VT (Patrick, 2007; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998). Clinicians’ culture is another factor that affects resilience. Clinicians’ culture may include different values, beliefs, and characteristics, which are specific to a certain population such as race/ethnicity, family unit, or religious affiliation (Meyer, 2010; Patrick, 2007). Clinicians that describe finding support throughout their cultural connections, such as a church community or extended family connections, have a higher resiliency than clinicians that do not find support in their culture (Meyer, 2010).

Lastly, childhood experiences also affect resiliency. The research conducted on resiliency in children suggests that early environments with negative characteristics, such as abuse or neglect, have harmful consequences to brain functioning and physiological processes (Luthar & Brown, 2007). For instance, negative consequences to brain functioning can include stunted development of neural networks and harmful affects to physiological process may include a child’s adrenal and pituitary glands not fully developing (Luthar & Brown, 2007). In addition, negative environments during childhood can increase levels of aggression, increase the likelihood of depressive symptoms and decrease healthy interpersonal skills, which all have the potential to lead to less resiliency in adulthood (Luthar & Brown, 2007; Russell, Springer, & Greenfield, 2010). This research regarding adults having less resiliency if they experience negative environments during childhood underscores one of the potential risk factors for VT, past personal
trauma, which can impact clinicians’ ability to protect themselves against negative consequences when working with clients experiencing trauma.

**Vicarious Resilience**

Just as researchers have illustrated that counseling clients who have experienced trauma can potentially lead clinicians to experience their clients’ trauma vicariously there is a small body of literature that includes potential benefits clinicians receive when working with survivors of trauma (Engstrom et al., 2008; Hernandez et al., 2007; Hernandez et al., 2010; Sexton, 1999; Sinclair & Hamill, 2007). Sexton (1999) suggested that it is necessary for clinicians to always keep in mind the reasons they chose to work with clients experiencing trauma and not forget the positive aspects that come from working with this specific population, such as helping clients grow and heal regarding their traumatic experiences. More recently, the literature has included the construct Vicarious Resilience (VR), which is the positive responses clinicians may experience when seeing their clients’ resilience or growth in therapy after having experienced a traumatic event (Engstrom et al., 2008; Hernandez et al., 2007; Hernandez et al., 2010). The construct of VR was coined by Hernandez, Engstrom, Gangsei, and their colleagues (2007, 2010; Engstrom et al., 2008) while working with clinicians at the organization, Survivors of Torture, International. Clinicians at the organization described positive experiences regarding their work counseling torture survivors (Hernandez et al., 2007). According to Engstrom et al. (2008) the positive aspects of working with trauma “may be a common and natural phenomenon, as is VT, although the mechanisms by which VT and VR develop are likely to be different” (p. 230). For instance, vicarious resilience includes
“positive meaning-making, growth, and transformations” (Hernandez et al., 2010, p. 72) in clinicians, which come from witnessing their clients’ resilience during the course of working on trauma related concerns. On the other hand, VT is the result of “a transformation in the therapist’s (or other trauma workers) inner experience resulting in empathetic engagement with the client’s trauma material” (Pearlman & Saakvitne, 1995a, p. 31).

Research conducted with clinicians in both the United States and Columbia showed that they reported changes in “their own attitudes, emotions, and behavior” after witnessing clients rise above the traumatic events discussed in counseling (Hernandez et al., 2010). Hernandez and his colleagues (2010) wrote about changes clinicians can potentially experience: focusing on their client’s “healing capacity” (p. 72); appreciating the benefits of counseling; recapturing “hope” (p. 72); reevaluating their own difficulties; appreciating spirituality in regards to “healing” (p. 73); finding and understanding the strength in “community healing” (p. 73); and being involved in social justice activities, such as delivering presentations to the public about trauma concerns in the community. This area of research is just beginning and therefore clinicians may be unaware of the potential benefits of working with clients who have been traumatized. Thus, it may be another important area that needs to be included in training for clinicians.

**Self Care**

Neumann and Gamble (1995) discussed clinicians’ self care as an ethical duty for clinicians; therefore, it seems imperative that they should never discount the importance of having ways to take care of themselves (Chrestman, 1999; Dass-Brailsford, 2010;
Osofsky, 2009; Patrick, 2007; Wicks, 2008). Scholars’ investigation into self care suggested that clinicians need to focus on maintaining active, balanced, healthy, and connected lives (Berzoff & Kita, 2010; Inbar & Ganor, 2001; Tehrani, 2009; Wicks, 2008). Maintaining an active life includes both physical and mental activity. Clinicians need to have a self care plan that includes activities that keep them moving such as mountain climbing, dancing alone/with others, or riding their bike to work. Additionally, clinicians need to find outlets to keep their mind and clinical skills active such as reading professional journals, attending conferences, or promoting clinical discussions during staff meetings (Bride & Figley, 2009; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998). To find balance between professional and personal lives, an important first step for clinicians is to set limits (Berzoff & Kita, 2010; Dass-Brailsford, 2010; Wicks, 2008). For example, clinicians need to work to balance recreational time, spiritual time, and professional time to help them feel at their best (Tehrani, 2009; Patrick, 2007). Along with staying active and finding balance, clinicians need to develop healthy behaviors such as time to journal their thoughts and feelings, engage in relaxation activities, and follow proper nutrition (Dass-Brailsford, 2010; Pearlman, 1999; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998). Additionally, clinicians can maintain healthy behaviors through taking the time to process traumatic material that was heard throughout the day using activities such as meditation, consultation, or supervision (Dass-Brailsford, 2010; Meyer & Ponton, 2006; Neumann & Gamble, 1995; Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998). Another healthy behavior for many clinicians is using humor to process traumatic material (Inbar
Laughter often helps create an outlet for the reactions of working with clients experiencing trauma; however, it is important for clients not to overhear these moments of levity (Meyer & Ponton, 2006; Patrick, 2007).

Lastly, clinicians need to focus on having connections such as a supportive network of family, friends, and colleagues that can help attend to their emotional, psychological, physical, interpersonal, and spiritual needs (Berzoff & Kita, 2010; Dass-Brailsford, 2010; Patrick, 2007; Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998; Radey & Figley, 2007; Wicks, 2008). Creating this supportive network includes building and sustaining relationships, which often takes time and energy. Therefore, clinicians need to be intentional in scheduling these activities such as setting aside time to e-mail colleagues and/or to go out with friends, especially since most clinicians have hectic and busy schedules. Another important way clinicians can build connections and create systems of self care in their professional lives is through mentoring. Mentoring can be defined as having direction, support, and guidance that helps clinicians become and stay effective helping professionals (Patrick, 2007), which is useful for all clinicians. For new clinicians, mentoring may be integral in helping define their professional identity, while also providing a collegial relationship in which to discuss working with trauma and VT. Neumann and Gamble (1995) promoted connections to “encourage trauma therapists to notice and share with others the acts of kindness they witness in everyday life” (p. 346), in hopes of counteracting the traumatic stories they hear. Self care can be challenging for all clinicians due to time and energy constraints. Specifically for new clinicians, it is
important to not create a pattern of neglect regarding self care when first learning how to balance the needs of their clients with their own (Neumann & Gamble, 1995).

A common and reoccurring topic in the self care literature includes clinicians need to have diverse professional responsibilities as well as various personal activities (Bride & Figley, 2009; Dass-Brailsford, 2010; Meyer & Ponton, 2006; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998). For example, clinicians need to include multiple modalities of therapy throughout their work, such as family, individual, couple, and group, as well as work with multiple populations of clients (e.g., trauma and substance abuse). In addition, clinicians need to intersperse other professional activities, such as consultation and teaching, into their professional world (Bride & Figley, 2009; Dass-Brailsford, 2010; Meyer & Ponton, 2006). In addition to clinicians having diverse responsibilities at work, they need to have various personal activities that they enjoy when they are not working. Thus, clinicians need to establish a range of personal activities, such as a balance of family time versus partner time, exercise versus restful activities, and interpersonal relationships versus being alone (Meyer & Ponton, 2006; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998). This balance for clinicians of professional responsibilities and personal activities is a holistic system of self care. Even with this growing understanding of clinicians’ need to incorporate intentional self care into their lives, most professionals do not have an awareness of how self care is integral in preventing VT. Thus, it is essential that we find a way to assess clinicians’ in training awareness and knowledge of how working with clients who have experienced trauma can impact their professional and personal lives.
Research on Vicarious Traumatization

The body of research conducted about VT is still relatively small. The majority of research has focused on responding to clinicians after they have already experienced VT, yet research has also been conducted on combating VT and understanding possible factors that allay VT (Adams & Riggs, 2008; Bober & Regehr, 2005; Harrison & Westwood, 2009; Iliffe & Steed, 2000; Musa & Hamid, 2008; Pearlman & Mac Ian, 1995; Steed & Bicknell, 2001; Ulman, 2008; VanDeusen & Way, 2006; Way, VanDeusen, Martin, Applegate, & Jandle, 2004). What follows is a synopsis of research focusing on the impact and risk factors of VT, ways to combat VT, and possible factors that may alleviate VT. To conclude, a brief summary addresses the need for preventative research regarding VT.

Pearlman and Mac Ian (1995) began investigating the effects of trauma work on clinicians after recognizing that clinicians were being traumatized when working with clients experiencing trauma. Their goal was to assess the effects of trauma work on therapists. The researchers found that length of time doing trauma work and the percentage of clients who are survivors that clinicians counsel contributed to a higher likelihood of experiencing VT. Other contributing characteristics for clinicians experiencing VT included being a therapist with a personal trauma history, having no supervision, and being a novice therapist. Pearlman and Mac Ian argued that new clinicians were more vulnerable to experiencing VT due to their study’s findings that therapists with less work experience reported more difficulties counseling clients’ experiencing trauma. Given these findings, they suggested that clinicians need training
specific to working with traumatic populations as well as the need for additional resources to combat the negative consequences of experiencing VT. Therefore, it seems imperative that clinicians-in-training have an understanding of VT in order to create protective measures.

Since Pearlman and Mac Ian’s (1995) study, further research has been conducted to gain a deeper understanding of VT. Researching the impact of VT on clinicians, Musa and Hamid (2008) found that approximately one fourth \((n = 13)\) of the aid workers in Darfur that participated in the study were negatively impacted by hearing their client’s traumatic experiences of witnessing the genocide in their country. In further research, clinicians impacted by VT reported hypervigilance (Jackson, Holzman, & Barnard, 1997; Rich, 1997; Steed & Bicknell, 2001; Steed & Downing, 1998); changes in how they viewed themselves and/or the world around them (Farrenkopf, 1992; Iliffe & Steed, 2000; Jackson et al., 1997; Rich, 1997; Steed & Downing, 1998); heightened sense of defenselessness (Steed & Downing, 1998); decrease in their self esteem (Rich, 1997); changes in their affect regulation in their professional and/or personal lives (Farrenkopf, 1992; Schauben & Frazier, 1995; Steed & Downing, 1998); isolating behaviors (Farrenkopf, 1992; Rich, 1997; Steed & Downing, 1998); lack of trust in their professional competence (Iliffe & Steed, 2000; Steed & Downing, 1998); and feelings of burnout (Iliffe & Steed, 2000; Jackson et al., 1997; Rich, 1997; Steed & Bicknell, 2001; Wasco & Campbell, 2002).

Research on VT risk factors found that clinicians with more current cases of trauma (Bober & Regehr, 2005; Brady, Guy, Poelstra, & Brokaw, 1999), with more cumulative exposure to traumatic material (Bober & Regehr, 2005; Brady et al., 1999;
Kassam-Adams, 1999; Schauben & Frazier, 1995), with past trauma history (Follette, Polusny, & Milbeck, 1994; Ghahramanlou & Brodbeck, 2000; Kassam-Adams, 1999; VanDeusen & Way, 2006; Way et al., 2007), and who are novices (Adams & Riggs, 2008; Baird & Jenkins, 2003; Bober & Regehr, 2005; Brady et al., 1999; Jenkins & Baird, 2002; Way et al., 2007) indicated a higher likelihood of experiencing VT. Additionally, clinicians who reportedly were younger in age (Adams et al., 2001; Way et al., 2007) and making lower annual salaries (Adams et al., 2001) were found to have a higher risk for VT. Adams and Riggs also found that an unhealthy defense style, “self-sacrificing,” which is represented by being “kind, helpful, and never angry” (p. 28), was another risk factor for VT.

After a deeper understanding of VT began to develop, researchers began to study ways to combat VT. One scholarly article by Clemans (2004) discussed a conceptual working model that incorporated both psychoeducational and therapeutic approaches to combating VT. Clemans created a training session with the purpose of defining and discussing VT as well as allotting time to discuss work-related issues. She also incorporated self-care though the creation of plans to deal with clinicians’ work-related stress. Another scholarly article by Ulman (2008) discussed clinicians reporting some success when attending group debriefing sessions to combat the impact of VT. Furthermore, Everly, Boyle, and Lating (1999) found that debriefings in a group setting were helpful for clinicians to reduce VT symptoms.

In addition to researchers investigating VT for further understanding and possible ways to combat the negative consequences of VT, research was conducted on possible ways to allay VT. Harrison and Westwood (2009) interviewed six “master therapists”
(p. 203) whose work experience with trauma populations ranged from 10 to 30 years. All six therapists “scored below average on the Burn Out and Compassion Fatigue subscales of the Pro-QOL (i.e., self-reports suggested they suffered less burnout and VT than the average practitioner)” (Harrison & Westwood, 2009, p. 207). Harrison and Westwood used a narrative analysis and found nine major characteristics as being helpful to alleviate VT: “countering isolation (in professional, personal and spiritual realms); developing mindful self-awareness; consciously expanding perspective to embrace complexity; active optimism; holistic self care; maintaining clear boundaries and honoring limits; exquisite empathy; professional satisfaction; and creating meaning” (p. 207). To further illustrate, for the area on expanding ones’ perspective and embracing complexity, participants described intentionally thinking of “other ways of viewing life by cueing themselves through self-talk, use of imagery or metaphor, time in nature, or interaction with people in other lines of work, to… counterbalance their skewed perspective on the world” (Harrison & Westwood, 2009, p. 210). Additionally, the area of exquisite empathy included participants’ discussion of how rewarding and energizing empathizing with clients can feel. One of the nine areas also contained a number of sub areas. In the area of countering isolation, the following factors were considered helpful in limiting the potential of VT: participating in regular supervision, attending continued trainings and professional development, creating mentorships, having organizational support as well as creating diverse professional roles, developing personal relationships, and finding spirituality (Harrison & Westwood, 2009). Please see the section on prevention for more discussion of ways to prevent VT.
Given that beginning clinicians and clinicians-in-training may possibly have an even greater risk of experiencing VT (Baird & Jenkins, 2003; Brady et al., 1999; Jenkins & Baird, 2002; Pearlman & Mac Ian, 1995; Salston & Figley, 2003), researchers have made suggestions for training programs to prevent VT as well as suggestions for all clinicians to combat VT, including (a) training on working with trauma populations, (b) VT education, (c) coping mechanisms and self care strategies, and (d) healthy work environments. Many different scholars in the literature discuss the limited or lack of training on working with trauma populations (Courtois & Gold, 2009; Danieli, 1994; Gold, 2004). Given this lack of training, it is not surprising students report that with regards to working with clients’ experiencing trauma, they feel unprepared (Alpert & Paulson, 1990; O’Halloran & O’Halloran, 2001; Pope & Feldman-Summers, 1992). Therefore, overall training on working with trauma populations is essential for beginning clinicians. In addition to training on trauma, Way et al. (2007) found that clinicians-in-training would benefit by having an understanding of VT. Thus, employers and training programs need to educate professionals and students about the potential harm of working with clients who have been traumatized (Pearlman, 1999; Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne, 2005; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998).

Lastly, researchers discussed clinicians need to design healthy work environments (Brady et al., 1999; Meadors & Lamson, 2008; Pearlman, 1999; Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998). Brady and his colleagues (1999) suggested that counseling psychologists working with clients surviving trauma need an emotionally supportive, physically safe,
and consistently respectful work environment. Additionally, clinicians would benefit if organizations set aside time in staff meetings to talk about trauma issues, have mandatory orientation training for all newly hired counselors, as well as include opportunities for continuing education on dealing with the effects of working with trauma clients (Pearlman, 1999; Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998). Healthy work environments also benefit organizations by increased productivity, decreased turnover, and fewer sick days (Meadors & Lamson, 2008). Along with training programs implementing these suggestions, it is imperative that we find a way to assess clinicians’ in training awareness and knowledge of how working with clients who have experienced trauma can impact their professional and personal lives.

**Training/Prevention and Vicarious Traumatization**

Many clinicians have reported that they do not feel they have the skills necessary to work with trauma (Alpert & Paulson, 1990: O’Halloran & O’Halloran, 2001; Pope & Feldman-Summers, 1992). Thus, it is essential for graduate programs to offer skills training on working with clients experiencing trauma. Unfortunately, authors show that these opportunities are often missing (Alpert, 1990; Alpert & Paulson, 1990; O’Halloran & O’Halloran, 2001; Pope & Feldman-Summers, 1992; Sexton, 1999). Below are brief summaries of literature on the training and prevention of VT.
**Training**

Jordan (2002) suggested that graduate training programs have a “responsibility to ensure that students are adequately prepared for the clinical training component of their program” (p. 30). However, according to Gold (2004), “the systematic study of the impact of trauma on psychological functioning is so recent that even the most elementary aspects of the identification, assessment, and treatment of psychological trauma have not been incorporated into the standard curriculum for training professional psychologists” (p. 363). Furthermore, Danieli (1994) argued that “traditional training generally has not prepared professionals to deal with massive trauma…and its long-term effects” (p. 370). Thus, it is not surprising students report that with regards to working with clients experiencing trauma, they feel unprepared (Alpert & Paulson, 1990; O’Halloran & O’Halloran, 2001; Pope & Feldman-Summers, 1992). Given this, it is important to understand how clinicians-in-training can feel prepared to work with the trauma population and prevent the negative consequences that could occur.

Salston and Figley (2003) stated “we have a special obligation to our students and trainees to prepare them for these hazards” (p. 173) of working with clients experiencing trauma. Moreover, Patrick (2007) argued that due to the increased risk for beginning clinicians to be impacted negatively when listening to clients’ traumatic material, “anticipatory preparation though formal education channels is essential” (p. 232). Therefore, “we must do all that we can to insure that those who work with traumatized people…are prepared” (Salston & Figley, 2003, p. 173). To begin, Courtois and Gold (2009) made the suggestion “to include and integrate basic information about trauma
across the entire psychology curriculum” (p. 14). Additionally, graduate programs need to include trauma specific training “in all clinical training courses, all practicum, internships, and externships, in all supervision models, and in research training areas…in an integrated way” (Courtois & Gold, 2009, p. 14). In addition to integrating training on working with trauma populations, VT training for students who will work with clients who have a trauma history is also a necessity (Meyer & Ponton, 2006; Pearlman, 1999; Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne, 2005; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998). O’Halloran and O’Halloran (2001) suggested that to incorporate training on working with clients experiencing trauma and increase clinicians awareness of VT, a safe environment needs to be created in which the class can discuss issues relating to trauma. Patrick (2007) suggested that students who have opportunities to learn about VT develop the ability to incorporate information in how to deal with listening to traumatic material into their professional identity. To be effective clinicians, students need to have an awareness of their own self care strategies so that if they ever experience the negative consequences of working with clients who have experienced trauma they have ways to cope that will help them not negatively impact their clients (Pearlman, 1999; Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne, 2005; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998).

In an article about remaining hopeful when working with trauma populations, Saakvitne (2005) wrote that she had overheard two students discussing their training. One student said:

I had two intense classes today. One is on trauma and the other on crisis intervention—so they’re both about trauma. In both classes today we were talking
about vicarious traumatization. I felt so overwhelmed and traumatized; it was intense. It really helped to talk about it. (p. 47)

Saakvitne’s response to hearing this was “what a change that students are now given a framework to think about their experiences!” (p. 147). It is wonderful to read that some clinicians-in-training are receiving education about VT; unfortunately, not all training programs provide this training. Therefore, training on trauma and the effects of working with trauma populations is necessary for graduate training programs. Additionally, clinicians cannot stop training after they graduate. Training on VT and working with trauma populations (as well as other topics) need to continue throughout clinicians’ careers. A study conducted by Meadors and Lamson (2008) on compassion fatigue illustrated that continued education can increase clinicians’ awareness of compassion fatigue. Equally important, clinicians reported feeling more prepared to prevent it in the future. Additionally, the clinicians reported increased feelings of calmness and peacefulness and decreased stress levels, such as feeling “less tense, jittery, or overwhelmed” (Meadors & Lamson, 2008, p. 33). Thus, the training outcome was twofold: it not only provided knowledge about the construct, but was also a resource for combating the negative consequences of clinicians’ work with trauma populations.

**Prevention**

Since several authors have suggested that beginning clinicians may be more at risk for experiencing VT (Adams & Riggs, 2008; Bride & Figely, 2009; Pearlman, 1999; Pearlman & Caringi, 2009; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne, 2005; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998; Way et al.,
2007), education for new clinicians regarding the effects of working with clients experiencing trauma seems essential to prevent VT. Trippany et al. (2004) discussed six possible ways to prevent VT: (a) decreasing the number of clients experiencing trauma in clinicians’ caseloads, (b) participating in regular supervision, (c) attending trainings focused on working with clients who have a trauma history, (d) having opportunities for professional resources, (e) creating mechanisms to help cope with stress, and (f) developing one’s spirituality.

First, decreasing the number of clients clinicians counsel each week who are working to resolve their traumatic material is one way clinicians can work to prevent VT (Pearlman, 1999; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998). Due to VT being a consequence of an ongoing process of listening to client’s traumatic material, reducing the trauma population that clinicians have on their caseloads allows helping professional to process the symptoms they have experienced from listening to their clients’ traumatic material as well as decreasing the amount of graphic trauma material they are hearing (Patrick, 2007; Pearlman, 1999; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996). Clinicians can also work to prevent VT by participating in regular supervision (Berzoff & Kita, 2010; Bride & Figley, 2009; McCann & Pearlman, 1990; Pearlman, 1999; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996). Whether supervision is individual or group; formal, such as with an identified supervisor; or informal, such as with peers, supervision provides a space for clinicians to consult on difficult cases and process clients’ traumatic material (Berzoff & Kita, 2010; Meyer & Ponton, 2006; Sinclair & Hamill, 2007).
Attending training specific to working with trauma populations is another way for clinicians to prevent VT (Bober & Regehr, 2005; McCann & Pearlman, 1990; Meyer & Ponton, 2006; Patrick, 2007; Pearlman, 1999; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996). Specific training that focuses on working with clients who have a trauma history is an important way for new clinicians to develop an awareness and working knowledge of VT. Thus, clinicians need to seek out educational opportunities, which include situations that provide information on trauma work as well as specific knowledge regarding VT (Pearlman, 1999; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998; Sinclair & Hamill, 2007).

Clinicians can also work to prevent VT by seeking out or being provided professional resources (Bride & Figley, 2009; Meadors & Lamson, 2008; Patrick, 2007; Pearlman & Saakvitne, 1995a, 1995b; Radey & Figley, 2007; Saakvitne & Pearlman, 1996). For example, clinicians report that it is helpful when administrative support is available when faced with various agency demands, such as large caseloads and minimal time for administrative tasks (Sexton, 1999; Sinclair & Hamill, 2007). According to Sexton (1999) and Meadors and Lamson (2008), employers would also benefit by decreasing workloads, offering additional training, and providing professional resources. The workplace is impacted by “decreased productivity, high turnover, and a greater number of sick days needed” (Meadors & Lawson, 2008, p. 26) when clinicians are negatively impacted by working with trauma populations; thus, it is to their benefit to provide such support. Furthermore, Bride and Figley (2009) stated that organizations must acknowledge that negative consequences can occur when clinicians work with
trauma populations, and it is not a weakness of a clinician, but rather an “occupational hazard” (p. 324).

Other possible ways to prevent VT include clinicians creating coping mechanisms and implementing self care strategies (Berzoff & Kita, 2010; Bride & Figley, 2009; Dass-Brailsford, 2010; Osofsky, 2009; Patrick, 2007; Pearlman, 1999; Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne, 2005; Saakvitne & Pearlman, 1996; Tehrani, 2009). Systems of coping for clinicians may include, but are not limited to, meditation, exercising, journal writing, personal therapy, time with family and friends, and/or proper nutrition (Inbar & Ganor, 2001; Patrick, 2007; Pearlman, 1999; Pearlman & Saakvitne, 1995a, 1995b; Salston & Figley, 2003). Another way clinicians may prevent VT is by participating in social justice activities. For instance, clinicians may decide to take political action such as writing letters to advocate for improved mental health legislation regarding funding for traumatic concerns (Pearlman, 1999; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996). Lastly, clinicians can work to prevent VT by developing their spirituality (Harrison & Westwood, 2009; Pearlman, 1999; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996). For example, clinicians can explore what opportunities exist in their community to create spiritual connections, such as attending meditation classes, prayer groups, or Wiccan meetings.

To further help prevent VT, Neumann and Gamble (1995) suggested that workplaces should provide the following opportunities specifically for new clinicians, yet this information could also apply to all helping professionals. First and foremost, employers need to have an atmosphere that does not set up the expectation that beginning clinicians need to know everything and allows them to struggle and learn to accept that there are
many things that they do not know. Clinicians also need to have the ability to take time off work. This is especially important given that the literature stresses the need for clinicians working with trauma to have self care strategies to keep a balanced and healthy lifestyle (Berzoff & Kita, 2010; Bride & Figley, 2009; Dass-Brailsford, 2010; Pearlman, 1999; Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne, 2005; Saakvitne & Pearlman, 1996; Tehrani, 2009). Clinicians also need to have opportunities to continue their professional development, which may include financial support. For example, attending conferences is a way for all clinicians to learn about current research regarding VT and working with clients experiencing trauma (Patrick, 2007). Employers also need to promote clinicians ability to have their own personal therapy (Bober & Regehr, 2005; Saakvitne & Pearlman, 1996), especially considering that therapy for clinicians’ still seems to be stigmatized since many report that they are less likely to see a therapist for their own concerns (Patrick, 2007; Sexton, 1999). Resources, such as journal subscriptions and free consultation, need to be offered and new clinicians encouraged to use them (Neumann & Gamble, 1995; Patrick, 2007). These resources aid new clinicians in developing strategies to cope with the effects of listening to clients’ traumatic material at the outset of their professional career (Neumann & Gamble, 1995). Lastly, continuing education on working with trauma and VT should be encouraged and provided (Courtois & Gold, 2009; Danieli, 1994; Gold, 2004; O’Halloran & O’Halloran, 2001; Pearlman, 1999; Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne, 2005; Saakvitne & Pearlman, 1996). Clinicians can continue learning about working with trauma through reading journals and attending more rigorous training on working with
trauma populations. An open acknowledgment of new clinicians’ hard work also seems paramount to promoting healthy views of their professional competence.

Even with the growth of the prevention literature, there is still a lack of understanding on how to effectively prevent VT (Sexton, 1999; Sinclair & Hamill, 2007; Trippany et al., 2004). Therefore, more research is needed to understand how to effectively prevent VT from occurring (Warren et al., 2003). When prevention is not in place, clinicians find themselves having to work to provide therapy for their clients while trying to manage the negative changes of being traumatized vicariously. Scholars suggest that clinicians need to be able to have an awareness of reactions to listening to their clients’ trauma stories as well as have insight into when they feel emotional, psychological, or physiological symptoms due to hearing clients’ traumatic material (Patrick, 2007; Pearlman, 1999; Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne, 2005; Saakvitne & Pearlman, 1996). Moreover, clinicians need a working knowledge of how to cope with negative changes they experience (Patrick, 2007; Pearlman, 1999; Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne, 2005; Saakvitne & Pearlman, 1996). Clinicians also need to be aware of how many clients experiencing trauma they should have on their caseload, rather than feeling overwhelmed by their clients’ trauma (Sexton, 1999). Given this, the purpose of the present study is to assess beginning clinicians’ awareness and understanding of VT by gathering information from clinicians who are completing their first practicum experience in a university training clinic. In addition, the researcher will implement an intervention to increase awareness and then assess clinician’s level of awareness of VT post intervention.
The following chapter will provide information about the study’s methods. Due to the nature of qualitative research, first person will be utilized by the researcher for Chapters III through V.
CHAPTER III

METHODS

In this chapter, I provide a thorough outline of the methodology for the study. To begin, I present the reader with a brief description of the purpose for conducting the study and the research questions. Next, as this study is a qualitative design, it is important to define qualitative methodology and provide a rationale for its use. This is followed by a brief description of the specific qualitative paradigm: multiple case study. As a case study requires multiple ways of obtaining the data of interest (Creswell, 1998), the next section provides a description of the instruments utilized as well as a brief discussion about my voice. This is followed by a description of the research procedures, which include the following: (a) participants and participant recruitment, (b) sampling criteria, and (c) step-by-step data collection procedures. Next, I provide a description of the analyses to be performed. To conclude, I present a discussion of rigor.

Purpose of the Study

As stated in Chapters I and II there has been very little research that addresses ways to prevent vicarious traumatization from occurring. This lack of research, along with the fact that new clinicians might have an increased risk for experiencing VT when working with clients who have experienced trauma, makes it important to understand the awareness and knowledge of VT of clinicians-in-training. Thus, I planned to learn more
about (a) beginning clinicians’ awareness about VT (ability to define VT and recognize
VT’s symptoms, risk factors, and impact); and (b) their knowledge about VT
(understanding didactic concepts) after receiving training in the symptomology, risks, and
negative consequences of VT. The research questions were: (a) What is the level of
awareness of VT in clinicians-in-training? and (b) What is the impact of a VT training
program on the ability of clinicians-in-training to recognize VT in others?

Qualitative Research

Qualitative research “involves understanding the complexity of people’s lives by
examining individual perspectives in context” (Heppner, Kivlighan, & Wampold, 1999,
p. 235). It is used in many disciplines including the social sciences because there is often
a need to focus on the way individuals make meaning. In essence, because qualitative
research offers the researcher more open-ended ways of collecting and analyzing data, it
can be viewed as offering the researcher a way to understand complex human experiences
more deeply than quantitative research. Shank (2002) defined qualitative research as “a
form of systematic empirical inquiry into meaning” (p. 5). Therefore, the qualitative
researcher can systematically investigate a phenomenon in order to gain an understanding
of that phenomenon. Qualitative research is very useful when examining understudied
areas because it allows for rich and in-depth data collection, which can greatly enhance
the knowledge about the phenomenon being studied (Silverman, 2005).

Regardless of the qualitative method the researcher uses to address a research
question, there are many commonalities among the qualitative paradigms (Bogdan &
Biklen, 2002; Creswell, 1998, 2003; Miller & Salkind, 2002). Some of the ways they may
be similar include: data being gathered in a natural setting, interviews being conducted with participants (Miller & Salkind, 2002), and collected data being descriptive in nature (Creswell, 1998, 2003). Additionally, the actual data collected as well as the manner in which the researcher obtains that data are rich and add to the understanding of the phenomenon. Finally, a researcher attempts to gain an understanding of the issue from the perspective of the participant rather than from one’s own (Erickson, 2005).

**Rationale for Using Qualitative Methodology**

To date, the construct of vicarious traumatization (VT) has been mostly examined from a reactionary rather than a preventative stance (Adams & Riggs, 2008; Brady et al., 1999; Clemans, 2004; Everly, Boyle, & Lating, 1999; Iliffe & Steed, 2000; Jenkins & Baird, 2002; Musa & Hamid, 2008; Pearlman & Mac Ian, 1995; Steed & Downing, 1998; VanDeusen & Way, 2006; Way et al., 2007; Way et al., 2004). This lack of research regarding how to prevent VT from occurring indicates that a more open-ended study of prevention may be beneficial. According to Patton (1980), qualitative research focuses on “open ended” (p. 22) data collection to understand individuals’ situations “in their own terms and in their natural settings” (p. 22), whereas quantitative research focuses on collecting data with standardized instruments that potentially limit the data collected (Patton, 1980, 2002). Moreover, qualitative research allows for a more in-depth and detailed understanding of what is being studied (Creswell, 1998, 2003; Erickson, 2005; Patton, 1980, 2002). The strengths of a qualitative methodology, such as using more open-ended questions regarding awareness level of VT of clinicians-in-training as well as the ability to gain a deeper and richer understanding of how training increases awareness
and knowledge of VT made a qualitative approach the best methodology for the present study. Therefore, I used a qualitative approach to address the research questions.

**Multiple Case Study Design**

In the current study, I used a multiple case study design to address the research questions. According to Creswell (1998), case studies are defined as “an exploration of a ‘bounded system’ of a case (or multiple cases) over time through detail, in-depth data . . . collection involves multiple sources of information rich in context” (p. 61). According to Patton (2002) a case study is useful when the researcher needs to be selective in sampling in order to allow for in-depth study of an understudied construct. Additionally, a multiple case study method is helpful when the researcher is trying to form a study that is “holistic” with more than one perspective (Patton, 2002, p. 447). For example, the present study gained multiple perspectives about awareness and knowledge of VT of clinicians-in-training by having seven participants. Case studies are also “context sensitive” (Patton, 2002, p. 447), which allowed the present study to focus on a context where clinicians were in training (e.g., students in a training practicum course). Case studies also require the collection of in-depth data using multiple methods of data collection (Creswell, 1998, 2003; Patton, 2002). For the current study, multiple forms of data allowed for a richer understanding of participants’ awareness and knowledge of VT. A demographic questionnaire, reflection questions, journals, and interviews were all used for in-depth data collection. In addition to the holistic, contextual, and in-depth data collection strengths afforded by a multiple case study, this method also allowed for an intervention (i.e., psychoeducational workshop on VT) to be implemented. The intervention was an
integral component for the second research question, which included assessing clinicians’-in-training awareness and knowledge of VT post intervention. Specifically, the multiple case study design, sometimes referred to as the collective case study, utilized more than one case to get a richer and more in-depth understanding of VT (Creswell, 2003; Stake, 2006). In the present study, I found the strengths of the multiple case study design an advantage, which allowed for a richer understanding of awareness and knowledge of VT in clinicians-in-training.

Procedures

Participants and Participant Recruitment

In qualitative research, researchers want to understand a construct in an in-depth way, therefore making participant selection critical. According to Morrow and Smith (2000), researchers need to be careful to select participants based on a specific set of criteria because it is important to have a sample that provides participant rich data for analysis. The goal in qualitative research is to seek information rich participant data. This is different from the goal of quantitative research, which is to seek a representative sample of participants. Therefore, within the multiple case study design, the goal is not necessarily large numbers of participants but rather the collection of multiple forms of data from fewer participants with varied descriptions that are in-depth and meaningful (Creswell, 1998, 2003; Patton, 2002; Stake, 2006). In order to ensure the potential for participants to provide rich data, seven data points were utilized in the study. This seemed an appropriate number of data collection points to provide multiple opportunities and
different methods to collect the same or similar types of information about their level of awareness and knowledge regarding VT from participants.

The participants for the current study included seven master’s-level clinicians-in-training enrolled in a beginning practicum course at a medium sized Midwestern university. All seven participants identified as Caucasian, heterosexual females. Ages of six of the seven participants ranged from 24 to 50 years old, with one participant not disclosing her age. Relationship status represented by participants included: married, divorced, partnered, and dating. Two master’s-level academic programs were represented: counseling psychology (CP) and counselor education: community counseling (CE: CC).

To recruit the participants from practicum classes in the two Counselor Education and Counseling Psychology Department training clinics, the Center for Counseling and Psychological Services in Kalamazoo and Grand Rapids, I contacted the clinic directors by telephone and obtained their permission to contact the instructors of record for counseling practicum taking place in their clinics (see Appendix A for the Script for Discussion with Clinic Director). After I obtained the clinic directors’ permission, I contacted the instructors and asked for permission to enter their classrooms to discuss the research study with their students (see Appendix B for the Script for Discussion with Instructor of Record). The total number of instructors contacted in each training clinic was three, for a total of six. Five out of the six instructors gave their permission for me to visit a class session, provide a brief description of the study to their students during class (see Appendix C for Script for Explanation of the Study for Students), and ask for volunteers to participate in the study. Additional details regarding the informed consent
process are included in the step-by-step data collection procedures. Once students agreed to participate, they signed the informed consent document (see Appendix D).

**Sampling Criteria**

To ensure that collected data are meaningful, case study methodology recommends that sampling criteria be established before data collection begins (Patton, 2002). In the present study, the sampling criteria for inclusion included beginning clinicians who were enrolled and participated in a master’s level clinical practicum course in the Center for Counseling and Psychology Services. By having only beginning clinicians in the present study, I am more likely to attain the data to answer my research questions.

**Instruments**

Case studies involve having many sources of data collection (Creswell, 1998, 2003; Patton, 2002; Stake, 2006). As I used a multiple case study design, a number of instruments were utilized to gather data. These instruments included a demographic questionnaire (see Appendix E), clinical case vignette (see Appendix F), reflection questions about the vignette (see Appendix G), journal exercise (see Appendix H), and interview questions (see Appendix I). In addition to the instruments utilized in the present study, an intervention was employed. The intervention used was a psychoeducational workshop on VT (see Appendix J). Below is a detailed description of each of the instruments and the psychoeducational workshop on VT.
**Demographic questionnaire.** The first instrument used for data collection was the demographic questionnaire (see Appendix E). Patton (2002), Creswell (1998, 2003), and Silverman (2005) all support the use of demographic questionnaires in order to gain descriptive data from participants. Gender, race/ethnicity, sexual orientation, and age were queried to assess information concerning specific aspects of participants’ diversity. To get a more complete picture of the participants, other descriptive data gathered included relationship status, current academic program, credit hours completed, number of clients on practicum caseload, trauma issues presented by their clients, and any other previous experience counseling others, either formally (e.g., as a clinician) or informally (e.g., as a colleague or family member), regarding trauma. According to Trippany et al. (2004), three possible ways to prevent VT include participation in regular supervision, continued training focused on working with clients who have a trauma history, and development of one’s spirituality. Thus, three questions included on the demographic questionnaire assessed experiences with supervision, training, and spirituality/religion. The question on supervision was open ended: *Please describe any supervision experiences you have had as a supervisee that have been helpful in your work with trauma survivors.* Questions on training and spirituality/religion were based on a 6-point Likert scale: *Please rate on a scale of 1 to 6 (1 being no preparation and 6 being extensive preparation) how well you feel your academic program has prepared you to counsel those who have been traumatized and Please rate on a scale of 1 to 6 (1 being low impact and 6 high impact) the degree to which spirituality/religion impacts your life.* The final question on the demographic questionnaire addressed the beginning clinicians’-in-training knowledge about VT. Asking about VT on the demographic questionnaire
provided the researcher with awareness about the participants’ initial knowledge of VT. The question regarding VT was the first time in the data collection process that the researcher obtained information about participants’ awareness and knowledge of VT.

**Clinical case vignette.** The clinical case vignette (see Appendix F) was not a data collection instrument by itself, yet was an integral part of the data collection process. Therefore, the clinical case vignette will be described here to provide a context for all data collected regarding the vignette. The development of the clinical case vignette was influenced by the seminal work *Vicarious Traumatization: A Contextual Model for Understanding the Effects of Trauma on Helpers*, by McCann and Pearlman (1990), who described the construct of VT. These scholars argued that it was important to understand the impact VT has on clinicians who work in the trauma field. Moreover, they hypothesized that most clinicians in the trauma field have no awareness of the construct of VT. Given this, the clinical vignette was used in the current study as the central means to obtain information about the awareness clinicians-in-training had regarding the construct of VT.

The clinical case vignette used for the present study was modeled after a clinical case vignette that was presented at the 2008 Great Lakes regional conference by this researcher and her colleagues (Cavanaugh, Davis, Wheeler, Beevers, & McDonnell, 2008). The clinical case vignette consisted of an African-American female clinician, a Caucasian female client, a voice that spoke the clinician’s internal responses to the client’s traumatic material, and a narrator. All of the individuals who created the role-play are clinicians in the mental health field. The clinician in the clinical case vignette was introduced as a beginning clinician who has a master’s degree in counseling and is
working in a private practice in the community. The clinical case vignette began as the clinician read the client referral form, and was followed by a compilation of the first three counseling sessions. The clinical case vignette then fast forwarded to a compilation of the 6th through 8th sessions and concluded by forwarding to the 12th session. The role play included the client’s traumatic story, the clinician’s external responses to the client’s story, the clinician’s internal thoughts to the client’s traumatic stories, and the narrated section of the clinical case. Throughout the clinical case vignette I incorporated VT symptomology, risk factors, and negative impact. For instance, I included four to six examples of specific symptoms from each area of VT symptomology: physiological, psychological, emotional, interpersonal, and foundational. The format for the clinical case vignette included video accompanied with verbatim transcriptions. This format allowed for in-depth processing of the clinical case vignette. It also allowed individuals with blindness or low vision and deafness or auditory difficulties to participate in the study; however, no participants reported having blindness, low vision, deafness, or auditory difficulties.

Due to the vignette being a foundational aspect of rich data collection, the clinical case vignette was analyzed by two professionals who have conducted extensive research in the area of VT and are thus considered experts. They critiqued the transcript of the vignette to make sure that the symptoms, risk factors, and impact of VT were recognizable. They reviewed the above components of VT using an evaluation form I created (see Appendix K). I made a few revisions to the vignette based on feedback from the reviewers. For instance, I created two additional examples of potential risk factors: supervisor stating that he or she had never had a similar case, and the clinician in the
vignette stating that she wished she had gone to an additional training last year. I then created a video recording from the trauma vignette transcript, which was approximately 18 minutes in length. The two experts viewed the video recording of the clinical case vignette to assess that it portrayed accurately the symptoms, risk factors, and impact of vicarious traumatization, and ultimately approved the video recording of the clinical case vignette.

**Reflection questions.** Scholars and researchers have illustrated that beginning clinicians are not trained on the construct of VT or how to work with clients who have experienced trauma (Alpert, 1990; Alpert & Paulson, 1990; O’Halloran & O’Halloran, 2001; Patrick, 2007; Pearlman, 1999; Pearlman & Saakvitne, 1995a, 1995b; Pope & Feldman-Summers, 1992; Sexton, 1999). Clemans (2004) stated that using open-ended discussion and reflection opportunities was a necessary component to combating VT. Additionally, she advocated that this may be an important component to help prevent clinicians from experiencing VT. Therefore, another instrument for data collection was reflection questions (see Appendix G). The function and purpose of the reflection questions was to assess participants’ level of awareness and knowledge of VT. The first set of reflection questions provided an initial assessment about their ability to define VT and describe the symptoms, potential risk factors, and impact of VT, before receiving the intervention. The second set of reflection questions were utilized to assess how level of awareness and knowledge of VT in others was impacted by the training program. The reflection questions were given at two different points in the data collection process, after participants viewed the clinical case vignette during the beginning of the study and toward the end of the study (please see the step-by-step data collection procedures for
more details). When designing reflection questions, especially for use with any under-researched phenomenon (e.g., VT), they need to be open ended to gather as rich data as possible (Creswell, 1998; Patton, 2002). Thus, the reflection questions in the present study consisted of four open-ended questions: (a) *As you think about the clinician and her work with this client, please describe what stood out for you about this case*; (b) *As you think about the clinician and her work with this client, please describe the thoughts and feelings you experienced*; (c) *As you reflect on the clinician’s experience of engaging with the client and her traumatic story, what specifically about vicarious traumatization did you identify*, and (d) *As you reflect on the internal voice of the clinician, please describe the thoughts and feelings you experienced*. The instructions for the reflection questions were: *Please take a few minutes to reflect on the vignette you just watched/read. Please respond to the following reflection questions as thoroughly as possible. There are no “right” or “wrong” answers. All information will be used strictly for the purpose of research and will be kept confidential. Thank you.*

**Journal exercises.** The third instrument that was used for data collection was the journal exercise (see Appendix H). Given that in a multiple case study design it is encouraged that there be multiple data points to attain as much information about the construct as possible (Patton, 2002; Stake, 2006), utilizing a journal seemed like an appropriate tool to aid me in attaining data about participants’ understanding and knowledge of VT. In addition, authors in both the VT and the self-care literature state that journal writing can be used as a coping resource for many clinicians who work with clients who have experienced trauma and VT (Inbar & Ganor, 2001; Neumann & Gamble, 1995; O’Halloran & Linton, 2000; Patrick, 2007; Pearlman, 1999; Pearlman &
Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Salston & Figley, 2003; Strumpfer, 2003). Therefore, the journal exercise had two purposes: (a) to gain rich data collection about the participant’s overall experience in the study, and (b) to provide participants with a self-care resource during the study. The journal exercise was meant to provide each participant with a way to process their participation in the study, such as any reactions they experienced during or after they viewed the vignette. Having the opportunity to process their experience and reactions could have served as an extra precaution to protect against experiencing VT. The journal exercise was distributed at two different times during the data collection process: after the participants first viewed the clinical case vignette, and after they viewed the vignette a second time (please see the step-by-step data collection procedures for more details). Both journal exercises included the following statement on a piece of paper: Please take a few minutes to think about your experience of participating in this study. Use the space provided below to journal any feelings or thoughts that come to mind. There are no “right” or “wrong” answers. Thank you.

**Interview questions.** Kvale and Brinkmann (2009) argued that interviews provide an excellent way to gather data. Thus, in the present study I conducted two separate interviews. The first interview was conducted after the participants viewed the clinical case vignette once and completed the first set of reflection questions as well as shortly after the psychoeducational workshop on VT. Participants were asked to bring their first completed journal to the first interview. The first interview included more general questions than the second interview (see Appendix I). For example, the first question was, Please take a few minutes to tell me what you learned from attending the
psychoeducational workshop. The second interview was conducted at the end of the study and included more in-depth questions about VT. For instance one of the questions was, *Please describe what you have learned about the symptoms of vicarious traumatization, by participating in the study.* The interview questions were constructed utilizing the seminal work of McCann and Pearlman (1990) as a guide.

**VT psychoeducational workshop.** A psychoeducational workshop about VT was presented to the participants (see Appendix J). I designed the workshop to include information regarding the symptoms, potential risk factors, and impact of VT as well as self care. The PowerPoint presentation began with a definition of VT and a description of the VT symptomology. Next, I presented potential risk factors and negative consequences of VT. The workshop concluded with a brief presentation about self care followed by a question-and-answer period regarding all of the material presented.

To begin, I presented McCann and Pearlman’s (1990) definition of VT: “a process through which the therapist’s inner experience is negatively transformed through empathic engagement with a client’s trauma material” (p. 279). VT is not a single occurrence of experiencing a client’s traumatic material, but a collective effect of working over time with a client or many clients who have experienced trauma (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995b). More importantly, VT does not reflect a shortcoming in a therapist, but is a normal risk associated with counseling trauma clients (Pearlman & Saakvitne, 1995a).

VT symptoms I included in the presentation were: (a) physiological, (b) psychological, (c) emotional, (d) interpersonal, and (e) foundational. Physiological symptoms were important warning signs for clinicians, because they illustrated that
clinicians were experiencing consequences due to listening to clients’ traumatic material (Pearlman, 1999; Pearlman & Saakvitne 1995a, 1995b). Examples of physiological symptoms I included were increased heart rate or body temperature, lack of energy, teeth grinding, and increased headaches and/or stomachaches (Pearlman & Saakvitne, 1995a, 1995b; Rosenbloom et al., 1999). Psychological symptoms of VT I discussed included flashbacks to the client’s traumatic story (Rosenbloom et al., 1999) and repeated thoughts about a client (Allen, 2005). I also discussed increased sensitivity to seeing or hearing about violence, hyperarousal, and hypervigilence.

Emotional symptoms of VT discussed included clinicians experiencing increased feelings of fear, sadness, or anger; lack of feelings, such as numbness; and intense feelings, such as extreme sadness (McCann & Pearlman, 1990). Next, I presented interpersonal symptoms of VT. For instance, clinicians who have experienced interpersonal symptoms may have difficulty connecting with others, such as having problems communicating with a partner about what they are thinking/feeling (McCann & Pearlman, 1990; Pearlman & Saakvitine, 1995a). Another example of an interpersonal symptom I discussed was clinicians wanting to isolate themselves from other people in their lives. Lastly, I discussed the foundational symptoms of VT. Foundational symptoms of VT included clinicians experiencing changes in their spirituality, sense of self, or worldview (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a, 1995b). I discussed three examples of foundational changes. First, I described how a clinician may experience an alteration in their belief in family and home being a safe place that offers unconditional love and support. Second, I explained that a clinician may not want to become more intimate with friends/family for fear of getting emotionally wounded.
Third, I described a counselor who believes in God may question how God could allow children to experience emotional, sexual, physical, and verbal trauma.

The risk factors that were addressed included (a) ongoing and repeated work with clients who are experiencing trauma, (b) clinicians’ personal trauma history, (c) present personal situation, (d) lack of supervision, (e) lack of training on working with clients who have experienced trauma, and (f) work environment. To begin, I discussed the potential risk factor of ongoing and repeated work with clients who have experienced trauma. For instance, this risk included repeated and/or ongoing exposure to graphic material, such as hearing about the cruelty people commit against one another (e.g., assault) or the horrors that people face (e.g., witnessing the torture of family members).

Next, I presented information about clinicians’ personal trauma history. I discussed that clinicians may have a tendency to “overgeneralize” (Salston & Figley, 2003, p. 170) their own trauma incidents with those of their clients. I also presented that clinicians’ unresolved personal trauma history being raised, such as memories of childhood abuse, is a risk when listening to clients’ traumatic material (Patrick, 2007; Pearlman & Saakvitne, 1995a, 1995b; Salston & Figley, 2003; Sexton, 1999). Clinicians’ unresolved trauma could be harmful to both clinicians and clients when it impeded the therapeutic process because it prevented clients’ ability to grow when, for example, clinicians focused on their own trauma versus being present with their clients’ concerns (Sexton, 1999).

The next potential risk factor of VT that I presented included clinicians’ present personal situation. According to Pearlman and Saakvitne (1995a), major stressors in clinicians’ lives, such as being pregnant, experiencing relationship difficulties, or dealing with the death of a loved one, could potentially increase their risk of being vicariously
traumatized. Different personal stressors in clinicians’ lives can impact their ability to focus in session and their overall desire to be at work. Lack of supervision was presented as another potential risk factor to the participants. For example, lack of opportunity to discuss difficult clients is one possible professional stressor. The importance of regular supervision when working with trauma is not only a vital professional responsibility for one’s own self care but an ethical duty for some clinicians (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a, 1995b; Salston & Figley, 2003). Lack of training on working with clients who have experienced trauma was the next risk factor I discussed. For instance, having limited or no specific training working with client trauma concerns could lead clinicians to feel confused on the best interventions to utilize with a client who has experienced trauma (Bober & Regehr, 2005; Meyer & Ponton, 2006; Patrick, 2007; Pearlman & Saakvitne, 1995a). Work environment was the last risk factor I presented. For example, negative work environments could include having inadequate work space, being isolated from other colleagues who work with clients who have experienced trauma, or being referred multiple trauma cases due to having training on working with trauma populations.

After the potential risk factors of VT, I presented the possible negative consequences of VT. The negative consequences of VT included the professional and personal aspects of peoples’ lives that may be changed by listening to clients’ traumatic material. Examples of negative professional impacts of VT included experiencing feelings of decreased professional competency, having difficulty empathizing with clients, and limiting the number of clients who have experienced trauma on a clinician’s caseload (Pearlman & McCann, 1990; Pearlman & Saakvitne, 1995a, 1995b). Examples
of VT impacting a clinician’s personal life included personal trauma resurfacing, mental health concerns, parenting issues, and interpersonal difficulties such as divorce (Pearlman & McCann, 1990; Pearlman & Saakvitne, 1995a, 1995b).

The workshop included a brief presentation about self care. Examples of self-care activities included setting boundaries, using relaxation techniques, arranging fun activities/time, practicing meditation, developing a mentoring relationship, developing and strengthening a social network, exercising, eating nutritionally, and developing an awareness of one’s spirituality. The psychoeducational workshop on VT concluded with a short period where students were able to ask questions regarding the material presented.

An expert in the area of VT was asked to critique the PowerPoint presentation of the psychoeducational workshop. I made a few revisions to the presentation based on the feedback. For instance, I added the example, hearing about cruel things people do to one another, to clarify the potential risk factor, ongoing and repeated work with clients who have experienced trauma.

**Researcher’s Voice**

As the current study utilized a multiple case study method, the process of the study is closely linked to and shaped by myself since I served as a critical data collection instrument (Morrow & Smith, 2000). Given this, it is important that I discuss my background, experience, and preconceived ideas or biases about working with clients who have experienced trauma. In addition, it is important that I discuss my awareness and knowledge about VT.
My background as an emerging clinician began during my fourth year of undergraduate education as an intern at the Assault Crisis Center. During my time there, I gained knowledge regarding childhood sexual abuse and the effects of violence on individuals, but it was not until I arrived at my counseling master’s program that I began to learn that listening to clients’ traumatic material impacted clinicians. While interning at a local domestic violence shelter, I experienced directly the impact of listening to clients’ traumatic stories. For instance, I felt myself become more vigilant when I would go out at night and found that I would turn the channel if interpersonal violence was depicted on television. Even with my knowledge about trauma growing and experiences of working with clients who had been traumatized, I still had not heard of the construct vicarious traumatization.

After I graduated from my master’s counseling program, I moved to Ohio and worked in a domestic violence shelter. While working in the shelter, I gained more knowledge regarding counseling clients who had experienced trauma. During this year, I became interested in burnout and how working with clients may more permanently affect clinicians. It was not until I arrived at my doctoral program and had conversations with my colleagues regarding changes clinicians may experience when working with trauma that I gained awareness about vicarious traumatization and the more negative potential consequences clinicians faced when repeatedly listening to clients’ traumatic material. Since my first introduction to VT, I have developed a passion to learn more about the construct of VT and the strategies that clinicians could use to combat and prevent the negative consequence of VT. This passion influenced my bias that VT is a potential consequence for all clinicians who work with clients who have experienced trauma.
Given my background, it is essential that as a researcher I understood how I could potentially have impacted data collection. Given that as the researcher, I am also a data collection instrument for the study (Morrow & Smith, 2000), it is essential that I think about and gain awareness regarding my biases and actively work to keep them from impacting the data collection and data analysis processes. To start this process, I included this section on my voice to begin the discussion about my background as well as my knowledge, preconceived notions, and biases associated with VT. Morrow (2005) discussed that a journal can be a helpful tool to reflect on one’s biases and reactions that exist throughout the study. Thus, I chose to write journal entries that consisted of my opinions and feelings throughout the study to allow for continual reflection of my biases during the data collection and analyses. In practice, I discovered that the journal provided an avenue to write my thoughts and preconceived notions down on paper so that I could look at them several times to consider how they could potentially impact data collection and analysis. It was my attempt to maintain awareness about my specific biases and what was occurring for me throughout the study. I also found that the journal served as a self-care measure to release my own thoughts and feelings. This was particularly helpful given that during this time I was completing my pre-doctoral internship and had a large caseload of clients who had experienced trauma. The differences between their reactions to the trauma material and what I was experiencing in my actual trauma work elicited strong emotional reactions from me. Thus, the journal became an important tool to help me understand the process I experienced while collecting and analyzing the participants’ data. Additionally, it was necessary to build in additional ways to keep any biases from influencing the data; thus, I included a follow-up with participants so they could review
the final narrative summaries for accuracy as well as to provide any additional comments. I also had an outside auditor check for completeness and accuracy of the analyzed data. More information about the follow-up with participants and the auditing process is provided in the data analysis section.

**Step-by-Step Data Collection Procedures**

There were many different contact points with the participants across a 5-week period: recruitment meeting, informed consent meeting where participants completed the demographic questionnaire, two meetings at which participants viewed the clinical case vignette and responded to the reflection questions, a psychoeducational workshop on VT, and two 1-hour individual interviews with each of the seven participants. The reason for the contact points was to obtain data that helped to assess participants’ level of awareness of VT and knowledge regarding the didactic concepts of the psychoeducational workshop on VT, which included VT symptoms, VT risk factors, VT’s impact, and resilience/self care. In addition to the multiple contact points with participants, there were also multiple sources of data collection. These included demographic questionnaires, reflection questions, journal entries, and interview questions. Below are the step-by-step procedures used to obtain the data described above. Please see Table 1 for an outline of the data collection procedures.

**Step 1 of the data collection procedures.** To begin, I obtained Western Michigan University’s Human Subjects Institutional Review Board (HSIRB) approval (see Appendix R).
### Table 1

**Data Collection Procedures**

<table>
<thead>
<tr>
<th>Step</th>
<th>Data Collection Procedure</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Researcher obtained HSIRB approval</td>
</tr>
<tr>
<td>2</td>
<td>Researcher contacted clinic directors</td>
</tr>
<tr>
<td>3</td>
<td>Researcher contacted instructors</td>
</tr>
<tr>
<td>4</td>
<td>Researcher attended class meetings and discussed informed consent process with potential participants</td>
</tr>
<tr>
<td>5</td>
<td>Individuals expressed interest and signed informed consent document</td>
</tr>
<tr>
<td>6</td>
<td>Participants completed demographic questionnaire</td>
</tr>
<tr>
<td>7</td>
<td>Participants viewed vignette and completed first set of reflection questions</td>
</tr>
<tr>
<td>8</td>
<td>Participants received first journal</td>
</tr>
<tr>
<td>9</td>
<td>Participants attended psychoeducational workshop on VT</td>
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<tr>
<td>10</td>
<td>Participants attended first interview and turned in first journal</td>
</tr>
<tr>
<td>11</td>
<td>Participants viewed vignette and completed second set of reflection questions</td>
</tr>
<tr>
<td>12</td>
<td>Participants received second journal</td>
</tr>
<tr>
<td>13</td>
<td>Participants attended second interview and turned in second journal</td>
</tr>
</tbody>
</table>

**Step 2 of the data collection procedures.** After HSIRB approval was obtained, I called the clinic directors to obtain their permission to contact the instructors of record for the counseling practicum that took place in their respective clinics. Additionally, I asked the clinic directors if I could use clinic space to collect data, which included viewing the case vignette, conducting two interviews with each participant, and presenting the
psychoeducational workshop on VT (see Appendix A for the script for discussion with the clinic directors).

**Step 3 of the data collection procedures.** After I received the clinic directors’ approval, I contacted each instructor by e-mail the following day to explain the study and ask for permission to recruit participants from the class (see Appendix B for the script for discussion with instructors of record).

**Step 4 of the data collection procedures.** After I obtained the course instructors’ permission, I attended class sessions the following week to present the study and discussed the informed consent process. During the visit to the classroom to explain the study, the instructor was not present in the classroom. Moreover, I explained that the instructor of record would not be informed by me about who participated and did not participate in the study. Below is a detailed description of the step-by-step procedures of the informed consent process.

I began the recruitment process with a brief introduction (see Appendix C for the script for explanation of the study for students). First, I introduced myself to the class and stated that I was a fourth-year counseling psychology doctoral student at Western Michigan University. Next, I informed potential participants that I was working on my doctoral dissertation and was attending their class to see if anyone was interested in participating in my study. I then informed the potential participants that the study included asking what clinicians-in-training understood about what it means to work with clients who have experienced trauma.

After my brief introduction, I passed out a copy of the informed consent document (see Appendix D) to potential participants and went over it with them. I highlighted
specific aspects of the study and paused to encourage students to ask any questions. The aspects of the study I highlighted included amount of time asked of participants (i.e., 5-6 hours), the duration of the study (i.e., 3-10 weeks), and study activities (e.g., two 1-hour individual interviews, a 45-minute psychoeducational workshop, and two viewings of a 20-minute vignette of a counseling case). I made sure to indicate that the vignette depicted several sessions of a trauma case that involved childhood sexual abuse and was a fictitious role-play. Additionally, I highlighted the limits of confidentiality. The limits of confidentiality included not being able to guarantee ultimate confidentiality when other participants were present; however, I asked all participants to keep confidential information that is shared by others. The consent document contained a detailed description of these areas. While I discussed the specific aspects of the study, I encouraged the potential participants to ask any questions they may have had concerning the specific aspects of the study.

Three areas that I provided more information during my presentation to the class included benefits of participation, risks and costs of participating, and the confidentiality of data. Potential benefits that I discussed participants might experience included (a) having a greater understanding of their awareness of VT; and (b) developing an understanding of the symptoms, risk factors, and consequences of experiencing VT. To aid in providing this knowledge, I indicated that all students who participated would receive an informational packet about VT (see Appendix N) and a list of references (see Appendix O) to gain further knowledge about VT. Although participants were not expected to experience any distress from gaining knowledge regarding the symptoms, risk factors, and negative impact of experiencing VT, I indicated that it was possible that
participation in the study might elicit negative feelings, such as possible thoughts of past trauma. To address this concern, individuals were given a list of resources, at the time of informed consent, which provided mental health services if they chose to address any emotions regarding VT or past trauma (see Appendix L). In addition, I stated that participants would take part in a debriefing session after the final interview, which was an added source of protection for participants. Furthermore, I indicated that they could withdraw from the study at any time.

Next, I discussed that additional protection for study participants included my own as well as my advisor’s knowledge, skill, and experience working with clients who have had traumatic concerns, which would enable us to identify any possible signs of distress. Furthermore, I provided my contact information as well as my advisor’s contact information on the informed consent document (see Appendix D). A cost of participating in the study is the amount of time, which is approximately 5 to 6 hours over a 5-week period. I discussed that to ensure confidentiality of all data collected, I would secure all of the data in a sealed envelope before transporting any paper or electronic files to my advisor’s office, where the data would be securely stored. Additionally, any data that needed to leave my advisor’s office for analysis would be copies of the original paper documents and any identifying information (e.g., name, instructor’s name) would be removed. Lastly, I indicated that all original paper and electronic documents would be kept for a minimum of 3 years in a locked file cabinet in my advisor’s office.

Individuals were invited to express their interest in participating in the study and to do so if they met the inclusionary criteria: beginning clinicians who were enrolled and participating in a master’s level clinical practicum course. In addition, individuals were
asked to carefully consider the content of the study and what was asked of them as a participant, when they made their decision about whether to be involved in the study. Additionally, I encouraged potential participants to not volunteer to be in the study if they believed they had any relationship with me or my advisor that would hinder their ability to take part in the study. Potential participants were informed that they could withdraw from the study at any point along the way. The potential participants were informed that my contact information as well as my advisor’s contact information was located on the informed consent document.

Next, I informed the students that I would be available in a private and confidential room (other than their classroom) to answer any additional questions and to have individuals interested in participating in the study make a commitment to do so and sign the informed consent document. The nature of the class was such that students had the flexibility to seek me out without compromising their confidentiality or privacy. The class format was less structured; students often worked independently and thus were able to take breaks at different times. Any student who expressed an interest in learning more about the study and/or was interested in participating in the study was invited to call me, by 5 p.m. the following day, using the contact information included on the informed consent document. Those who were not interested in participating in the study were instructed to please shred the informed consent document. At the conclusion of the meeting with the class, I provided a list of mental health resources (see Appendix L) to address any mental health concerns that may have arisen from hearing about the topic of trauma.
**Step 5 of the data collection procedures.** Seven students from five different practicum classes expressed interest in participating in the study. Each participant signed an informed consent document (see Appendix D) when meeting with me individually to express their interest for participating in the study. This took place on the day I visited the class to present information about the study.

**Step 6 of the data collection procedures.** Directly after students signed the informed consent document, they were asked to complete the demographic questionnaire (see Appendix E), which took each participant approximately 10 minutes. After each participant signed the Informed Consent Document and completed the Demographic Questionnaire, I asked her for an available time to meet for the next step in the data collection process and scheduled that meeting.

**Step 7 of the data collection procedures.** One week after the completion of the demographic questionnaire, each participant individually viewed a 20-minute clinical case vignette depicting counseling sessions between a clinician and a client who had experienced trauma (see Appendix F). While each participant viewed the clinical case vignette, I was present to attend to any technical difficulties and to ensure that participant’s safety regarding any reaction she might have experienced due to the nature of childhood sexual abuse that was represented in the vignette. At the conclusion of viewing the vignette, each participants was then asked to complete a set of reflection questions (see Appendix G), which took approximately 10 to 15 minutes. After completing the reflection questions, each participant signed up for one of the times during which the psychoeducational workshop would be presented.
Step 8 of the data collection procedures. At the end of the meeting when each participant viewed the clinical case vignette and completed the reflections questions, I handed her the first journal exercise (see Appendix H), which had the following instructions: Please take a few minutes to think about your experience of participating in this study. Use the space provided below to journal any feelings or thoughts that come to mind. There are no “right” or “wrong” answers. Thank you. Each participant was asked to bring the completed first journal exercise to the first individual interview, which was scheduled at the participant’s convenience and held at the clinic where she was recruited.

Step 9 of the data collection procedures. One week later, the participants attended the 45-minute psychoeducational workshop on VT (see Appendix J). Three different options of days/times for attending the workshop were offered to the participants and these were held at the clinic where the participants were recruited. Three participants attended the first scheduled workshop, two participants attended the second scheduled workshop, and two participants attended the third and final scheduled workshop. All of the participants received the same workshop content. The format of the workshop included a didactic PowerPoint presentation on the symptoms, risk factors, and negative consequences of VT (see Appendix J). The didactic component of the workshop was followed by a short period where students asked questions regarding the material presented. I began the workshop with a reminder to all participants that the information shared by the participants would be held confidential by me; however, I informed participants that I could not guarantee ultimate confidentiality due to other participants were present. I then asked all participants to keep confidential any information that was shared by other participants.
Step 10 of the data collection procedures. One week after participants attended the psychoeducational workshop on VT, the first individual interviews were held at the clinic where they were recruited. The individual interviews were approximately 1 hour in length, audio recorded, and included questions designed to assess beginning clinicians’ awareness and knowledge of VT (see Appendix I). The participants turned in their first completed journal exercise at this time.

Step 11 of the data collection procedures. One week after the individual interviews were conducted, participants viewed the clinical case vignette for the second time. The clinical case vignette was the same 20-minute video that depicted counseling sessions between a clinician and a client who had experienced trauma (see Appendix F). While each participant individually viewed the clinical case vignette, I was again present to attend to any technical difficulties and to ensure participant safety regarding any reactions due to the nature of childhood sexual abuse that was represented in the vignette. After a participant observed the vignette, she completed the reflection questions (see Appendix G), which took approximately 10 to 15 minutes.

Step 12 of the data collection procedures. At the end of the session when each participant viewed the vignette and completed the second set of reflection questions, I handed her the second journal exercise (see Appendix H), which had the following instructions: Please take a few minutes to think about your experience of participating in this study. Use the space provided below to journal any feelings or thoughts that come to mind. There are no “right” or “wrong” answers. Thank you. Each participant was asked to bring the completed journal exercise to the second individual interview, which was
scheduled at the participant’s convenience and was again held at the clinic where she was recruited.

**Step 13 of the data collection procedures.** One week later, participants attended the second individual interview. At this time, participants turned in their second completed journal exercise. The second individual interview lasted approximately 1 hour in length, was audio recorded, and included questions that were designed to assess beginning clinicians’ awareness and knowledge of VT (see Appendix I). At the conclusion of the second interview, I conducted a debriefing session (see Appendix M) with each participant, which was also audio recorded. After the debriefing, I confirmed the participants’ contact information and asked for their approval for a brief follow-up asking for feedback of their narrative summary from the single case analysis (see Appendix P for the script for the explanation of the single case narrative member check). Lastly, the participants received an informational packet on the symptoms, risk factors, and negative consequences of VT (see Appendix N); a list of mental health resources (see Appendix L); and a list of references for participants to gain further knowledge about VT (see Appendix O).

**Data Analysis**

The data analysis process has multiple steps: (a) data preparation, (b) single case analysis, and (c) cross case analysis. Below is a description of these steps. To conclude, I provide a discussion of the study’s rigor.
Data Preparation

Creswell (1998, 2003) argued that data preparation is extremely important in a multiple case study design due to the essential component of creating an in-depth and thorough account of the cases being studied. Given this, I created files in Microsoft Word where I transcribed all participants’ interviews to aid in a more accurate analysis of the interview data. Participants’ interviews were transcribed verbatim from the audiotapes. To assess the transcriptions for accuracy, I reread the transcripts twice while I listened to the participants’ taped interviews. While rereading the transcriptions for accuracy, I was able to immerse myself in the data.

Additionally, I created files in Microsoft Word for the demographic questionnaire, reflection questions, and journals. These files were stored on two flash drives to provide a back up copy of the data, which were protected by a password. It is important to note that I omitted any identifying information about the participants (e.g., name, instructor’s name) from the data. Additionally, to protect the participants’ confidentiality, all of the different data points were assigned code numbers and confidential data (tapes and transcripts) were stored in a secure location (i.e., a locked cabinet) when not in use. According to Patton (2002), the next step is to edit the data and eliminate all of the redundant information. Thus, I reread all of the participants’ data, double checked that all identifying information about the participants was omitted and reduced any redundancy, such as deleting “umm” and any repeated words from the interview transcriptions. After I edited all the data, the data preparation was complete.
For the single case and the cross case analyses, both Merriam’s (1998) and Stake’s (2006) guidelines comprised the process of analysis for the present study. As described above, the process began with data preparation. After data preparation was completed, I started the single case analyses.

**Single Case Analysis**

After the data were prepared and organized, I read through the demographic questionnaire, reflection questions, journals, and interview transcripts for each participant to have a greater understanding of the entirety of the data for each individual participant. Stake (2006) described this process as the beginning of the creation of a “picture of the case,” which is then followed by the creation of “a portrayal of the case for others to see” (p. 3). To begin the creation of the single narrative case summary, I created a table of each participant’s data that stood out to me as an important point. After listing the important points for one participant, I then went through the other participants’ data, one by one, to list the important points (Stake, 1995, 2006). To make sure that I did not miss any important points, I read through each of the participants’ data three times. After pulling out important points, I looked for patterns in the points that I then labeled as general research areas. Stake (2006) and Merriam (1998) both advocated developing areas or themes through searching for meaningful pieces of data and patterns of data that seem to signify importance. For each area, the findings that emerged as important seemed to center around a potential research question that summarized that area. According to Stake (2006), research questions help steer the search for understanding and “the report will be structured, in part, around the research questions” (p. 14). When conducting the single
case analysis, I found this organizational approach to be extremely helpful in guiding my understanding of the important findings found from each participant’s data. The areas found during the single case analysis were awareness level of VT, recognition of VT symptoms, recognition of potential VT risk factors, recognition of VT’s impact, and resilience/self care. To accurately portray each of the participant’s voices in the single narrative case summary, I intertwined the participant’s quotations. In other words, I took quotations from each of their data points to create a complete picture for their single narrative case summary reports.

Due to the importance of triangulation in multiple case study methodology (Merriam, 1998; Morrow, 2005; Stake 1995, 2006), which is described in more detail in the section on rigor, I met with an auditor, a doctoral level professional in the counseling psychology field, to discuss the accuracy of my single case narratives. At our first meeting, I gave my auditor a flash drive with all seven participants’ data and discussed the logistics of meeting over the phone during the process of data analysis. To ensure confidentiality of the participants’ data, I rechecked that any identifying information about the participants was removed and that all of the different data points were assigned code numbers. Due to being colleagues from the same doctoral program, the auditor and I have an existing relationship with open communication. I felt comfortable that she would be able to freely point out any inaccuracies of the data as well as any biases she saw impacting the data analysis.

After completing drafts of the narrative case summaries, we scheduled two phone meetings. Both phone meetings lasted approximately two hours in length. During the meetings we discussed each narrative summary, including the areas previously noted, the
summary research questions and the findings that emerged. The auditor fulfilled an important role in the examination of the organizational structure, research questions, and emerging findings. Above all, the auditor came with a fresh perspective that enabled her to identify any errors in the coding and development of the themes as well as notice any bias that may have impacted my coding or generation of areas. My auditor did not notice any discrepancies regarding coding or the development of areas. Therefore, she stated she did not have any recommendations regarding additional areas for the single case narratives; however, she did recommend that further quotations be added to fully illustrate the depth and richness of the participants’ data. I believe that my fear of being repetitive initially made me too cautious in using participants’ quotes. We discussed different ways to add participants’ quotes that would best facilitate further richness in the single case narratives. For instance, one participant had very long quotes that were shortened by replacing sentences with ellipses. We also discussed ways to make each case narrative more of a story of each participant’s journey through the study, which focused on adding transitions rather than simply reading quote after quote. After meeting with my auditor I reread all of the data points for each participant and added relevant quotes for each of the findings to allow for greater understanding of the participants’ voices. After these revisions, I met with my auditor for a follow up phone meeting where she reported the extra quotations added richness. She stated she had no further recommendations for the single narrative case summaries.

Scholars have discussed the importance of participants providing researchers feedback regarding data collected in qualitative studies (Creswell, 1998, 2003; Merriam, 1998; Patton, 2002). Thus, to obtain participants’ feedback and to further check the
accuracy of the single case study analysis, I conducted member checks. At the end of the second interview, I had asked participants if I could contact them in approximately six months to a year to follow up and ask for their feedback regarding the data reports that I would write from their participation in the study (see Appendix P). When asked if they could be contacted for a follow up, all seven participants agreed. All of the participants stated that e-mail was their preferred method of contact and each participant provided me with a phone number in case there were any problems contacting them by e-mail.

Each participant was e-mailed (see Appendix Q) a copy of her single narrative case summary and asked to comment on the accuracy of the case report as well as provide any additional comments regarding the report. Two of the seven participants responded within the first 4 days and reported that the narrative case summaries were accurate representations of their participation in the study and they did not have any additional comments. A second e-mail was sent (see Appendix Q) that asked the remaining five participants to comment on the accuracy of the case report and provide any additional comments they may have regarding the report. Two of the remaining five participants responded within 3 days of the second e-mail and reported that the narrative case summary was an accurate report of their participation in the study. They both stated they did not have any additional comments to add to their reports. The final three participants were called (see Appendix Q) to inform them that the case report was completed and asked the best way to get their feedback on the accuracy of the report. One participant out of the final three participants called later in the day and reported that she had sent the e-mail. She resent the e-mail and I thanked her for her feedback. She reported that she had one comment regarding her narrative case summary:
I was surprised to see you report that I said the most important thing I learned was the definition of VT. I can’t remember my words, but I would say it was very important to learn of the existence of this occupational hazard, what the symptoms are, and how to deal with them, or better yet, prevent them.

I revised her narrative case summary to reflect the comment she provided. An additional participant out of the final three participants e-mailed 2 days following the phone call. She apologized that she had not e-mailed me sooner. She reported in her e-mail that the summary was accurate and that she did not have any comments. The final participant received a second phone call (see Appendix Q) 5 days after the first phone call that informed her that the case report was completed and asked the best way to get her feedback on the accuracy of the report. I received no response from the final participant.

As stated earlier, completing the single case study analysis before the cross case analysis is recommended by multiple authors (Creswell, 2003; Merriam, 1998; Patton, 2002; Stake, 1995, 2006). Given this, I developed each participant’s narrative summary before starting the cross case analysis.

**Cross Case Analysis**

Stake (2006) and Merriam (1998) discussed the importance of immersing oneself in participants’ data before conducting the cross case analysis. Given that I had read each participant’s data multiple times to create each of their single case narrative summaries, I felt immersed in all of the individual participants’ data. To prepare for cross case analysis and feel more immersed in all seven participants’ data, I compiled their narrative case summaries into one Word document. I read all of the case narratives, one directly after the other, which I had not done up to this point in an effort to help keep the participants’
data separate in my mind. Stake stated that the analysis across the cases can be conducted by noticing important points or patterns in the data or by picking out points or patterns from the data that are supported and based on the literature. I chose to analyze the data across cases by picking out the important points or patterns found in the data without restricting my analysis by only looking for points that were supported by the literature. This seemed especially important to allow the participants’ voices to be heard as well as a practical decision due to the lack of literature that discussed awareness and knowledge of VT in clinicians-in-training.

After rereading the narratives, I started to see points among the seven participants’ data that seemed important as well as similar or unique. The areas that I found during the single case analysis were again the most prominent and prevalent patterns that emerged across all seven cases with the exception of one additional pattern, the participants’ responses to the vignette. Stake (2006) discussed using an Excel spreadsheet or a table to further understand what important points from participants’ data fall into a specific theme. Given this, I created tables where I noted potential areas being discussed by each of the seven participants and also included specific participant quotes that were related to the important points found in each area. Stake (2006) advocated that the data then be labeled with regard to relevance to each specific area. Thus, my next step included labeling each of the important points and the participants’ quotations in all of the potential areas as either having a high relevance, medium relevance, or low relevance to the area.

After gaining a greater understanding of the areas regarding the levels of relevance, I saw a similar organizational structure for the potential areas as I did in the
single narrative reports. The areas were originally organized into two categories based on the two research questions, level of awareness of VT and impact of the VT psychoeducational workshop. As I rated the relevance for all of the participants’ data, a third category emerged, participants’ responses to the vignette. For the category, impact of the VT psychoeducational workshop, the same four areas developed as in the single case analysis: recognition of VT symptoms, recognition of potential VT risk factors, recognition of VT’s impact, and resilience/self care. I found these areas helpful to organize the emerged findings across all seven participants’ data. To further help with organizing the emerged findings in those areas, I created tables that illustrated when each participant discussed the different aspect of VT. For instance, the recognition of symptoms table had all five areas of symptoms listed. Under each symptom area, I wrote whether the participant had not discussed the symptom, discussed the symptom before attending the psychoeducational workshop on VT, discussed the symptom after attending the workshop, or both before and after attending the workshop.

At this point in the cross case analysis, I met with my auditor to discuss the accuracy of the emerged categories and areas. The auditor analyzed each of the categories and areas compared with all seven participants’ data to assess for accuracy and completeness. The auditor had no recommendations for revising any of the emerged categories or areas; however, she recommended additional quotations be added to fully support the emerged findings. According to Lincoln and Guba (1985), illustrative quotations from the participants’ data enables others to determine the transferability of results to other settings. In addition, additional quotations help to create a richer and more complete picture of each participant’s data (Stake, 1995, 2006). Therefore, after meeting
with my auditor I reread the narrative case summaries and added additional quotations to provide support for the emerged findings. After these revisions, I met with my auditor for a follow-up phone meeting where she stated she had no further recommendations.

After rating the participants’ data for relevance, Stake (1995, 2006) discussed developing tentative assertions. Stake described that tentative assertions have a single purpose, allowing others to understand the multiple cases using supportive data from the participants. Findings from multiple participants then became a tentative assertion. For instance, all seven participants had findings that illustrated that they described more accurately and clearly VT’s impact after they attended the psychoeducational workshop on VT. Due to the very specific context of the seven cases (i.e., Caucasian, heterosexual females who are master’s level clinicians from counseling psychology or counselor education graduate training programs at a Midwestern university) as well as the limited number of participants, the assertions are very tentative. I had a final meeting with my auditor to discuss the accuracy of the tentative assertions. The auditor analyzed each of the tentative assertions and recommended no revisions.

Rigor

According to Morrow (2005), rigor is an essential component of qualitative research that concerns the quality of the research conducted. Merriam (1998) stated that triangulation, which increases rigor, uses several investigators, different sources of data, and/or additional methods of verifying the findings. Stake (2006) described the purpose of triangulation is “to assure that we have the picture as clear and suitably meaningful as we can get it, relatively free of our biases, and not likely to mislead the reader greatly”
Stake (1995, 2006) discussed that there are many different types of triangulation. Data source triangulation is one type of triangulation where cases remain “the same at other times, in other spaces, or as persons interact differently” (1995, p. 112). Investigator triangulation is another type of triangulation that includes another researcher examining participants’ data. Theory triangulation is a third type of triangulation where participants’ data are analyzed from a different theory. Methodological triangulation is another form of triangulation where a study has multiple forms of data collection.

For the current study, I utilized two different types of triangulation. Methodological triangulation was obtained by having different data collection instruments: demographic questionnaire, reflection questions, journals, and interviews. Data source triangulation was employed by asking participants to complete two reflection questions, journals, and interviews over 5 weeks. Additionally, Stake (2006) described talking with other colleagues throughout the process of data collection and data analysis. I had many conversations with my auditor and my dissertation chair to discuss any discrepancies, limitations, and difficulties as well as to discuss my biases and preconceived notions about VT. I found these conversations to be helpful and I was reminded that research should not be an insular experience (Morrow, 2005; Stake, 2006). Stake (1995, 2006), Merriam (1998), and Morrow (2005) all described another way to enhance a study’s rigor is through obtaining participants feedback regarding the outcome of the analysis. Therefore, I contacted participants (see Appendix Q) after creating the single case narrative summaries to check for accuracy and to elicit any comments the participants had regarding the results of the single case analysis.
Saturation is an extremely important construct in qualitative research that entails investigators illustrating that they have enough rich data to answer their research questions. Bowen (2008) argued the importance of researchers providing a complete picture of saturation which allows the reader to know that all effort was made to gather enough data, “saturation is reached when the researcher gathers data to the point of diminishing returns, when nothing new is being added” (p. 140). Data saturation occurred in the current study when I analyzed participants’ data and found no new or similar findings from participants’ data about the study’s two research questions. For instance, one participant questioned the need for a second journal entry, because she felt she had no additional information to share with me. Given her reaction, it makes sense that data saturation in a multiple case study occurs because of the multiple points of data collection. Therefore, data saturation was confirmed during participants’ feedback after receiving their single case analysis for the member check. In short, none of the participants reported that there were missing pieces to their single case reports. On the other hand, data saturation also became evident in the cross case analysis. During this piece of the analysis I was able to get a full understanding of the research questions based on the patterns that were found across the cases. Perhaps most importantly, saturation was evident because after completing my analyses (single and cross case) no part of my research questions went unanswered.

Generalizing study findings is another construct related to rigor. Lincoln and Guba (1985) describe generalizing study findings to other contexts or cases as transferability. Stake (2006) described that is important to “check carefully to decide how much the total
descriptions warrants generalization” (p. 37). He recommended asking the following questions:

Do your conclusions generalize across other times of day, other times of the year, other years? Do your conclusions generalize to other places? Do your conclusions about the aggregate of these persons generalize to individuals? Do findings of the interaction among individuals in this group pertain to other groups? Do findings of the aggregate of these persons here generalize to a population? (p. 37)

These questions are just a starting point for researchers when thinking about generalizing the findings of their study (Stake, 2006). Merriam (1998) advocated that the reader must be given an accurate and proper description of the case so that she or he may make her or his own decision about generalizing the study’s findings. In addition, Merriam stated that the ability to generalize to other cases is helped if there are multiple cases. Authors in the literature discussed that providing generalizations cautiously is an important piece of a multiple case study (Creswell, 1998; Lincoln & Guba, 1985; Merriam, 1998; Stake, 2006). Therefore, I provided very tentative generalizations with a cautionary note about the very specific context of the study: Caucasian, heterosexual females who are master’s level clinicians from counseling psychology or counselor education graduate training programs at a Midwestern university.

I, being the researcher, am a data collection instrument for the study (Morrow & Smith, 2000). Thus, it is essential that I think about and gain awareness regarding my biases and actively work to keep them from impacting the data collection and data analysis processes. Above, I included a section called Researcher’s Voice to begin the discussion about my background as well as my knowledge, preconceived notions, and biases about VT. For continued reflection of my biases through the data collection and analyses, I wrote journal entries that consisted of my opinions and feelings throughout the
study. Morrow (2005) discussed that a journal can be a helpful tool for a researcher to reflect on one’s reactions and biases throughout the study. In summary, to enhance the study’s rigor I used methodological triangulation, data source triangulation, informal discussions with colleagues, participant feedback regarding single case analysis reports, an external auditor, and a reflective journal throughout data collection and data analysis.

In Chapter IV, I present the study’s findings. In Chapter V, I provide an interpretation of the emerged findings and a discussion of my journal entries throughout the data collection and data analyses processes.
CHAPTER IV

RESULTS

In this chapter, I present a thorough outline of the results of the study. To begin, I provide the reader with a brief description of the purpose for conducting the study and the research questions to be answered. This is followed by a brief review of the instruments participants completed throughout the study. Additionally, the time line of instruments administered to participants is presented to help orient the reader to the study’s different steps. The next section addresses each participant’s findings. Participants’ case studies are presented through narrative summaries, which include quotes intertwined throughout the narrative to accurately portray the participants’ voices. Finally, I present a description of the cross case findings.

Purpose of Study and Research Questions

The purpose of this study was to assess clinicians’ in training awareness and understanding of vicarious traumatization (VT). In addition, I implemented a psychoeducational workshop on VT and then assessed the level of awareness of VT post intervention. I proposed to answer the following research questions: (a) What is the level of awareness of VT in clinicians-in-training? and (b) What is the impact of a VT training program on clinicians’ in training ability to recognize VT in others?
Instruments

The following instruments were utilized to collect data from the participants: a demographic questionnaire (see Appendix E), reflection questions (see Appendix G) about the clinical case vignette (see Appendix F), a journal exercise (see Appendix H), and interview questions (see Appendix I). The participants completed the demographic questionnaire (see Appendix E) at the start of data collection to provide descriptive data. After completing the demographic questionnaire, participants viewed the clinical case vignette (see Appendix F) and answered the reflection questions (see Appendix G). The first journal exercise (see Appendix H) was given to participants to complete after the first viewing of the clinical case vignette. Participants were asked to bring the completed journal to the first interview. Next, the participants attended the psychoeducational workshop on VT (see Appendix J). After participants attended the psychoeducational workshop on VT, I conducted the first interview with each participant. After the participants attended the first interview, they viewed the clinical case vignette a second time and answered the reflection questions. The second journal exercise was given to participants after the second viewing of the case vignette. Participants were asked to bring the completed journal to the second interview. I conducted the second interview for participants after they viewed the clinical case vignette the second time.

The research intervention was the psychoeducational workshop on VT (see Appendix J). The workshop included a presentation of the symptoms, risk factors, and negative consequences of VT. The workshop concluded with a brief presentation about self care followed by a question-and-answer period regarding all of the material.
presented. The VT symptoms that the researcher included in the presentation were:
(a) physiological, (b) psychological, (c) emotional, (d) interpersonal, and (e) foundational.
The risk factors addressed included: (a) ongoing and repeated work with clients who are
experiencing trauma, (b) clinicians’ personal trauma history, (c) present personal
situation, (d) lack of supervision, (e) lack of training on working with clients who have
experienced trauma, and (f) work environment. The negative consequences of VT
discussed included the professional and personal characteristics of peoples’ lives that are
changed by listening to clients’ traumatic material.

Single Case Analysis

According to Creswell (1998), single case analysis includes presenting
participants’ data into emerging themes called “direct interpretation” (p. 154). Therefore,
below I provide narrative case summaries that emerged directly from each participant’s
data. An interpretation found across participants’ cases is presented in the cross case
analysis. In the following chapter, I will present a discussion of the results found in the
single case and cross case analyses.

The narrative case summaries begin with a brief synopsis of each of the
participant’s background information. Examples of background information included are
participants’ race, sexual orientation, age, relationship status, academic program, trauma
issues addressed with practicum clients, and trauma issues addressed with others, either
as a clinician, colleague, or family member. I have also included within the background
information three questions regarding training, spirituality, and supervision. According to
researchers and scholars, participation in continued training focused on working with
clients who have a trauma history, development of one’s spirituality, and regular supervision are all important components in preventing VT (Patrick, 2007; Pearlman, 1999; Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne, 2005; Saakvitne & Pearlman, 1996; Trippany et al., 2004). Thus, I have reported the participants’ answers to three questions on the demographic questionnaire that focused on training, spirituality, and supervision. The first two questions regarding training and spirituality/religion were based on a 6-point Likert scale: Please rate on a scale of 1 to 6 (1 being no preparation and 6 being extensive preparation) how well you feel your academic program has prepared you to counsel those who have been traumatized and Please rate on a scale of 1 to 6 (1 being low impact and 6 high impact) the degree to which spirituality/religion impacts your life. The last question regarding supervision was an open-ended question: Please describe any supervision experiences you have had as a supervisee that have been helpful in your work with trauma survivors.

After presenting the participants’ background information, I have included direct interpretations from the following five areas: (a) awareness level, (b) recognition of VT symptoms, (c) recognition of VT risk factors, (d) recognition of VT’s impact, and (e) resilience and self care. For each area, the findings presented will be preceded by a research question that summaries that area. Stake (2006) stated that research questions help steer the search for understanding and believed that “the report will be structured, in part, around the research questions” (p. 14). When conducting the single case analysis, I found this organizational approach to be helpful in guiding my understanding of the findings found from each participant’s data. One area, awareness level of VT, included participants’ ability to define the construct of VT and recognize VT in others. The
following three areas, recognition of VT symptoms, recognition of VT risk factors, and recognition of VT’s impact, included the participants’ description of the specific characteristics of VT. The final area, resilience and self care, included the participants’ description of possible ways clinicians can protect themselves from experiencing the negative consequences of listening to clients’ traumatic material. All participants were assigned an alias to maintain their confidentiality and anonymity. To present as much of the participant’s voice as possible, quotations are intertwined throughout each case.

**Sam**

**Background**

The participant Sam self-identified as a Caucasian, heterosexual, married female. She discussed she felt uncomfortable disclosing her age. Sam was a master’s level student in a counseling psychology academic program. At the beginning of the study, she had completed 42 out of a total 48 semester hours.

Sam reported that during her practicum training she counseled two clients, eight and seven sessions, respectively. Both of her clients discussed sexual, emotional, and physical abuse as issues they wanted to address in counseling. Sam stated that she had never previously counseled others, formally (e.g., as a clinician) or informally (e.g., as a colleague or family member), regarding trauma. Sam was asked to answer three questions on the demographic questionnaire that focused on training, spirituality, and supervision. Sam responded with a rating of 2 when she reported that she felt her academic program had included little preparation to counsel clients who had experienced trauma. She
responded with a 1 when she indicated that spirituality/religion had a minimal impact on her life. Sam did not list any experiences when asked on the demographic questionnaire to describe supervision experiences that had been helpful in her work with trauma survivors.

**Findings that Emerged**

**Awareness level of VT.** The research question for awareness level of VT was:

*Can Sam define VT and recognize the symptoms, risk factors, and impact of VT in others?*

At the start of data collection, Sam reported on the demographic questionnaire that she had no awareness of VT. When Sam completed the demographic questionnaire, she did not answer the question, *How do you define vicarious traumatization?* In her first journal, after she viewed the clinical case vignette, yet before she attended the psychoeducational workshop on VT, she wrote about her feelings and thoughts of participating in the study. She expressed that she “didn’t know the term vicarious trauma or even that such a reaction had a name.” Sam also wrote in her first journal entry that she had thought about VT with regard to her own client experience:

I visited a psychologist sometimes and as we have gotten to know each other better, she has shared bits of her life with me. At first I was astonished that someone who had experienced quite a bit of trauma herself was strong enough to do the job she did, or that she would want to… I am not sure [how] she keeps from absorbing vicarious trauma.

Sam discussed in her first interview, which occurred after she viewed the vignette once and attended the psychoeducational workshop on VT, that she had not had any coursework that covered VT. After she attended the psychoeducational workshop on VT,
Sam’s awareness level changed. During the first interview she discussed characteristics of VT, such as “vicarious trauma is cumulative” and that VT may have long-term effects, which she indicated she was not aware of before attending the psychoeducational workshop on VT. Sam also wrote in her second journal that the “presentation gave me something new to worry about, but it also prepared me to think about this phenomenon [of VT] ahead of time and find ways to recognize [vicarious trauma] as it sneaks up behind me.” During the second interview, which occurred after she attended the psychoeducational workshop on VT and viewed the clinical case vignette twice, Sam stated “learning about [vicarious trauma], learning the definition” was the most helpful part of the study. When Sam was contacted for comments on the accuracy of her case report after the initial rough draft of her case, she stated:

I was surprised to see you report that I said the most important thing I learned was the definition of VT. I can’t remember my words, but I would say it was very important to learn of the existence of this occupational hazard, what the symptoms are, and how to deal with them, or better yet, prevent them.

She described the above quotation as a more accurate description of what she found to be the most helpful part of the study.

**Recognition of VT symptoms.** The research question for the recognition of VT symptoms was: *Can Sam describe the symptoms (e.g., physiological, psychological, emotional, interpersonal, and foundational) of VT?*

After the first viewing of the clinical case vignette, Sam wrote in her reflection questions that she was surprised that the clinician in the clinical case vignette had an emotional reaction of “shock and horror” after the client in the vignette described her traumatic experiences. Additionally, in her first journal entry, which she completed before
she attended the psychoeducational workshop on VT, she wrote a similar statement that she was surprised that the clinician in the clinical case vignette had a strong emotional reaction when hearing the client’s story. After she attended the psychoeducational workshop on VT and viewed the vignette twice, Sam listed in her second set of reflection questions the physiological (e.g., “physical symptoms”), psychological (e.g., “having flashbacks and nightmares”), interpersonal (e.g., “withdrawing from peers and husband”), and foundational (e.g., “questioning faith”) symptoms that she observed the clinician in the clinical case vignette experience.

During both the first and second interviews Sam discussed the importance of the foundational symptoms. For instance, she stated that she was surprised and unclear why the counselor in the clinical case vignette started to see the “whole world was traumatized.” During the last interview, Sam was again able to talk about different physiological, psychological, interpersonal, and foundational symptoms. When she discussed the physiological symptoms, Sam described that clinicians felt different physical symptoms, but was unable to list any specific examples of physical symptoms. The psychological symptoms she described the clinician in the vignette experiencing included “taking her work home in her mind and worrying about it” and “having flashbacks and nightmares.” Interpersonal symptoms included that the clinician had no “support” and was “withdrawing from other people.” Sam also discussed that the clinician in the vignette did not want to go to a “movie with her husband” that featured a mother’s children being taken away. “Doubting everything in the whole world and doubting her faith” as well as “feeling unsafe in the world” were foundational symptoms that she saw portrayed in the clinical case vignette. “Disillusioned with the whole world”
was another foundational symptom that Sam described the clinician in the vignette experienced. After attending the psychoeducational workshop on VT, it seemed that Sam was able to discuss VT symptoms in more depth and provide more specific examples.

**Recognition of VT risk factors.** The research question for the recognition of VT risk factors was: *Can Sam describe the risk factors (e.g., ongoing and repeated work with clients who are experiencing trauma, clinicians’ personal trauma history, present personal situation, lack of supervision, lack of training on working with clients who have experienced trauma, and work environment) of VT?*

When Sam answered the first set of reflection questions regarding the vignette, which were completed before the psychoeducational workshop, she wrote about three potential risk factors of VT. She listed that the clinician in the clinical case vignette did not “educate herself about [the] phenomenon of child abuse” and did not seek supervision to help her work with the details of the client’s trauma. She indicated that it surprised and irritated her that the clinician in the clinical case vignette did not make any attempts to get additional training while the clinician worked with the client. Sam also wrote about a third potential risk factor for VT regarding a clinician who had experienced previous trauma. For example, Sam questioned if “younger girls’ fresh new lives will leave them enough strength to do this work more easily, without drinking in too much hurt” or if a clinician who has experienced trauma in her personal life may have the advantage due to having “been tested” and “survived.” This question of a “young” clinician versus a “tested” clinician appeared personally relevant to Sam since she disclosed that she felt she was a more “tested” clinician having experienced personal trauma. Sam did not provide any information related to the kind of personal trauma she had experienced.
During the first interview, which occurred after she viewed the vignette once and attended the psychoeducational workshop on VT, Sam discussed one of the same risk factors that she listed on her reflection questions before she attended the workshop, lack of training. For example, she stated how “unprepared the counselor [in the vignette] was… [she] really needed to educate [herself] on how to work with trauma.” Sam also discussed the potential risk factor of having experienced trauma and expressed that she worried about her own risk. She described feeling surprise and worry that she may meet many of the potential risk factors that were presented in the workshop. She stated she felt “like [she was] in a pretty high risk category, so it was sobering.” In Sam’s second journal, which she wrote after she viewed the clinical case vignette twice and attended the psychoeducational workshop on VT, she continued to reflect on her own personal trauma history in relation to VT. She concluded her journal with the following statement: “I feel like the cumulative aspect [of having experienced trauma] is going to be a big negative for me” and something important to consider in the future.

In the last interview, which occurred after she attended the psychoeducational workshop on VT and viewed the clinical case vignette twice, Sam described in more detail different potential risk factors for VT. When she discussed lack of training for the clinician in the vignette, she mentioned the clinician in the clinical case vignette “just waded in, did not go to her computer or her library or her professional journals.” Sam thought the counselor’s lack of training was apparent since the clinician in the vignette stated, “I wish I [had] taken that training;” Sam stated she was irritated that the clinician in the vignette wished she had more training. Sam’s response to the clinician in the vignette regarding training included: “Well… do something about it.” Sam also discussed
the clinician’s lack of supervision. She stated that the supervisor’s response of never having heard of being affected by hearing traumatic material felt like he “dropped the ball,” and yet, Sam seemed taken aback that the clinician did not seek any other supervision or consultation. Sam also discussed the importance of people in the counselor’s work environment. She stated that the clinician in the vignette did not receive support at work from her colleagues. In addition, Sam continued her discussion of a counselor’s personal trauma history as a possible risk factor for VT and her concern regarding her own past trauma. For instance, Sam proposed the following question, “Am I more vulnerable because I have already been traumatized?” about her own experiences of personal trauma. Sam was able to identify potential risk factors before she attended the psychoeducational workshop on VT, yet it seemed that after attending the workshop she was able to discuss in more depth the same factors as discussed previously as well as identify additional unique potential risk factors for VT.

**Recognition of VT’s impact.** The research question for the recognition of VT’s impact was: *Can Sam describe the impact (e.g., personal and professional) of VT?*

Sam discussed the impact of a clinician’s work when she answered the first set of reflection questions, which occurred after she viewed the vignette the first time yet before she attended the psychoeducational workshop on VT. She stated that the clinician in the vignette was not effectively helping the client due to the reactions she experienced after hearing the client’s story: “her personal fears and close involvement [with the details of the client’s traumatic story] were preventing her from working effectively.” After she attended the psychoeducational workshop on VT, Sam wrote about the impact of working with clients that have experienced trauma. For instance, a negative professional impact
that affected the counselor in the vignette included her refusal to counsel “similar clients.” During the first interview, which occurred after she viewed the vignette once and attended the psychoeducational workshop, Sam correctly described the impact VT has on clinicians as part of her participation in the study. She stated that VT can have a negative impact on clinicians. She expressed that clinicians may be very affected and therefore not empathize or be able to connect with their clients. During the second interview, which occurred after she viewed the vignette twice and attended the psychoeducational workshop on VT, Sam discussed many different personal and professional consequences of VT. Negative personal consequences of a clinician who experienced VT could include feeling “mentally traumatized” by the details of a client’s traumatic story and feeling “super depressed.” Additionally, she stated VT “can screw up your home life.” Sam described professional consequences of VT could include a clinician “distancing” themselves from a client as well as “shutting off their ability to give empathy.” Sam stated that clinicians may even be forced to “give up their career over [VT].” After attending the psychoeducational workshop on VT, it seemed that Sam was able to discuss in more depth the negative personal and professional consequences of VT.

**Resilience and self care.** The research question for resilience and self care was:

*Can Sam describe possible ways that clinicians can protect themselves from experiencing the negative consequences of listening to clients’ traumatic material?*

Throughout the study’s activities, Sam briefly discussed different ways that self care can be viewed. Before she attended the psychoeducational workshop on VT, she wrote in her first journal that her own therapist had “good support,” and “was able to leave her work at work most of the time.” Additionally, she wrote that her own therapist
discussed that she had activities that she enjoyed outside of her work interests. Sam wrote her second journal entry after she viewed the vignette twice and attended the psychoeducational workshop. She stated in that journal entry how important her own support system is for her own self care: “If I am going to survive. That is if I ever get a job, I need to be sure I have colleagues to talk to” as well as “good support” from family and friends. When she concluded her last interview, which occurred after she viewed the vignette twice and attended the psychoeducational workshop on VT, Sam described that self care should begin “when you start being a counselor… so that you have supportive and knowledgeable people around you.” She also discussed that she believed clinicians should do activities that they “enjoyed doing” instead of “waiting until they get upset about something.” Sam indicated clinicians need to work to prevent VT rather than having to manage the negative consequences of VT.

Taylor

Background

Taylor self-identified as a 50-year-old Caucasian, heterosexual, married female. Taylor was a student in a counselor education: community counseling academic program. At the beginning of the study she had completed 37 out of 48 total semester hours.

Taylor reported that she had seen two clients during her practicum training, seven and two sessions, respectively. One of her clients reported that loss related to a traumatic event was a concern that needed to be discussed in counseling. The other client did not report having any issues related to trauma. Taylor stated that she had previously
counseled others, formally (e.g., as a clinician) or informally (e.g., as a colleague or family member), regarding childhood sexual abuse. Taylor was asked to answer three questions on the demographic questionnaire that focused on training, spirituality, and supervision. Taylor chose a rating of 3, medium level of preparation, when she described how well she felt her academic program prepared her to counsel clients who had experienced trauma. She chose a 5 when she answered that spirituality/religion had an important impact in her life. Taylor did not list any experiences when asked on the demographic questionnaire to describe supervision experiences that had been helpful in her work with trauma survivors.

Findings that Emerged

Awareness level of VT. The research question for awareness level of VT was:

*Can Taylor define VT and recognize the symptoms, risk factors, and impact of VT in others?*

At the start of data collection, Taylor reported on the demographic questionnaire that she had no awareness of VT. Taylor defined VT on the demographic questionnaire as “multiple smaller events that pileup (sic) and negatively affect the client.” When she completed her first journal entry before she attended the psychoeducational workshop, Taylor wrote that understanding about VT is “worthwhile” and that clinicians need “to be aware of this information [about VT] in advance of its need.” At the beginning of the first interview, which occurred after she viewed the clinical case vignette once and attended the psychoeducational workshop on VT, Taylor had difficulty defining VT and tried to define “vicarious,” which confused me, because it seemed she actually defined the word
spontaneous. She then combined that definition of spontaneous to counseling clients who have experienced trauma to define VT.

Vicarious without looking at a dictionary just means wildly out there, springing on you all of a sudden… People who need help have [experienced] trauma unexpectedly and that unless they had tools in their toolbox won’t know how to handle it and will need help.

As the first interview continued Taylor also discussed her hopes that she would be able to identify VT in herself in order to combat any issues: “[she] hopes that [she] would recognize [vicarious trauma] in [herself] when it happens because sometimes you don’t see [VT]…[VT] is like the slippery slope.” During the last interview, which occurred after she had viewed the clinical case vignette twice and attended the psychoeducational workshop, Taylor stated that her participation in the study “made [VT] more real” and she more accurately described the construct of VT, “easy to transfer trauma from one to another and that in being helpful we put ourselves out there and risk being hurt.”

**Recognition of VT symptoms.** The research question for the recognition of VT symptoms was: *Can Taylor describe the symptoms (e.g., physiological, psychological, emotional, interpersonal, and foundational) of VT?*

After she viewed the clinical case vignette once, Taylor wrote that the counselor in the vignette “developed personal issues in that one client’s motherly abilities could be universal.” For instance, Taylor further described that the clinician in the vignette believed that one “bad” mother who abused her children could mean that all mothers may hurt their children. Additionally, she wrote that the clinician in the vignette “wondered what kind of world her child would be born into” after she heard the client’s story of generational childhood sexual abuse. After Taylor attended the psychoeducational
workshop on VT and viewed the clinical case vignette the second time, she wrote in her reflection questions that the clinician in the clinical case vignette had experienced changes in the way she viewed the world due to having heard the client’s traumatic story.

During the second interview, which occurred after Taylor attended the workshop on VT and viewed the clinical case vignette twice, she discussed how the clinician in the clinical case vignette saw the world around her change: “it expanded… to her community” and her “symptoms… went from personal to global.” Taylor described that she observed the clinician in the vignette “withdraw from her spouse and friends” as an additional interpersonal symptom of VT. Before Taylor attended the psychoeducational workshop on VT, it seems that she could only describe the foundational experiences she observed the clinician in the clinical case vignette experience. After she attended the psychoeducational workshop on VT, Taylor described in more depth the foundational symptom of experiencing changes in the way the clinician in the vignette viewed the world as well as the interpersonal symptom of the clinician in the clinical case vignette withdrawing from the people around her.

**Recognition of VT risk factors.** The research question for the recognition of VT risk factors was: *Can Taylor describe the risk factors (e.g., ongoing and repeated work with clients who are experiencing trauma, clinicians’ personal trauma history, present personal situation, lack of supervision, lack of training on working with clients who have experienced trauma, and work environment) of VT?*

When Taylor answered the first set of reflection questions, which were completed after she viewed the vignette the first time, yet before she attended the psychoeducational workshop on VT, Taylor listed lack of supervision as a possible risk factor. During the
first interview, which occurred after she attended the psychoeducational workshop on VT and viewed the clinical case vignette once, Taylor discussed her disappointment in the clinician in the vignette, who acted as a passive professional rather than actively seeking the information and support she felt she needed to work with her client. Taylor also stated that she was frustrated the clinician did not go “to the library” or continue to educate herself in any way. Additionally, Taylor discussed that a clinician may experience a “risk of transference” from having heard the details of a client’s traumatic story as a potential danger of ongoing and repeated work with clients who have experienced trauma.

After Taylor attended the psychoeducational workshop on VT and viewed the vignette twice, she listed three possible risk factors: lack of training, “untrained supervision,” and a change in worldview (e.g., “the belief all families are safe places”) on the second set of reflection questions. During the last interview, which occurred after she attended the psychoeducational workshop on VT and viewed the clinical case vignette twice, Taylor discussed two different potential risk factors. She strongly stated that clinicians should not work with clients they are not trained to work with proficiently. Another risk factor that Taylor discussed was being “unsupervised” when a clinician counsels a client who has experienced trauma. She stressed the importance for all clinicians to find “good” supervision. After attending the psychoeducational workshop on VT, Taylor was able to discuss in more depth the one potential risk factor she discussed previously as well as identify additional unique potential risk factors for VT.

**Recognition of VT’s impact.** The research question for the recognition of VT’s impact was: *Can Taylor describe the impact (e.g., personal and professional) of VT?*
After Taylor attended the psychoeducational workshop on VT and viewed the vignette twice, she listed on the second set of reflection questions two possible negative consequences of working with clients who have experienced trauma. First, she described a negative impact on her “personal life, her family life.” Second, she indicated that a clinician’s “ability to work with a client” in a competent manner would be negatively impacted. During the last interview, which occurred after she viewed the vignette twice and attended the psychoeducational workshop on VT, Taylor discussed how the client’s “trauma could invade a person’s life and affect them in ways they might not recognize right away.” The clinician “then gets more involved to the point where [VT] is out of control unless it is taken care of,” impacting both a clinician’s professional and personal life.

**Resilience and self care.** The research question for resilience and self care was:

*Can Taylor describe possible ways that clinicians can protect themselves from experiencing the negative consequences of listening to clients’ traumatic material?*

In the first interview, which occurred after she viewed the vignette once and attended the psychoeducational workshop on VT, Taylor discussed the value of finding healthy ways to cope with hearing clients’ traumatic stories. During the last interview, Taylor discussed the importance of self care, stating, “we have to protect ourselves and by talking to others about [VT] and being supervised or going to therapy for what we are going through in our own practices.” In the first interview, Taylor spoke more generally about self care, whereas in the last interview she identified a few specific examples of ways clinicians can cope.
Chris

Background

The participant Chris self-identified as a 39-year-old, Caucasian, heterosexual, married female. Chris was a master’s level student in a counseling psychology academic program. At the beginning of the study she had completed 42 out of a total 48 semester hours.

Chris reported that during her practicum training she had worked with three clients for six, four, and four sessions, respectively. A presenting concern that one of her clients discussed wanting to address in counseling included physical and emotional abuse perpetrated by past husbands. Chris indicated that her other two clients did not present any trauma-related issues. She reported that she had previously counseled others, formally (e.g., as a clinician) or informally (e.g., as a colleague or family member), regarding physical and emotional abuse. Chris was asked to answer three questions on the demographic questionnaire that focused on training, spirituality, and supervision. Chris selected a 4 on the Likert scale, medium preparation, when she indicated how well her academic program prepared her to counsel clients who had experienced trauma. She selected a 6, indicating that spirituality/religion has had a significant impact in her life. Chris did not list any experiences when asked on the demographic questionnaire to describe supervision experiences that had been helpful in her work with trauma survivors.
Findings that Emerged

**Awareness level of VT.** The research question for awareness level of VT was:  
*Can Chris define VT and recognize the symptoms, risk factors, and impact of VT in others?*

At the start of data collection, Chris wrote on the demographic questionnaire that she had no awareness of VT. She defined VT on the demographic questionnaire as “witnessing abuse/trauma of others and being adversely affected.” She later described in the first interview that at the start of the study she incorrectly believed that VT was a potential client concern. Chris wrote in her first journal regarding her feelings and thoughts of her participation in the study after she viewed the vignette once, yet before she attended the psychoeducational workshop on VT. She indicated that she was “grateful” for a “heads-up” that her personal history of traumatic experiences may increase her risk of experiencing VT in the future. Chris discussed her own personal trauma history during the first interview, which took place after she had watched the first vignette and attended the psychoeducational workshop. She described that she had witnessed her “mother being abused” by her father as well as her brother being “abused at school by peers” due to being diagnosed as “autistic.” Chris described that she grew up in “a very hateful environment.” She discussed that due to her childhood she was not surprised by the client’s traumatic story of childhood sexual abuse. Chris also discussed how glad she was that she had been introduced to the construct of VT during the study since it was not on her “radar at all that vicarious traumatization was an issue for counselors.” She reported that she first believed that vicarious trauma was a construct
related to a client’s experience and expressed surprise and worry that VT was something that affected clinicians who counseled clients who had experienced trauma.

My first thought was that it had to do with clients and you could miss things that a client is dealing with because they were not the actual sufferer and so you would dismiss it… so I was thinking it was more of an issue of the client being at risk of the counselor not being aware of vicarious traumatization… that was a little surprising to me like oh wait a minute this is about the counselor, it is not about the client. So then I thought “ooh” it does expose my vulnerability and I do not necessarily like being vulnerable so… I need to be aware that when trauma is filtered through the human condition it has potential to do damage and as I am a human… I am vulnerable to [VT].

She expressed gratitude at the “heads up” and discussed how “helpful” it was to know what she “should be looking out for” as well as possible “steps to make sure that [she] can either have an accountability supervisor or just be aware that the trauma load could impact [her].” Chris mentioned several times throughout the interview how important it was for clinicians, herself specifically, to have an awareness of VT and know the possible risk that exists. At the end of the first interview, Chris reiterated how glad she was to have heard the “term vicarious traumatization” and that she now knows that “this is something that really does happen” and can therefore prepare herself to the effects of hearing traumatic stories in the future. After she attended the psychoeducational workshop, Chris wrote that she “believes [she] will be less vulnerable to experiencing vicarious trauma now that [she] is armed with an understanding of [VT’s] origins and symptoms” when she described her feelings and thoughts of her participation in the study in her second journal entry.

During the last interview, which took place after she viewed the vignette twice and attended the psychoeducational workshop, Chris stated the most helpful part of the study was that she gained an understanding that VT is a concern for clinicians to be aware
of instead of a possible client concern. She further discussed how helpful it was to realize that it is important for her to focus on her “well being,” and to not “take one for the team and go in and do whatever [she] can for the client” without thinking about her own mental health. She stated, “I felt like that was a good perspective change” for my future healthy well being.

**Recognition of VT symptoms.** The research question for the recognition of VT symptoms was: *Can Chris describe the symptoms (e.g., physiological, psychological, emotional, interpersonal, and foundational) of VT?*

After she viewed the vignette the first time, yet before she attended the psychoeducational workshop on VT, Chris reported she had strong reactions regarding the clinician in the clinical case vignette. She wrote in her first reflection questions:

>[The] clinician seemed to have her feelings involved with the case from the beginning, first making statements about how the mother couldn’t be guilty, families are safe for children and then progressing to being sure of her guilt, which led to [the clinician’s] anger.

Chris also listed several symptoms she witnessed the clinician in the clinical case vignette had experienced. She described that the clinician in the vignette experienced changes in her interpersonal relationships, such as she “began to withdraw from her husband and other social contacts and activities in her life.” Chris also listed one psychological symptom. For example, Chris observed the clinician in the clinical case vignette was “bothered by intrusive thoughts about the case.” In addition, Chris reported that she noticed the clinician in the clinical case vignette experienced “fears associated with her own children and their safety.”
During the first interview, which occurred after she viewed the vignette once and attended the psychoeducational workshop, Chris identified a number of symptoms the clinician in the clinical case vignette experienced. She described that the clinician in the vignette expressed worry about her children being in a world where parents sexually abuse their children and had a great deal of “fear with respect to her kids.” Chris stated that she believed the clinician in the vignette was “being negatively impacted.” She also noticed the clinician in the vignette withdrew from the relationships in her life, and stated “she did not feel like going out to social gatherings” and exhibited “some isolation behaviors.” Chris also discussed that she had her own fears that she would have also experienced “changes in my relationships” and “in my mood” after she heard the client’s traumatic story.

After Chris viewed the vignette twice, she wrote in the second set of reflection questions that the clinician in the clinical case vignette was affected by the client’s story regarding her own children and their safety. She also repeated again that the clinician’s interpersonal relationships were affected; “the counselor began to want to isolate herself from those close to her.” During the last interview, which occurred after she viewed the vignette twice and attended the psychoeducational workshop, Chris discussed in more detail a number of similar symptoms previously discussed. For instance she described foundational symptoms that she recognized the clinician in the vignette had experienced, “black and white thinking” and to “label everything… good or bad or evil.”

Chris discussed in depth the difficulties as well as her disappointment with the clinician in the vignette applying labels to the client. She described that she felt the clinician was “trying to slap judgment and labels on the world in general” as well as the
client who “did not meet her expectations.” Chris also stated that the clinician in the clinical case vignette seemed fearful that the “bad situation is actually going to make its way into her own life.” In addition to the clinician’s worries about her children’s safety, Chris also reported that the clinician experienced “intrusive thoughts” and “nightmares” regarding the details of the client’s traumatic story. Finally, Chris discussed how the clinician in the vignette isolated herself from others, which she described as “the biggest danger” due to her strong belief that “through connection with others” is how counselors “stay stable.” Therefore, if clinicians are isolated from their support network, Chris described it as “cutting… off from the lifeline” that exists to help them “unpack” the difficulties of hearing a client’s traumatic story and “processing it.” Chris strongly believed all clinicians need a strong support network in their lives that they utilize to stay healthy and “sane.”

**Recognition of VT risk factors.** The research question for the recognition of VT risk factors was: *Can Chris describe the risk factors (e.g., ongoing and repeated work with clients who are experiencing trauma, clinicians’ personal trauma history, present personal situation, lack of supervision, lack of training on working with clients who have experienced trauma, and work environment) of VT?*

During the first interview, which occurred after Chris viewed the vignette once and attended the psychoeducational workshop, she commented on her own personal trauma history and the risk that potentially comes from having experienced trauma. For instance, she stated that her “relationship that [she has] already experienced with trauma and with other peoples’ trauma is a backdrop on which [her] clients’ relationships with trauma will be filtered.” When she answered the second set of reflection questions, after
she viewed the vignette the second time and after she attended the psychoeducational workshop, Chris wrote about the possible risk factors of the clinician in the vignette not having had good supervision or co-workers that were able to help the counselor process the client’s traumatic story. For example, “her supervisor and fellow counselor did not do a good job in identifying her VT or supporting her.” Additionally, the clinician “kept focusing on the fact that she wished she were better trained for such a case” yet the clinician did not “seek out such assistance.”

During the last interview, which occurred after she viewed the vignette twice and attended the psychoeducational workshop, Chris observed several similar potential risk factors when she described the clinical case vignette. She observed that the clinician in the vignette had a “lack of good supervision.” The clinician was “blown off” by her supervisor after she sought help when she experienced VT symptoms. Second, Chris discussed how the clinician did not receive support from her co-workers and stated with emphasis “what a pathetic support network that was.” Next, she described that the clinician did not have “appropriate training working with people with trauma” and that lack of training can put a clinician at risk for experiencing VT. Fourth, she discussed the risk of “having past trauma” or “having similar trauma that [has not been] worked through.” Chris also discussed the possible difficulties with being a new counselor who does not know how to deal with hearing issues of trauma as well as “seasoned counselors” who are known to be trauma specialists and therefore have a “whole caseload” of clients who have experienced issues related to trauma. Chris correctly stated that both extremes, no experience with trauma and repeated exposure to trauma, add potential risk for clinicians who hear clients’ traumatic stories. Overall, Chris discussed
that all clinicians are possibly “at risk” for VT. Towards the end of the last interview, Chris discussed more systemically how she felt about the clinical case vignette and work environment for clinicians:

I feel sorry for the counselor in the vignette because she clearly doesn’t feel like she knows where to turn and I would hope that the system could work better for specifically new counselors… I watched the vignette and then was thinking I hope the system works better than that for [a counselor] who is in trouble.

**Recognition of VT’s impact.** The research question for the recognition of VT’s impact was: *Can Chris describe the impact (e.g., personal and/or professional) of VT?*

During the first interview, which occurred after she viewed the vignette once and attended the psychoeducational workshop, Chris stated she watched the clinician in the vignette make “real decisions… in her life on a day to day basis that specifically arose from the information that is being shared in the client session,” such as not going to the movie with her husband or wanting to cancel date night, which “put meat” on understanding how clinicians may be impacted by VT. Chris discussed that “depending on the topic, the actual subject matter of the trauma, and the counselor’s history and some intertwining of those two things the counselor can be impacted in all kinds of ways” due to the complexity of VT’s impact.

In the last interview, Chris described a possible impact of VT included “limiting yourself professionally” if clinicians feel that they are unable to work with clients who have experienced trauma. It can also impact clinicians’ “career path.” For instance, a clinician who goes into the field wanting to work with trauma and then finds they are being impacted by hearing the details of a client’s trauma story may decide they are unable to work with client’s who have experienced trauma. Chris stated VT’s impact was
“potentially great to both” a clinician’s “professional life and personal life” when she concluded her last interview.

**Resilience and self care.** The research question for resilience and self care was:

*Can Chris describe possible ways that clinicians can protect themselves from experiencing the negative consequences of listening to clients’ traumatic material?*

At the end of the first interview, which occurred after she viewed the vignette once and attended the psychoeducational workshop, Chris discussed different ways clinicians need to utilize self care. She expressed the importance of “debriefing” either with “a supervisor or a peer.” Additionally, she described the importance of self care for clinicians:

I think good self care in general is always important whether you are mothering or counseling or dealing with your own past trauma or specifics about your counseling. I think that self care is always necessary and that self care looks different for different people and in different seasons of life… but counselors need to always have the self care piece.

In the second interview, Chris reiterated that self care is so important because clinicians “are susceptible” to VT when hearing clients’ trauma stories because hearing the details of clients trauma “impacts the human condition.” Therefore, the system needs to “make sure that people hear” clinicians when they have stated they are “struggling and make sure [other people] don’t just gloss over or disregard [their] concerns,” but rather hear the need for “peer support or supervision.” Another vital element to self care that Chris identified was having “a good support system when… struggling” and not being alone with the difficult things that may have been shared by a client.
Background

Lee self-identified as a 46-year-old Caucasian, heterosexual, divorced female. Lee was a master’s level student in a counseling psychology academic program. At the beginning of the study she had completed 54 semester hours; 48 semester hours are required by her academic program.

Lee reported that during her practicum training she had seen two clients, six and eight sessions, respectively. She expressed no issues of trauma were discussed by either of her two clients. She reported that she had previously counseled others, formally (e.g., as a clinician) or informally (e.g., as a colleague or family member), regarding physical, verbal, emotional, and childhood sexual abuse. Lee was asked to answer three questions on the demographic questionnaire that focused on training, spirituality, and supervision. Lee chose a rating of 4, medium preparation, when she described how well she felt her academic program prepared her to counsel clients who had experienced trauma. She chose a 6 indicating that spirituality/religion has had a significant impact in her life. Lee did not list any experiences when asked on the demographic questionnaire to describe supervision experiences that had been helpful in her work with trauma survivors.

Findings that Emerged

Awareness level of VT. The research question for awareness level of VT was:

*Can Lee define VT and recognize the symptoms, risk factors, and impact of VT in others?*
At the start of data collection, Lee wrote on the demographic questionnaire that she had heard of the concept of VT while taking a one-credit Post Traumatic Stress Disorder (PTSD) Course. However, when completing the demographic questionnaire she did not answer the question, *How do you define vicarious traumatization?* When Lee wrote in her first journal about her feelings and thoughts of her participation in the study after she viewed the vignette once, yet before she attended the psychoeducational workshop on VT, she wrote the study “gave [her] some things to watch for to assure that [her] clients received the best service possible without endangering [herself] as [she] tried to help [her] clients work through trauma.” She also wrote about her “plan to specialize in trauma” and stated that she hoped to learn information about VT that would help her “avoid some of the pitfalls” of counseling clients who have experienced trauma. Before attending the psychoeducational workshop on VT Lee had some awareness of the construct of VT; yet, she did not define VT on the demographic questionnaire.

During the first interview, which occurred after she viewed the vignette once and attended the psychoeducational workshop, Lee stated that the workshop made her “start thinking that it was a possibility that [clinicians] could be traumatized in this way.” She stated that previously she questioned the construct of VT: “Wow, is that possible that [clinicians] can be traumatized by something that happened to someone else?” She later described that she felt the vignette and the workshop “opened up [her] mind to the possibility that [vicarious trauma] can happen.” Lee not only discussed how she felt the study had “opened me up to explore the possibility” of VT impacting clinicians, but also made her want to look at the possible ways “we can prevent [VT] from happening.” In addition to increasing her awareness of the construct of VT, Lee discussed the importance
of VT being “studied” and how that helped diminish her feelings of “insecurity or inability to be a good therapist” because VT is not “a personal weakness” but rather a possible side effect for any clinician who empathically connected with a client who had experienced trauma. To conclude the first interview Lee stated that it seems very important the field “prepare clinicians” for the possibility of VT.

In her second journal entry, she wrote about the feelings and thoughts she had while she participated in the study. She specifically wrote about what she experienced after having viewed the vignette twice and having attended the psychoeducational workshop. Lee described she had “some anxiety about the things [she] may hear about in therapy and how they may affect [her] well being.” Lee wrote that she “was of the opinion that if [her] clients could go through these traumas the least [she] could do was listen to their stories and not be affected. I now wonder if that will be possible” which concluded her second journal entry.

During the last interview, which occurred after she viewed the vignette twice and attended the psychoeducational workshop on VT, Lee described the two main lessons she took away from the study. The first lesson included that she gained some “self knowledge… that [she] may hear some things that are tough for [her].” The second lesson included that she understood that clinicians can be traumatized by listening to trauma stories. She described she had “an unrealistic expectation that [she] should be big enough and strong enough to be able to handle whatever [she] heard and that maybe that was not a healthy perception.” She discussed that this was a lesson that may take some time for her to fully absorb. She also discussed how important it was for her to remember that VT is not a “personal weakness,” but rather a potential impact of hearing a client’s traumatic
story. She also discussed that the study helped her to see “that therapists and helping individuals can be traumatized by the trauma cases they hear about and can affect them in their lives and in their own well being.” She talked about how important it was to “watch out for” symptoms of VT and find interventions “that we can use to prevent” vicarious trauma.

**Recognition of VT symptoms.** The research question for the recognition of VT symptoms was: *Can Lee describe the symptoms (e.g., physiological, psychological, emotional, interpersonal, and foundational) of VT?*

During the first interview, which occurred after Lee viewed the clinical case vignette once and attended the psychoeducational workshop, she focused on one symptom of VT that she was most surprised by, a clinician having a flashback of the client’s traumatic story. She questioned “how could [a clinician] have a flashback about vicarious traumatization?” After she viewed the vignette and attended the workshop, she expressed that she was able to see that a clinician could have a flashback after having heard the client’s traumatic story: “Sure enough if I was traumatized by what I heard I could flash back to it.” After she viewed the vignette twice and attended the psychoeducational workshop, Lee stated on her reflection questions several psychological, interpersonal, and foundational symptoms that she observed the clinician in the vignette had experienced. For example, she wrote she witnessed the clinician “lose some of her joy in life” and also started “to obsess about the case in an unhealthy way.” Lee indicated that hearing the client’s traumatic story was potentially damaging for the clinician in the vignette due to the clinician’s “excessive worry not only about the client’s children, but about her own.” She also wrote that the counselor’s “home life and
relationships” were affected when she counseled her client. Lee stated that “the clinician was not prepared to deal with the issues that were presented and they threatened her worldview and security,” which was clearly a concern for Lee, who expressed concern at the clinician’s lack of training.

During the last interview, which occurred after Lee attended the psychoeducational workshop on VT and viewed the clinical case vignette twice, she discussed different psychological and emotional symptoms, such as “nightmares” and feeling “worried or scared.” Lee also reported how in the clinical case vignette the clinician heard her client’s traumatic story, which “affected her other relationships” and “her life” such that “she took the problems that were presented to her and made them about her life and the people in her life.” Lee described how the clinician heard the client’s traumatic story and related it “directly to what was going on with her,” such as “hearing about children when she was pregnant” and “about children when she had small children” as two examples of foundational symptoms of VT. After attending the psychoeducational workshop on VT, Lee discussed different VT symptoms as well as provided specific examples.

**Recognition of VT risk factors.** The research question for the recognition of VT risk factors was: *Can Lee describe the risk factors (e.g., ongoing and repeated work with clients who are experiencing trauma, clinicians’ personal trauma history, present personal situation, lack of supervision, lack of training on working with clients who have experienced trauma, and work environment) of VT?*

After she viewed the vignette the first time, Lee listed two main risk factors that she observed in the vignette: lack of training and lack of supervision on her first set of
reflection questions. Lee wrote that the counselor’s lack of necessary supervision and training made the clinician “unable to be effective.” During the first interview, which occurred after she viewed the vignette once and attended the psychoeducational workshop, Lee stated that the clinician in the vignette “needed some additional training and supervision.” After she viewed the vignette the second time, Lee wrote she felt an additional risk factor was the clinician’s present state of “pregnancy” as well as having a young child. Both potential risk factors “interfered with her effectiveness” because the clinician was too focused on how her children could be safe living in a world where people sexually abused children.

During the last interview, Lee discussed three additional potential risk factors. She described that working with “trauma a lot of the time or being a trauma specialist” could be considered a “danger.” Lee also indicated “problems… in [clinicians’] lives that need to [be] dealt with” which may also increase clinicians risk for VT, though she could not think of any specific examples of problems. In addition, Lee stated that a personal trauma history may also be a potential risk factor of VT. After attending the psychoeducational workshop on VT, Lee seemed to be able to discuss in more depth the two potential risk factors she discussed previously as well as identify additional unique potential risk factors for VT.

**Recognition of VT’s impact.** The research question for the recognition of VT’s impact was: *Can Lee describe the impact (e.g., personal and/or professional) of VT?*

After she viewed the vignette the first time yet before she attended the psychoeducational workshop on VT, Lee wrote in her first reflection questions that the clinician was being professionally impacted. For instance, she stated “she missed
opportunities to connect” with the client. Additionally, Lee stated that the counselor “was only able to focus on being afraid and judgmental.” During the last interview, which occurred after she viewed the vignette twice and attended the psychoeducational workshop, Lee discussed both professional and personal impacts of VT. She stated that vicarious trauma “can interfere with your life.” Lee strongly believed that clinicians “need to watch out for [VT]” and be aware of how one reacts to hearing their clients’ trauma stories. She discussed that if a clinician specializes in trauma, they need to be aware of any VT signs so they can continue “helping people with trauma” and be “available” as a trauma specialist. A more personal impact included a person’s outlook on the world. Lee stated that VT may facilitate a person’s “feelings” to become “hardened.” Lee stated clinicians need to be able to “still help people without traumatizing” themselves when she concluded her last interview.

**Resilience and self care.** The research question for resilience and self care was:

*Can Lee describe possible ways that clinicians can protect themselves from experiencing the negative consequences of listening to clients’ traumatic material?*

Lee wrote in her first journal about her feelings and thoughts of her participation in the study, before she attended the psychoeducational workshop on VT, that she “liked hearing that if [she] was affected by the trauma [she] heard, it is not a personal weakness, just a side effect of dealing with trauma on a regular basis.” Lee also wrote about specific self care strategies that she believed clinicians should utilize. She described counselors need to “set appropriate boundaries” with clients and utilize “relaxation” techniques. Lee did not discuss any specific relaxation techniques. Additionally, she discussed “additional
training and supervision and mentoring as needed” as important factors for clinicians to continue to seek throughout their career.

In the first interview, which occurred after she viewed the vignette once and attended the psychoeducational workshop, Lee reiterated how important it was for her to learn that VT was “not [her] fault and it [was] not a weakness.” Previously, Lee described VT “was going to be a personal failing if [she] wasn’t strong enough to handle” hearing clients’ trauma stories, because if “people are strong enough to go through these problems [she] should be strong enough to listen.” Lee discussed that one of the important components to preventing VT was to employ self care strategies and stated that she “knew to do self care.” Lee also discussed similar specific self care components that were in her first journal entry. For example, clinicians need to set “good boundaries” and to have “a way for them to process the trauma” that a clinician has heard. In her second journal entry, Lee wrote that one self care strategy for herself would be “peer consultation.” Additionally, she listed that all clinicians need to reflect on “self care and how to process these traumas” so that they will be “better be able to help” their clients.

Alex

Background

Alex self-identified as a 24-year-old Caucasian, heterosexual, married female. Alex was a master’s level student in a counselor education: community counseling academic program. At the beginning of the study she had completed 39 out of a total 48 semester hours.
Alex reported that during her practicum training she had seen one client for eight sessions who reported wanting to discuss issues of childhood abandonment. She reported that she had previously counseled others, formally (e.g., as a clinician) or informally (e.g., as a colleague or family member) regarding sexual assault, physical, verbal, and emotional abuse. Alex was asked to answer three questions on the demographic questionnaire that focused on training, spirituality, and supervision. Alex responded with a rating of 2 when she reported that she felt her academic program had included little preparation to counsel clients who had experienced trauma. She responded with a 4 when she described how spirituality/religion has impacted her life. Alex did not list any experiences when asked on the demographic questionnaire to describe supervision experiences that had been helpful in her work with trauma survivors.

Findings that Emerged

**Awareness level of VT.** The research question for awareness level of VT was:  

*Can Alex define VT and recognize the symptoms, risk factors, and impact of VT in others?*

When Alex completed the demographic questionnaire, at the start of data collection, she wrote that she had heard about VT in recent readings that were assigned by a course instructor. She defined VT on the demographic questionnaire as “trauma suffered by a clinician as the result of hearing and reliving a client’s experience during the course of therapy.” In contrast, during the first interview, which occurred after she viewed the vignette once and attended the psychoeducational workshop, Alex stated that she had not “heard the term [VT] before” she participated in the study. When asked what she
knew about VT during the first interview, after she had attended the psychoeducational workshop on VT, she responded that she would define the construct as “some sort of traumatic feelings by a therapist” and that she felt she had a “general thought of what it” was. Additionally, Alex described that she had learned a lot of new information from the workshop presentation that she was not aware of before the workshop. Alex stated the study helped her have a “more concrete” and “broader” definition of VT. In addition, she also discussed that she felt “a little worry” that VT might be “a problem in the future” she may face. When Alex wrote in her second journal about her feelings and thoughts of participating in the study after she viewed the vignette twice and attended the psychoeducational workshop, she indicated that she “felt more aware of how trauma can affect therapists.” She expressed during the second interview that “an awareness of [vicarious trauma], that VT exists” was one of the important messages she learned from her participation in the study. Alex’s awareness level of VT seemed unclear because she stated that she had some awareness regarding the construct of VT at the start of data collection; however, she also indicated that she had no awareness of VT during the first interview.

**Recognition of VT symptoms.** The research question for the recognition of VT symptoms was: *Can Alex describe the symptoms (e.g., physiological, psychological, emotional, interpersonal, and foundational) of VT?*

After she viewed the vignette the first time yet before she attended the psychoeducational workshop on VT, Alex completed the first set of reflection questions and wrote about the symptoms of VT she witnessed the clinician in the clinical case vignette experience. For instance, she described three different interpersonal symptoms,
which included the counselor “withdrawing from friends,” “not wanting to spend time with her family,” and not wanting to go to a movie that featured “a mother having her children removed.” Alex also reflected that the clinician in the clinical vignette questioned “how safe are families.” She expressed that she “identified with the clinicians questions about ‘how safe are families’ after she heard the client’s story” of generational childhood sexual abuse.

During the first interview, which occurred after Alex viewed the vignette once and attended the psychoeducational workshop on VT, she continued to discuss the symptoms she observed the clinician in the clinical case vignette experience. For instance, she observed the clinician get “angry towards the end.” Alex also discussed that she observed the clinician in the vignette felt “guilt” that the client’s story was “horrible.” Furthermore, she stated:

When [a clinician] works with a client who has trauma and are really hearing their story and trying to be completely there with them, [the clinician] can start to feel some of those things [described by the client], mixed with [a clinician’s] own feelings.

Toward the end of the first interview, Alex also discussed that she observed the clinician in the vignette have flashbacks as well as the clinician felt “overwhelmed.”

After Alex viewed the vignette the second time, she reported in her second set of reflection questions that she noticed how the clinician in the vignette was “so disgusted and troubled by this case.” She wrote that she witnessed the “physiological reactions (dizziness and feeling sick) from hearing specific details” of the client’s traumatic story. Alex also wrote about interpersonal symptoms of VT that she witnessed the clinician in the vignette experience, such as “socially withdrawing from her friend and husband
“canceling plans)” as well as “becoming overprotective as a parent.” In addition, Alex listed that the clinician could not “stop think[ing] about the client” and seemed to have feelings of “anger/disgust toward the client.” Another symptom of VT Alex observed from the vignette was how the clinician worried about her children’s safety due to having heard the client discuss that she sexually abused her own children. For instance, the clinician “wonders if her kids are even safe because of people like [her client] out there.”

Alex described that she “identified with the clinician’s growing (throughout the vignette) mistrust for people.” When she wrote in her second journal about her feelings and thoughts of her participation in the study after she attended the psychoeducational workshop, Alex stated,

> After watching the video last week and then working with my normal clients I felt more drained than normal. I normally was not tired after my usual sessions, but last week I was. I just felt kind of heavy even though all I had to do was watch the video.

During the last interview, Alex described many different physiological, psychological, interpersonal, and foundational symptoms. For example, she stated that “physical symptoms as far as headaches or feeling nausea or dizziness” and “symptoms of depression” can characterize VT. Alex also discussed how interpersonal relationships may be affected by VT. She included “socially withdrawing from friends and family,” “canceling some of your plans” or being “overprotective as a parent.” Additionally, Alex described clinicians “not wanting to do things that” they used to like doing or “feeling that with people like that out there that your kids are never going to be safe.” During the last interview, Alex discussed that the participation in the study helped her have a much better understanding of the symptoms of VT.
Recognition of VT risk factors. The research question for the recognition of VT risk factors was: Can Alex describe the risk factors (e.g., ongoing and repeated work with clients who are experiencing trauma, clinicians’ personal trauma history, present personal situation, lack of supervision, lack of training on working with clients who have experienced trauma, and work environment) of VT?

After she viewed the vignette once, Alex wrote that not having proper supervision was a risk factor for VT. For instance, she stated in the vignette that she observed the clinician seek out “her supervisor for help, but was blown off.” When Alex wrote in her first journal entry about her feelings and thoughts of her participation in the study before she attended the psychoeducational workshop she reflected on her own work environment as not “very healthy.” She indicated that she had “no real office space” and a “huge caseload.” Additionally, she stated that her own supervisor was “so overwhelmed and undertrained that he doesn’t really care very much.” Alex wrote that she “doesn’t feel even close to trained enough to work with the client in the video.” In concluding her first journal entry, she indicated that she would not “know what [she] would do if [she] heard that story from a client.”

During the first interview, which occurred after Alex viewed the clinical case vignette once and attended the psychoeducational workshop on VT, she described that she had a picture of VT occurring with an “overworked agency person that with the economy… is going to be very common as far as huge caseloads, not enough time in the day and not enough help in a day.” Alex continued by saying that she believed VT occurred “without training or without any sort of education and help.” After she viewed the vignette the second time, she wrote in her second set of reflection questions that she
“identified with the clinician not knowing what to do to help the client.” During the last interview, which occurred after she viewed the clinical case vignette twice and attended the psychoeducational workshop on VT, Alex discussed that she believed clinicians have two main potential risk factors for VT, lack of good supervision and work environment. Alex described that where a clinician works can greatly increase risk for VT, specifically she indicated that community “agency places” have “a higher risk” for the clinicians who work there. She stated that community agency settings are “work settings that… have more” potential work environment risk factors. Alex did not discuss specific examples of potential work environment risk factors found in community agency settings. During the last interview, Alex also discussed “going through some of the risk factors and bringing to the front of [her] mind that there are specific risk factors and that if [she] was doing those that could possibly be a problem” was the most helpful experience of her participation in the study.

**Recognition of VT’s impact.** The research question for the recognition of VT’s impact was: *Can Alex describe the impact (e.g., personal and/or professional) of VT?*

After she viewed the clinical case vignette the first time yet before she attended the psychoeducational workshop on VT, Alex wrote in her first set of reflection questions that the personal and professional impact of VT for the clinician in the vignette included “having problems at home,” not “willing to work with any more CPS cases” and not wanting “to work with a similar client.” During her first interview, which occurred after Alex viewed the vignette once and attended the psychoeducational workshop, she described three different personal and professional ways VT can negatively impact clinicians. For instance, she discussed VT’s impact on a person’s home life, such as
“disrupting your marriage or causing divorce” as well as impacting a person’s parenting (e.g., “causing you to not be the best parent”). She discussed one impact that VT could possibly have on a clinician’s professional life included “burnout.” Alex did not list any other professional impacts that VT could have for a clinician.

After she viewed the vignette the second time, Alex reflected that she felt the clinician was “falling apart at home.” She also expressed concern that the clinician never wanted to work with “CPS cases again.” During the last interview, Alex discussed burnout was the biggest impact VT had on a clinician. She also discussed a clinician “being unhappy in [her] work environment” and “wanting to leave the field,” as other possible negative professional impacts of VT. Towards the end of the interview, Alex described clinicians who experienced VT as “becoming less effective… or becoming numb to some of the traumas” and therefore provided “a decreased quality in therapy” when working with clients who have experienced trauma. After attending the psychoeducational workshop on VT, Alex seemed to be able to discuss in more depth the three consequences of VT that she had discussed previously as well as identify additional unique negative personal and professional impacts of VT.

**Resilience and self care.** The research question for resilience and self care was:

*Can Alex describe possible ways that clinicians can protect themselves from experiencing the negative consequences of listening to clients’ traumatic material?*

During the first interview, which occurred after Alex viewed the clinical case vignette once and attended the psychoeducational workshop on VT, she discussed not practicing regular self care due to having such a busy schedule. Alex stated that she “worried that [she] didn’t do many of those things as a grad student and mom.” When she
discussed specific aspects of self care in her second interview, she reported that she felt clinicians need to have a supportive “social network” as well as time to relax and time to “let go of cases” so that clinicians “won’t have to worry about [their clients] all the time.” Alex also indicated that a good support network was extremely important for clinicians. In the first interview, Alex spoke more generally about self care, whereas in the last interview she identified a few specific examples of ways clinicians can cope.

**Drew**

**Background**

Drew self-identified as a 25-year-old Caucasian, heterosexual, partnered female. Drew was a master’s level student in a counselor education: community counseling academic program. At the beginning of the study she had completed 59 semester hours; 48 semester hours are required by her academic program.

Drew reported that during her practicum training she had seen two clients, eight and seven sessions, respectively. Both clients discussed emotional abuse as an issue of trauma that they wanted to address in counseling. She reported that she had previously counseled others formally (e.g., as a clinician) or informally (e.g., as a colleague or family member), regarding sexual assault and physical and emotional abuse. Drew was asked to answer three questions on the demographic questionnaire that focused on training, spirituality, and supervision. Drew selected a rating of 3, medium preparation, when she described how well she felt her academic program prepared her to counsel clients who had experienced trauma. She selected a 5 when she described that spirituality/religion had
an important impact in her life. Drew did not list any experiences when asked on the
demographic questionnaire to describe supervision experiences that had been helpful in
her work with trauma survivors.

Findings that Emerged

**Awareness level of VT.** The research question for awareness level of VT was:
*Can Drew define VT and recognize the symptoms, risk factors, and impact of VT in
others?*

At the start of data collection, Drew reported on the demographic questionnaire
that she had no awareness of VT. Drew did not answer the question on the demographic
questionnaire, *How do you define vicarious traumatization?* In her first journal entry,
which she completed after she first viewed the clinical case vignette and before she
attended the psychoeducational workshop on VT, Drew wrote about the importance of
prevention for new clinicians. For instance, “new counselors should know the risks of
working with clients that abuse [or] have been abused.” After she viewed the vignette the
first time, Drew wrote on her first set of reflection questions that she did not “know much
about vicarious traumatization.” When Drew discussed her awareness level in the first
interview, which occurred after she viewed the vignette and attended the
psychoeducational workshop, she repeated that before she participated in the study she
“didn’t really know anything about VT.” Drew wrote in her second journal her feelings
and thoughts regarding her participation in the study after she viewed the vignette twice.
She expressed that the “study [had] been interesting to participate in because it allowed
me to think about what it will be like” to hear clients’ trauma stories.
Recognition of VT symptoms. The research question for the recognition of VT symptoms was: *Can Drew describe the symptoms (e.g., physiological, psychological, emotional, interpersonal, and foundational) of VT?*

After she viewed the vignette the first time, yet before she attended the psychoeducational workshop on VT, Drew listed different emotional, interpersonal, and foundational symptoms in her first set of reflection questions. She wrote that the clinician in the vignette was “grossed out, confused, and disturbed by the client’s story.” She indicated that she identified with the clinician and may have “felt similarly grossed out, confused, and disturbed by the client’s story.” She also expressed surprise at hearing the client’s trauma story from the vignette, “I have personally never heard such a thing.” Drew observed the clinician in the vignette struggle in her interpersonal relationships, she noticed the counselor “started fighting with her husband,” and also noted the clinician “wanted to be alone.” Drew also wrote that the clinician had experienced a number of foundational symptoms, which included questioning her spirituality (e.g., “the clinician really was haunted by this case and asked God why things like that could happen to kids”), safety concerns (e.g., “felt a need to protect her family”), and trust issues (e.g., “she started to doubt and question everyone”).

After she viewed the clinical case vignette once and attended the psychoeducational workshop on VT, Drew discussed her own reactions to the vignette during her first interview. She stated she felt “shock” and disbelief that “someone could do this” after she viewed the vignette the first time. She also described some emotional symptoms she observed the clinician in the clinical case vignette experience, such as “feeling more stressed out” and “sadness” due to how challenging it was to “hear about
really difficult things that clients have been through.” When Drew discussed foundational symptoms, she described the clinician in the vignette “becoming paranoid” that “similar situations” could occur in her own life. After she viewed the vignette the second time, Drew listed on her second set of reflection questions that she observed the clinician’s reaction to the client’s traumatic story was to feel “afraid for her own kids,” “stressed out,” and “full of shock.” In addition, “the clinician started out thinking or assuming the best about the client and by the end was questioning all mothers.” Drew also reflected on the clinicians desire to “be alone.”

Drew wrote in her second journal entry, after she viewed the clinical case vignette twice and attended the psychoeducational workshop on VT, that she “was very distressed by watching the video” because she felt “nervous to work with clients like that.” During the last interview, Drew discussed the same interpersonal relationship symptoms as she described in her first interview: “pushing away [her] partner at home” and “wanting to be alone a lot more.” Additionally, Drew expressed the importance of being aware of the reactions clinicians have to hearing clients’ trauma stories and how clinicians need to be aware of the “internal dialogue” all clinicians experience when thinking about clients.

**Recognition of VT risk factors.** The research question for the theme recognition of VT risk factors was: *Can Drew describe the risk factors (e.g., ongoing and repeated work with clients who are experiencing trauma, clinicians’ personal trauma history, present personal situation, lack of supervision, lack of training on working with clients who have experienced trauma, and work environment) of VT?*

When Drew answered the first set of reflection questions, which were completed before she attended the psychoeducational workshop on VT, Drew wrote about several
potential risk factors. Drew reflected that the clinician’s colleagues in the vignette “were not understanding or supportive at all” and indicated not having a support network at work could be a possible risk factor for VT. Additionally, she observed “the counselor could have educated herself more about the topic as opposed to just regret missing past trainings.” After she viewed the clinical case vignette once and attended the psychoeducational workshop on VT, Drew discussed how the clinician in the vignette did not have good supervision and felt that was a big risk factor for the clinician in the vignette experiencing VT. After she viewed the vignette the second time, Drew reflected that the clinician being pregnant was an additional risk factor for VT. During the last interview, Drew discussed many of the same risk factors again, such as lack of supervision and being pregnant. In addition, Drew discussed being a new counselor in the field was a potential risk factor for VT. After attending the psychoeducational workshop on VT, Drew seemed to be able to discuss in more depth the potential risk factors she discussed previously as well as identify additional unique potential risk factors for VT.

**Recognition of VT’s impact.** The research question for the recognition of VT’s impact was: *Can Drew describe the impact (e.g., personal and/or professional) of VT?*

During the first interview, which occurred after Drew viewed the clinical case vignette once and attended the psychoeducational workshop on VT, she strongly believed that “burnout” was one of the main negative professional impacts of VT. Besides burnout, she also discussed a clinician not wanting to work with clients who have experienced trauma. On the second set of reflection questions, which were completed after she viewed the vignette the second time, Drew discussed one potential impact for clinicians who work with clients who have experienced trauma. For instance, a noticeable
impact was that the clinician did not want to “work with any other trauma cases.” During the second interview, Drew mentioned the same possible impacts of VT as she did in the first interview and second set of reflection questions, such as burnout and not wanting to work with clients who have experienced trauma. For example, Drew described clinicians who had “VT… might not really be able to work with people that have trauma or feel like [they] can’t work with people that have trauma.” The overall impact Drew reported as a result of viewing the clinical case vignette was that a clinician experiencing VT may not want to continue counseling clients who have experienced trauma.

**Resilience and self care.** The research question for resilience and self care was:  
*Can Drew describe possible ways that clinicians can protect themselves from experiencing the negative consequences of listening to clients’ traumatic material?*

During the first interview, which occurred after she viewed the clinical case vignette once and attended the psychoeducational workshop on VT, Drew stated “I think about listening to someone that has abused [others] and I think about self care.” Furthermore, she discussed that a warning sign included “not having good self care methods.” She described a way to prevent VT included implementing self care strategies; however, Drew did not elaborate on what self care strategies clinicians can use to prevent VT. When she wrote in her second journal about her feelings and thoughts of her participation in the study after she viewed the vignette a second time, she wrote the study was helpful in explaining “how to be effective in self care.” During the second interview, which occurred after she viewed the vignette twice and attended the psychoeducational workshop on VT, Drew expressed that clinicians “can help other people as well and not burn out” if they take care of themselves.
Jordan

Background

Jordan self-identified as a 24-year-old, Caucasian, heterosexual, dating female. Jordan was a master’s level student in a counseling psychology academic program. At the beginning of the study she had completed 39 out of a total 48 semester hours.

Jordan reported that during her practicum training she had seen two clients, seven and three sessions, respectively. Physical and sexual abuse were the two issues of trauma that one of her clients discussed as concerns that needed to discussed in counseling. The other client did not report having any issues related to trauma. Jordan stated that she had never previously counseled others, formally (e.g., as a clinician) or informally (e.g., as a colleague or family member), regarding trauma. She was asked to answer three questions on the demographic questionnaire that focused on training, spirituality, and supervision. Jordan responded with a 1 when she reported that she felt her academic program had included no preparation to counsel clients who had experienced trauma. She responded with a 1 when she indicated that spirituality/religion had a minimal impact on her life. Jordan did not list any experiences when asked on the demographic questionnaire to describe supervision experiences that had been helpful in her work with trauma survivors.

Findings that Emerged

Awareness level of VT. The research question for awareness level of VT was:

Can Jordan define VT and recognize the symptoms, risk factors, and impact of VT in others?
When Jordan completed the demographic questionnaire, at the start of data collection, she reported she had no awareness of VT. Jordan defined VT on the demographic questionnaire as “my guess is trauma that has occurred to one individual and is experienced through another (maybe?).” Later, she reported that she took a “guess” when she tried to define VT on the demographic questionnaire. When she wrote in her first journal about her feelings and thoughts of her participation in the study, before she attended the psychoeducational workshop on VT, Jordan stated she had “never really thought about working with a client with severe trauma until now.” After she attended the psychoeducational workshop on VT and viewed the clinical case vignette once, Jordan discussed during the first interview that she had “never heard of vicarious traumatization before” in any context, either “learning or research.” When she described VT she “related it to kind of being in a critical situation” associated with an “adrenaline” response and denied ever thinking of it in a clinical context where she would experience any negative consequences. For example, she stated she did not “really think about [any negative consequences] being a young passionate counselor” rather she focused on being able “to save the world and everyone [was] going to be so healthy and everyone would love each other, but you know it is not going to work out that way, but it [was] awesome to pretend.” Also during the first interview, Jordan discussed what she had learned about VT while she participated in the study. She stated “I hadn’t heard of [vicarious trauma] before so anything I learned today was new.” Overall, she described thinking of VT as a sort of “countertransference,” where the clinician was “almost feeling the experience that the client [was] feeling.” During the second interview, which occurred after she viewed the clinical case vignette twice and attended the psychoeducational workshop on VT, Jordan
reiterated that she had “never really heard” about VT before she participated in the study. She also stated that the “most helpful” part of the study included “watching the vignette first and then doing the workshop.” She stated that it helped gain an understanding and “then watching it again” helped to apply the construct of VT to a clinical example.

**Recognition of VT symptoms.** The research question for the recognition of VT symptoms was: *Can Jordan describe the symptoms (e.g., physiological, psychological, emotional, interpersonal, and foundational) of VT?*

After Jordan viewed the clinical case vignette the first time, she wrote in her first set of reflection questions about a foundational symptom that she observed the clinician in the vignette experience. For example, “the clinician started questioning individuals and situations in her own life.” When Jordan wrote in her first journal about her feelings and thoughts of her participation in the study before she attended the psychoeducational workshop on VT, she wrote that one of the symptoms for a clinician counseling clients who have experienced trauma may include feeling depleted. For example, “I feel that working with a trauma client will be especially exhausting mentally.” During the first interview, which occurred after Jordan viewed the clinical case vignette once and attended the psychoeducational workshop on VT, she stated specifically the “different components” of VT, which included “psychological,” “physiological,” and foundational symptoms as well as the “emotional” reactions that clinicians may experience. For instance, an example of a psychological symptom was “feeling hopeless for the client,” an example of a foundational symptom included “losing faith” and an example of an emotional symptom of VT included feeling “a little bit of disgust for the way that adult
was behaving.” Jordan discussed that clinicians need to “be aware” when they get “really emotional” after hearing a client’s traumatic story.

After she viewed the clinical case vignette the second time, Jordan stated she “felt empathy for the counselor” and also may have felt there was “a hopeless ending” for this client. She also observed the clinician “at times... was not present with the client and became consumed by fearful thoughts.” During the last interview, Jordan described her own reaction to the vignette; she stated she “felt sad.” When she discussed what she learned about VT, she compared VT with PTSD. For example, if someone “in the military” had “post traumatic stress disorder” due to a “traumatic experience and the therapist experienced it” the clinicians reactions are “very parallel” to their clients. The clinician would have “parallel... physiological reactions” as well as “psychological and emotional” reactions. The “parallel” feelings of the client and the clinician go “beyond empathic” reactions. Jordan did not describe what she meant by beyond empathic. Jordan described the clinician in the vignette becoming a “fearful human being” and “constantly shut off to the world” as two examples of foundational symptoms. After attending the psychoeducational workshop on VT, Jordan seemed to be able to discuss in more depth the VT symptoms she discussed previously as well as identify additional symptoms of VT.

**Recognition of VT risk factors.** The research question for the recognition of VT risk factors was: Can Jordan describe the risk factors (e.g., ongoing and repeated work with clients who are experiencing trauma, clinicians’ personal trauma history, present personal situation, lack of supervision, lack of training on working with clients who have experienced trauma, and work environment) of VT?
Jordan had a difficult time discussing potential risk factors; however, during the last interview, which occurred after Jordan viewed the clinical case vignette twice and attended the psychoeducational workshop on VT, she described a clinician may experience emotional (e.g., “feeling sad”) or interpersonal (e.g. “being shut off” from others) symptoms if they hear repeated trauma stories over time. She also briefly mentioned that a clinician who had “experienced something similar” to a client’s traumatic experience may also be at risk for VT.

**Recognition of VT’s impact.** The research question for the recognition of VT’s impact was: *Can Jordan describe the impact (e.g., personal and/or professional) of VT?*

Jordan discussed the impact of the clinician’s work in the clinical case vignette when she answered the first set of reflection questions. For example, “I felt that she became judgmental and ineffective to the client, especially as sessions continued.” During the first interview, Jordan expressed feeling conflicted, she stated she felt “fear that I would not be able to help them” as well as “hope that I can help this person.” After she watched the vignette the second time, Jordan answered the second set of reflection questions and wrote that she observed how VT had impacted the clinician in the vignette. She listed VT had “affected her personal life” as well as interfered with the clinician’s feeling of being able to “help her client.”

When she wrote in her second journal about her feelings and thoughts of participating in the study after she viewed the clinical case vignette twice and attended the psychoeducational workshop on VT, Jordan stated she was worried about being impacted by the clients’ traumatic stories. For instance, “originally [she] thought [she] could leave all work issues at work, but now [she] felt worried that working with traumatic clients
may affect more of [her] than just [her] professional self.” During the last interview, which occurred after she viewed the clinical case vignette twice and attended the psychoeducational workshop on VT, Jordan indicated the study helped her become “more aware that [VT] very much can affect [a clinician’s] personal life.” Furthermore, it can have a large impact on “issues that [a clinician] just never thought [VT] would,” such as not feeling and even not being “as helpful to a client.” For instance, the clinician in the vignette “couldn’t help that client.” Overall, Jordan stated the impact “on the counselor being that it really consumed her personal, professional, and her relationships in her life.” She stated that she felt the clinician should have said she did not “feel like [they] can work together because [she] thought what [the client] did was so wrong” instead of simply thinking that what the client did was wrong.

Jordan noted that VT may be “a subconscious thing” even though a clinician may have some awareness that they are “hurting” and “that [they] know these things”; however, “overall” clinicians may “not really realize what a heavy impact” having heard clients’ traumatic stories “can make on a [clinician’s] personal life.” Jordan concluded the interview stating “the impact was much more than you think it would be. It seemed like it was all consuming” for the clinician in the vignette.

**Resilience and self care.** The research question for resilience and self care was: *Can Jordan describe possible ways that clinicians can protect themselves from experiencing the negative consequences of listening to clients’ traumatic material?*

Jordan did not mention the idea of self care at any point in the study. During the second interview, when she discussed things she learned in the study, Jordan briefly mentioned the idea of resilience and stated that a new counselor may “feel like you can
really overcome a lot of things.” She also expressed hope that a new counselor has the ability to overcome hurdles they have experienced.

**Cross Case Analysis**

According to Yin (2009), an important aspect of multiple case study research is an analysis of all cases that seeks to unify each case under common themes or categories. Moreover, Stake (2006) stated that researchers have “an obligation to provide interpretation across the cases” (p. 39). Thus the final section of this chapter is a presentation of the analysis across all seven case studies. To begin, I present a narrative description of all seven participants’ backgrounds. To provide the reader a visual summary, the demographic variables will also be summarized in two tables. Lastly, I provide findings that emerged across the single case studies.

**Background**

The participants reported many of the same demographic variables (see Table 2). All seven of the participants identified as Caucasian, heterosexual females. Ages of six of the seven participants ranged from 24 to 50 years old. One participant chose not to report her age. Relationship status for four of the seven participants was married. One participant reported each of the following: divorced, partnered, and dating. Two master’s level academic programs were represented: counseling psychology (CP) and counselor education: community counseling (CE: CC).
Table 2

Demographic Variables

<table>
<thead>
<tr>
<th>Participants</th>
<th>Race</th>
<th>Gender</th>
<th>Sexual Orientation</th>
<th>Age</th>
<th>Relationship Status</th>
<th>Academic Program</th>
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</thead>
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<tr>
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<td>Married</td>
<td>CP</td>
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<td>Taylor</td>
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<td>Heterosexual</td>
<td>50</td>
<td>Married</td>
<td>CE: CC</td>
</tr>
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<td>Chris</td>
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<td>Female</td>
<td>Heterosexual</td>
<td>39</td>
<td>Married</td>
<td>CP</td>
</tr>
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<td>Caucasian</td>
<td>Female</td>
<td>Heterosexual</td>
<td>46</td>
<td>Divorced</td>
<td>CP</td>
</tr>
<tr>
<td>Alex</td>
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<td>Female</td>
<td>Heterosexual</td>
<td>24</td>
<td>Married</td>
<td>CE: CC</td>
</tr>
<tr>
<td>Drew</td>
<td>Caucasian</td>
<td>Female</td>
<td>Heterosexual</td>
<td>25</td>
<td>Partnered</td>
<td>CE: CC</td>
</tr>
<tr>
<td>Jordan</td>
<td>Caucasian</td>
<td>Female</td>
<td>Heterosexual</td>
<td>24</td>
<td>Dating</td>
<td>CP</td>
</tr>
</tbody>
</table>


On the demographic questionnaire, participants were asked to provide the following additional information: (a) how spirituality/religion impacted their life; (b) how well they felt prepared by their academic program to counsel clients who have experienced trauma; (c) supervision experiences that they found helpful in working with clients who had experienced or were experiencing trauma; (d) trauma issues addressed with practicum clients; (e) trauma issues addressed with others, either as a clinician,
colleague, or family member; (f) number of credit hours completed in their current master’s program before their participation in the current study; and (g) number of current practicum clients seen and the number of sessions with each client. The last question on the demographic questionnaire asked participants: Have you heard of the construct of vicarious traumatization before today? If yes, where, when, and how did you hear of the construct and how do you define vicarious traumatization? According to the VT literature, important components of preventing VT include: participation in continued training focused on working with clients who have experienced trauma, development of spirituality, and regular supervision (Patrick, 2007; Pearlman, 1999; Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne, 2005; Saakvitne & Pearlman, 1996; Trippany et al., 2004). Given the importance of training, spirituality, and supervision in VT prevention, I have included the participants’ answers to the three questions on the demographic questionnaire that focused on training, spirituality, and supervision.

Participants’ answers regarding spirituality/religion’s impact on their life ranged from having low impact to high impact. Two of the seven participants selected a 1 (low impact), one participant selected a 4, two participants selected 5, and two participants selected 6 (high impact). When they reported how well they felt prepared by their academic program to counsel those who have been traumatized, participants answers ranged from no preparation to medium preparation. One of the seven participants chose a 1 (no preparation), two participants chose 2, two participants chose 3, and two participants chose 4. When participants were asked to list any supervision experiences they found helpful in working with clients who had experienced or were experiencing
trauma, none of the participants reported any helpful supervision experiences. However, it is important to note that participants were not asked a more open question related to supervision. Therefore, we do not know if participants would have shared unhelpful supervision experiences or if for some reason they were not receiving supervision; however, students not receiving supervision during their practicum course seems very unlikely due to the department’s firm policy that each student see a supervisor for one hour each week.

Trauma issues addressed with practicum clients in counseling sessions at the time of data collection when the participant was enrolled in the course included: physical and emotional abuse perpetrated by past husbands; sexual, emotional, and physical abuse; childhood sexual abuse; childhood abandonment; and anxiety from loss. One of the seven participants reported that her practicum clients did not present any issues of trauma to discuss in counseling. Trauma issues addressed when participants previously counseled others, either formally (e.g., as a clinician) or informally (e.g., as a colleague or family member), included: physical and emotional abuse, verbal abuse, childhood sexual abuse, and sexual assault. Two participants disclosed they had never previously counseled others, either formally (e.g., as a clinician) or informally (e.g., as a colleague or family member), outside of the practicum course with regard to trauma. Number of credit hours participants completed in their current master’s program before their participation in the current study ranged from 37 to 59 hours. Number of current practicum clients seen ranged from one to three. The number of sessions with each client ranged from two to eight. Lastly, five participants reported that they had never heard of the construct of vicarious traumatization before completing the demographic questionnaire. The two who
reported hearing about VT before completing the demographic questionnaire reported they heard about VT in a course. One of the participants that had reported hearing about VT while taking a course on post traumatic stress disorder (PTSD) before completing the demographic questionnaire did not define VT; however, three participants who had not heard of VT before completing the demographic questionnaire wrote incorrect definitions for VT. Please see Tables 3 and 4 for a summary of the participants’ additional information from the demographic questionnaire.

Across most demographic variables the participants were a homogenous sample with the exception of age. None of the seven participant indicated feeling significantly prepared by their academic program to counsel clients who have experienced trauma. Nor did any participant list any supervision experiences that they found helpful in working with clients who had experienced trauma. This lack of preparation and supervision is in contrast to the fact that six of the seven participants reported they counseled practicum clients who had experienced some form of trauma. Five of the seven participants reported they had not previously heard of the construct VT; however, three of those five participants wrote down definitions of VT that were incorrect, which may further support that they did not have an awareness of VT. One of the participants who reported having heard of VT before completing the demographic questionnaire in a PTSD course did not define VT, yet the other participant who reported that she heard about VT in a class before completing the demographic questionnaire defined VT correctly.
## Table 3

**Additional Participant Information I**

<table>
<thead>
<tr>
<th>Participants</th>
<th>Academic Preparation</th>
<th>Spirituality/Religion</th>
<th>Supervision Experiences</th>
<th>Trauma Issues (Practicum clients)</th>
<th>Trauma Issues (other people)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sam</td>
<td>2</td>
<td>1</td>
<td>None listed</td>
<td>Emotional, physical, sexual abuse</td>
<td>None listed</td>
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<tr>
<td>Taylor</td>
<td>3</td>
<td>5</td>
<td>None listed</td>
<td>Loss</td>
<td>Childhood sexual abuse</td>
</tr>
<tr>
<td>Chris</td>
<td>4</td>
<td>6</td>
<td>None listed</td>
<td>Physical, emotional abuse</td>
<td>Physical, emotional abuse</td>
</tr>
<tr>
<td>Lee</td>
<td>4</td>
<td>6</td>
<td>None listed</td>
<td>None listed</td>
<td>Physical, emotional, verbal abuse childhood sexual abuse</td>
</tr>
<tr>
<td>Alex</td>
<td>2</td>
<td>4</td>
<td>None listed</td>
<td>Childhood abandonment</td>
<td>Physical, emotional, verbal abuse Sexual assault</td>
</tr>
<tr>
<td>Drew</td>
<td>3</td>
<td>5</td>
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<td>Emotional abuse</td>
<td>Sexual assault physical, emotional abuse</td>
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<tr>
<td>Jordan</td>
<td>1</td>
<td>1</td>
<td>None listed</td>
<td>Physical, sexual abuse</td>
<td>None listed</td>
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</tbody>
</table>

**Note.** Academic Preparation: 1 = no preparation, 6 = extensive preparation, Spirituality/Religion: 1 = low impact, 6 = high impact. Supervision experiences: Participants were asked: Please describe any supervision experiences you have had as a supervisee that have been helpful in your work with trauma survivors. Trauma Issues (Practicum clients): Participants were asked to list the type of trauma discussed by their practicum clients. Trauma Issues (other people): Participants were asked to list the type of trauma that they had ever counseled others.
Table 4

*Additional Participant Information II*

<table>
<thead>
<tr>
<th>Participants</th>
<th>Number of credit hours completed</th>
<th>Number of practicum clients</th>
<th>Number of sessions</th>
<th>Previously heard about VT (where, when, how)</th>
<th>Definition of VT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sam</td>
<td>42</td>
<td>2</td>
<td>8 &amp; 7</td>
<td>No</td>
<td>Not reported</td>
</tr>
<tr>
<td>Taylor</td>
<td>37</td>
<td>2</td>
<td>7 &amp; 2</td>
<td>No</td>
<td>Multiple smaller events that pile up and negatively affect the client.</td>
</tr>
<tr>
<td>Chris</td>
<td>42</td>
<td>3</td>
<td>6, 4, &amp; 4</td>
<td>No</td>
<td>Witnessing abuse/trauma of others and being adversely affected</td>
</tr>
<tr>
<td>Lee</td>
<td>54</td>
<td>2</td>
<td>6 &amp; 8</td>
<td>Yes (PTSD Course, when was not reported, reading PTSD Research)</td>
<td>Not reported</td>
</tr>
<tr>
<td>Alex</td>
<td>39</td>
<td>1</td>
<td>8</td>
<td>Yes (In a class, in the past year, during recent readings)</td>
<td>Trauma suffered by a clinician as the result of hearing and reliving a client’s experience during the course of therapy</td>
</tr>
<tr>
<td>Drew</td>
<td>59</td>
<td>2</td>
<td>8 &amp; 7</td>
<td>No</td>
<td>Not reported</td>
</tr>
<tr>
<td>Jordan</td>
<td>39</td>
<td>2</td>
<td>7 &amp; 3</td>
<td>No</td>
<td>My guess is trauma that has occurred to one individual and is experienced through another… (?) maybe</td>
</tr>
</tbody>
</table>

*Note.* Questions on the demographic questionnaire regarding number of credit hours completed before participating in the study, number of practicum clients and number of sessions for each client as well as participants report of previously hearing about VT and defining VT were all open-ended questions.
Findings that Emerged

As stated at the beginning of this chapter, I proposed to answer the following two research questions: (a) What is the level of awareness of VT in clinicians’ in training? and (b) What is the impact of a VT training program on clinicians’ in training ability to recognize VT in others? Thus, initially the findings that emerged during the cross case analysis were organized into two categories, level of awareness of VT and impact of the VT psychoeducational workshop. As the cross case analysis progressed, a third category emerged: participants’ responses to the vignette. Therefore, I discuss these three categories below.

**Awareness level of VT.** Five of the seven participants reported that they had no awareness of the construct of VT at the start of data collection. One of the seven participants reported having some awareness of VT, which included having heard of the construct of VT while taking a one credit Post Traumatic Stress Disorder (PTSD) course. One of the seven participants provided conflicting information. On the demographic questionnaire she reported she had heard about VT in course readings; however, during the first interview she stated she “had never actually heard the term before [she completed her] demographic questionnaire.” To summarize, at the start of data collection, five of the seven participants had no awareness of VT, one participant had some awareness of VT, and one participant had an unclear awareness level of VT.

**Impact of the VT psychoeducational workshop.** During the cross case analysis findings emerged for four main areas. The areas included: recognition of VT symptoms, recognition of VT risk factors, recognition of VT’s impact, and resilience and self care.
Below is the description of how participants responded before and after they attended the psychoeducational workshop on VT. The four areas are summarized in separate tables to provide the reader a visual summary of when participants described the different aspects of VT.

**Recognition of VT symptoms.** A review of all the data collected across the cases yielded the following findings regarding the five areas of VT symptoms (i.e., physiological, psychological, emotional, interpersonal, and foundational). Of the five areas of VT symptoms, participants seemed to have the most difficulty recognizing physiological symptoms of VT. Only after they attended the psychoeducational workshop on VT, three of the seven participants listed the overall area of physical symptoms of VT; however, only two described limited examples of the physiological symptoms. For instance, one participant described “physical symptoms as far as headaches or feeling nausea or dizziness.” Another participant indicated one physiological symptom, “feeling depleted,” while the third participant discussed clinicians experiencing physiological symptoms, but stated that she was not able to recall specific examples.

When emotional symptoms of VT were analyzed, two of the seven participants listed emotional symptoms before they attended the psychoeducational workshop on VT, such as the clinician in the clinical case vignette experienced “shock and horror” when she heard the client’s traumatic experiences. After they attended the workshop, four participants discussed emotional symptoms of VT in more detail and expressed more specific examples. For instance, examples included clinicians possibly experiencing feelings “of sadness” or feeling “overwhelmed” regarding hearing clients’ traumatic stories. Additional examples of emotional symptoms participants reported included their
observations of the clinician in the clinical case vignette. The participants described the clinician was “disgusted and troubled by this case,” and expressed that she felt “anger/disgust toward the client,” “shock,” and “guilt that this is horrible.”

Within the area of psychological symptoms, two of the seven participants described psychological symptoms before they attended the psychoeducational workshop. For example, one participant stated that the clinician in the clinical case vignette was “bothered by intrusive thoughts about the case.” After the participants attended the workshop on VT, six participants discussed psychological symptoms in greater depth. For instance, one participant described in detail the clinician in the vignette “having flashbacks.” Furthermore, participants expressed different examples of psychological symptoms after they attended the psychoeducational workshop on VT, such as “nightmares,” “symptoms of depression,” and “feeling hopeless for the client.”

Interpersonal VT symptoms, such as the clinician in the vignette “wanted to be alone,” were listed by three of the seven participants before they attended the psychoeducational workshop on VT. Six participants provided richer discussion as well as more specific examples regarding interpersonal symptoms after they attended the psychoeducational workshop on VT. Examples included the clinician in the vignette: “did not feel like going out to social gatherings,” “socially withdrawing from friends and family,” “wanting to be alone a lot more,” “to the movie with her husband,” “experiencing some personal issues of withdrawal at her job and with her husband,” and “canceling plans.” One participant expressed her concern regarding the clinician in the vignette experiencing interpersonal symptoms of VT.
She started to not want to do stuff with her husband, not wanting to go out with friends, not want to attend things, [which] is the biggest danger that I would see because it is through connecting with others that she is gonna be able to stay stable so if your first gut reaction is oh gosh I need to just withdraw and process this then you are cutting yourself off from the lifeline that you would have to be able to unpack it and process it and verbalize it.

Two interpersonal symptoms that participants described as possible for all clinicians who work with clients who have experienced trauma included “disrupting your marriage” and “pushing away your partner at home or wanting to be alone a lot more.”

The foundational symptoms of VT were most easily recognized and most often discussed by all seven participants. For instance, five of the participants wrote about foundational symptoms, such as “the clinician started questioning individuals and situations in her own life,” before they attended the psychoeducational workshop. All seven participants’ explained foundational symptoms in greater detail and provided more specific examples after they attended the psychoeducational workshop. Participants reported different foundational symptoms they saw portrayed in the clinical case vignette, such as the clinician “took the problems that were presented to her and made them about her life and the people in her life,” she began “doubting not only… [her] client but doubting everything in the whole world and doubting her faith,” she was also “questioning safety of the world and safety of her kids in the world… and questioning her faith,” and the clinician “was not prepared to deal with the issues that were presented and they threatened her worldview and security.” Furthermore, one participant discussed in greater detail after she attended the psychoeducational workshop on VT the struggle she observed the clinician in the clinical case vignette experience:

[the clinician in the vignette] got stuck and didn’t know where to file stuff when it didn’t fit any of her labels, because (sic) she didn’t want to find this woman evil
because she was abused as a child, but then she said “wow I can’t believe that people can be so evil,” but yet she was wrestling with “but [the client] was abused.”

Please see Table 5 for a visual description of when participants discussed VT symptoms.

**Table 5**

*Recognition of VT Symptoms*

<table>
<thead>
<tr>
<th>Participants</th>
<th>Physiological</th>
<th>Psychological</th>
<th>Emotional</th>
<th>Interpersonal</th>
<th>Foundational</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sam</td>
<td>After</td>
<td>After</td>
<td>Before</td>
<td>After</td>
<td>After</td>
</tr>
<tr>
<td>Taylor</td>
<td>Before/After</td>
<td></td>
<td></td>
<td>After</td>
<td>Before/After</td>
</tr>
<tr>
<td>Chris</td>
<td>Before/After</td>
<td>After</td>
<td>Before/After</td>
<td>Before/After</td>
<td>Before/After</td>
</tr>
<tr>
<td>Lee</td>
<td>After</td>
<td></td>
<td></td>
<td>After</td>
<td>After</td>
</tr>
<tr>
<td>Alex</td>
<td>After</td>
<td>After</td>
<td>After</td>
<td>Before/After</td>
<td>Before/After</td>
</tr>
<tr>
<td>Drew</td>
<td>Before/After</td>
<td>Before/After</td>
<td>Before/After</td>
<td>Before/After</td>
<td>Before/After</td>
</tr>
<tr>
<td>Jordan</td>
<td>After</td>
<td>Before/After</td>
<td>After</td>
<td>After</td>
<td>Before/After</td>
</tr>
</tbody>
</table>

*Note.* Before indicates the participant mentioned symptoms before she attended the psychoeducational workshop on VT and After indicates the participant mentioned symptoms after she attended the workshop. Empty spaces indicate the participant did not discuss the symptoms.

**Recognition of VT risk factors.** A review of all seven case studies found the following findings regarding potential risk factors (i.e., ongoing and repeated work with clients who have experienced trauma, clinicians’ personal trauma history, present personal situation, lack of supervision, lack of training on working with clients who have experienced trauma, and work environment). Out of all the potential risk factors, participants had the most difficulty recognizing clinicians’ current personal situation as a
potential risk factor of VT. For instance, just two of the seven participants expressed the clinician in the vignette’s present personal situation (e.g., “being pregnant” and “having a young child”) was a potential risk factor of VT only after they attended the psychoeducational workshop. Another potential risk factor that participants had difficulty recognizing was the danger of ongoing and repeated work with clients who have experienced trauma. Three of the seven participants described this risk factor only after they attended the workshop. Two examples of repeated work with clients who had experienced trauma from different participants that are similar included, “seasoned counselors who [are]… good with trauma find [their] whole caseload gets [filled with] trauma victims” and “dealing with a lot of trauma a lot of the time or being a trauma specialist was a danger.”

Within the area of work environment as a potential risk factor, participants had difficulty recognizing factors that could potentially increase a clinician’s risk for VT. Before they attended the psychoeducational workshop on VT, two of the seven participants provided examples of how work environment was a potential risk factor. Examples included, having “no real office space” and colleagues that are “not understanding or supportive at all.” After they attended the workshop, only three participants reported factors they recognized related to work environment as being a potential risk factor for VT. For example, one participant described a potentially risky work environment as an “overworked agency person” with “huge caseloads, not enough time in the day and not enough help in a day.”

One of the seven participants expressed that a clinician’s own personal past trauma was a potential risk factor of VT before she attended the psychoeducational
workshop. For example, she questioned if a clinician who has experienced trauma in her personal life may have an advantage due to having been “tested” and “survived.” After participants attended the workshop, four recognized that a clinician’s personal trauma history may be a potential risk factor for VT. For instance, “having past trauma yourself,” “having similar trauma that you haven’t worked through,” and “relating (sic) to the traumas too closely might be a danger.” One participant described how she thought about her own past trauma with regards to being a clinician, “I think that my relationship that I’ve already experienced with trauma and with other peoples’ trauma is a backdrop on which my clients’ relationships with trauma will be filtered through.”

Lack of training was discussed by four of the seven participants as a potential risk factor for VT before they attended the psychoeducational workshop on VT. One example included the clinician in the vignette did not “educate herself about [the] phenomenon of child abuse.” After they attended the psychoeducational workshop on VT, six participants discussed in greater depth and with more examples, how lack of training was a potential risk factor for VT. Participants discussed with more frequency how the clinician in the vignette had an increased risk for VT due to her lack of training. For instance, participants reported she was “wishing for more knowledge but not seeking it,” “she just waded in, didn’t go to her computer or her library or her professional journals and didn’t look up anything… she obviously felt lost because she said so a few times,” she “was traumatized by the case because of her lack of training,” she could have gone “to the library and looked things up any number of ways that might of interrupted her downward spiral,” she “kept focusing on the fact that she wished she were better trained for such cases, but didn’t seek out such assistance,” she had “not had coursework and she kept saying I
haven’t been trained for this I haven’t been trained for this so I would say maybe not having had appropriate training of working with people with trauma increases risk [for VT],” “I feel like she needed some additional training,” and she was “unprepared… [she] really needed to educate [herself] on how to work with trauma.” Two participants more generally discussed how lack of training could increase clinicians risk for VT, “I think without training or without any sort of education and help with it [VT] could be a problem” and “working with clients that you are incapable [or] untrained… increases risk.”

Within the area of supervision as a potential risk factor for VT, four of the seven participants discussed lack of supervision before they attended the psychoeducational workshop on VT. For example, one participant stated the clinician in the vignette had “untrained supervision,” which was a potential risk factor for VT. Six participants discussed lack of supervision in greater depth and with more examples as a potential risk factor after they attended the workshop. Examples expressed about the clinical case vignette included: “the supervisor’s response of never having heard of being affected by hearing traumatic material felt like he dropped the ball,” “her supervisor was probably not familiar with VT and dismissed her attempt at contact,” “she needed some additional supervision,” and “when she asked her supervisor and said you know I find myself thinking back about the case and the supervisor said woo I have never had that happen before and that was the end it.” Moreover, four participants discussed in general how lack of supervision can increase clinicians risk for VT. For instance, “the big [risk factor] that stood out for me is supervision, not having a good supervisor,” “getting bad supervision,” “not having good supervision,” “lack of supervision,” and “untrained supervision.” Please
see Table 6 for a visual description of when participants discussed potential VT risk factors.

Table 6

Recognition of VT Risk Factors

<table>
<thead>
<tr>
<th>Participants</th>
<th>Ongoing/Repeated Work</th>
<th>Personal Trauma History</th>
<th>Present Personal Situation</th>
<th>Lack of Supervision</th>
<th>Lack of Training</th>
<th>Work Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sam</td>
<td>Before/After</td>
<td>Before/After</td>
<td>Before/After</td>
<td>Before/After</td>
<td>After</td>
<td>After</td>
</tr>
<tr>
<td>Taylor</td>
<td></td>
<td></td>
<td>Before/After</td>
<td></td>
<td></td>
<td>After</td>
</tr>
<tr>
<td>Chris</td>
<td>After</td>
<td>After</td>
<td>After</td>
<td>After</td>
<td>After</td>
<td>After</td>
</tr>
<tr>
<td>Lee</td>
<td>After</td>
<td>After</td>
<td>After</td>
<td>Before/After</td>
<td>Before/After</td>
<td>Before/After</td>
</tr>
<tr>
<td>Alex</td>
<td></td>
<td></td>
<td>Before/After</td>
<td>Before/After</td>
<td>Before/After</td>
<td>Before/After</td>
</tr>
<tr>
<td>Drew</td>
<td></td>
<td></td>
<td>After</td>
<td>After</td>
<td>Before</td>
<td>Before</td>
</tr>
<tr>
<td>Jordan</td>
<td>After</td>
<td>After</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. Before indicates the participant mentioned risk factors before she attended the psychoeducational workshop on VT and After indicates the participant mentioned risk factors after she attended the workshop. Empty spaces indicate the participant did not discuss a potential risk factor.

Recognition of VT’s impact. A review of all seven case studies found the following findings regarding VT’s impact (i.e., personal and professional). Within the area of personal impact, participants had a difficult time recognizing possible personal impacts of VT before they attended the psychoeducational workshop on VT. For instance, only one of the seven participants listed “having problems at home” as a potential personal impact of VT before she attended the workshop. Six participants provided more
examples of negative personal consequences of VT after they attended the psychoeducational workshop. Examples of negative personal impacts of VT included: “[VT] can screw up your home life,” “cause divorce,” “cause you to not be the best parent,” and cause “disruption in home life.” One participant stated that working with trauma populations is “almost having it be a subconscious thing like you are aware… that you know these things but overall not really realizing what a heavy impact it can make on your personal life.”

Potential professional impacts of VT were discussed by three of the seven participants before they attended the psychoeducational workshop on VT. For example, one participant stated about the clinician in the clinical case vignette: “her personal fears and close involvement [with the details of the client’s traumatic story] were preventing her from working effectively.” After they attended the workshop, six participants described in more detail VT’s impact on a clinicians’ professional life. Examples of potential negative professional consequences of VT included: “burnout,” “shutting off their ability to give empathy,” “limiting yourself professionally,” “becoming less effective as therapists,” “not wanting to work with any other trauma cases… not wanting to come to work the day that you see your client that has trauma,” and “wanting to leave the field.” One participant described the importance of combating the impact of VT, she stated “it is important that you deal with [the impact] so that if you are someone who is good at helping people with trauma you can be available… so that your feelings aren’t hardened, so that we can still help people without traumatizing ourselves.” Please see Table 7 for a visual description of when participants discussed the impact of VT.
Table 7

*Recognition of VT’s Impact*

<table>
<thead>
<tr>
<th>Participants</th>
<th>Personal</th>
<th>Professional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sam</td>
<td>After</td>
<td>Before/After</td>
</tr>
<tr>
<td>Taylor</td>
<td>After</td>
<td>After</td>
</tr>
<tr>
<td>Chris</td>
<td>After</td>
<td>After</td>
</tr>
<tr>
<td>Lee</td>
<td>After</td>
<td>Before</td>
</tr>
<tr>
<td>Alex</td>
<td>Before/After</td>
<td>Before/After</td>
</tr>
<tr>
<td>Drew</td>
<td></td>
<td>After</td>
</tr>
<tr>
<td>Jordan</td>
<td>After</td>
<td>Before/After</td>
</tr>
</tbody>
</table>

*Note.* Before indicates the participant mentioned impact of VT before she attended the psychoeducational workshop on VT and After indicates the participant mentioned impact of VT after she attended the workshop. Empty spaces indicate the participant did not discuss impact of VT.

**Resilience and self care.** A review of all seven case studies found the following findings regarding resilience and self care. Within the area of resilience, six of seven participants did not describe the construct of resilience. This lack of discussion regarding resilience may be due to no question asked participants to describe the construct of resilience. One participant discussed the construct of resilience after she attended the psychoeducational workshop on VT. She described a new counselor may feel able “to really overcome a lot of things.” Within the area of self care, participants had a difficult time describing the construct before they attended the psychoeducational workshop on VT. For instance, two of the seven participants discussed aspects of self care clinicians
should implement before they attended the workshop. Examples included: clinicians finding “activities they enjoy outside of work” and clinicians setting “appropriate boundaries” with clients. However, after the participants attended the psychoeducational workshop, six participants discussed the construct of self care and provided additional specific examples of ways clinicians can cope. Discussions of the construct self care included: “need to make sure [clinicians] are debriefing…with someone like a supervisor or a peer,” creating a supportive “social network,” “need to set up some good boundaries,” “[clinicians] have to have a way for them to process all of the trauma that they are dealing with second hand,” and “be sure that clinicians have a support system.” Additionally, one participant described self care overall, “we have to protect ourselves and by talking to others about [VT] and being supervised or going to therapy for what we are going through in our own practices.” Please see Table 8 for a visual description of when participants discussed the constructs of resilience and self care.

Across the four main areas found regarding the impact of the VT psychoeducational workshop (i.e., recognition of VT symptoms, recognition of VT risk factors, recognition of VT’s impact, and resilience and self care) participants discussed the constructs of resilience and self care the least. Participants recognized the symptoms of VT the most, with six of the seven participants providing more examples of VT symptoms after they attended the psychoeducational workshop on VT. Moreover, as the researcher conducted the cross case analysis, it become evident that the participants consistently provided answers included in the different areas more accurately and clearly after they attended the psychoeducational workshop on VT. It is important to note that despite the increased ability to recognize all four areas after they attended the
psychoeducational workshop participants still had difficulty discussing the different aspects of VT. For instance, only three participants discussed all five categories of VT symptoms and none of the participants discussed all six of the potential risk factors for VT.

Table 8

Discussion of Resilience and Self Care

<table>
<thead>
<tr>
<th>Participants</th>
<th>Resilience</th>
<th>Self Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sam</td>
<td>Before/After</td>
<td></td>
</tr>
<tr>
<td>Taylor</td>
<td>After</td>
<td></td>
</tr>
<tr>
<td>Chris</td>
<td>After</td>
<td></td>
</tr>
<tr>
<td>Lee</td>
<td>Before/After</td>
<td></td>
</tr>
<tr>
<td>Alex</td>
<td>After</td>
<td></td>
</tr>
<tr>
<td>Drew</td>
<td>After</td>
<td></td>
</tr>
<tr>
<td>Jordan</td>
<td>After</td>
<td></td>
</tr>
</tbody>
</table>

*Note.* Before indicates the participant mentioned resilience/self care before she attended the psychoeducational workshop on VT and After indicates the participant mentioned resilience/self care after she attended the workshop. Empty spaces indicate the participant did not discuss resilience/self care.

**Participants’ responses to the vignette.** The third category that emerged during the cross case analysis was the participants’ responses after they viewed the clinical case vignette. Six of the seven participants discussed their personal reactions after they viewed the case vignette. Participants’ responses included two main areas: reactions to the
clinician and more general responses to the vignette. Four participants expressed that they put themselves in the clinician’s position and felt similar feelings as the clinician experienced in the vignette, both after the first and second times they viewed the vignette. Examples included: “helplessness,” “anger,” “confusion,” “fear,” “disbelief,” and “hopelessness.” To further illustrate, one participant wrote in her first set of reflection questions after she viewed the vignette the first time that she “really identified with the clinician when she started getting… angry.” Three participants described feeling disappointed or irritated that the clinician judged the client, such as disappointment with the clinician “trying to slap judgment and labels on” the client. Two participants described feeling disappointed and irritated towards the clinician in the vignette for not seeking additional training. For example, the response by one participant to the clinician in the vignette’s wish that she get more training after she viewed the clinical case vignette twice included, “well… do something about it.” One participant expressed feeling surprised at the clinician’s reactions toward her client after she viewed the vignette the second time. The participant stated, “I was surprised at her level of shock” at the client’s story.

Four of the seven participants expressed pronounced feelings after they viewed the vignette, such as “sadness,” “distress,” “anxiety,” and “mistrust of others.” To further illustrate, after a participant viewed the vignette twice, she stated that she “identified with the clinician’s growing (throughout the vignette) mistrust for people.” Two participants stated they felt untrained to counsel the client’s presenting concerns of generational childhood sexual abuse. For example, after she viewed the vignette twice, one participant stated that she “was very distressed by watching the video” because she felt “nervous to
work with clients like that.” The participant’s responses to the clinical vignette illustrated the potential impact of hearing client’s traumatic material. Additionally, the participants’ reactions also defined a need that clinicians-in-training would benefit if they received specific education regarding working with clients who experienced trauma and the construct of VT. During the first interview, one participant expressed this as a necessity; she stated, “I need to be aware that when trauma is filtered through the human condition it has potential to do damage and as I am a human… I am vulnerable to [VT].”

The next chapter will discuss the findings that emerged from the analysis as well as implications, limitations, and areas of future study. Additionally, I will provide a discussion of my journal entries throughout data collection and data analyses.
CHAPTER V

DISCUSSION

The purpose of this chapter is to provide a discussion of the results of the study. To begin, I will interpret the findings that emerged from the analysis. When applicable, previous research and scholarship is included to further interpret these findings. This is followed by a discussion of my journal entries throughout data collection and data analyses. The next section addresses limitations of the study. The chapter concludes with a discussion of implications and areas of future study.

Interpretation of Emerged Findings

In the first chapter of this dissertation, the following research questions were posed: (a) What is the level of awareness of Vicarious Traumatization (VT) in clinicians-in-training? and (b) What is the impact of a VT training program on the ability of clinicians-in-training to recognize VT in others? I conducted an analysis of all seven participants’ data to gain an understanding of the participants experiences around the questions asked. Below is my interpretation of the findings that emerged organized in two main areas: level of awareness of VT and impact of the VT psychoeducational workshop. For the richness of the data presented in the results chapter to be represented an emphasis is placed on examining ideas from individual participants up to ideas from all seven
participants. It is important to note that not all of the findings interpreted were represented by all seven participants.

**Level of Awareness of VT**

With respect to the first research question, assessing level of awareness of clinicians-in-training, most of the participants in this study had no awareness of VT at the start of data collection. Five of the seven participants reported no awareness or prior knowledge of VT. One individual indicated some familiarity, having heard of the term during a one credit hour course on PTSD. The other participant initially indicated she had heard about VT in course readings, but later during her first interview (which occurred after the psychoeducational workshop) she reported she had never actually heard of the term before it was introduced to her through the demographic questionnaire. Perhaps she had initially been unclear about what the term meant. These findings may illustrate that clinicians’ level of development may impact how they learn about VT. For instance, clinicians that are new to working with any client population, not only trauma clients, may not have a schema or frame of reference to understand how hearing clients’ traumatic stories may impact clinicians. The lack of awareness and lack of training regarding VT is troubling particularly since researchers have found that clinicians who are novices have a higher likelihood of experiencing VT (Adams & Riggs, 2008; Bober & Regehr, 2005; Brady et al., 1999; Way et al., 2007).

These findings of limited or lack of awareness are consistent with the current literature. Scholars who have written on the curriculum of general psychology training programs concluded that education regarding trauma as well as the consequences of
working with trauma populations, such as VT, is often missing in graduate training programs (Courtois & Gold, 2009; Danieli, 1994; Gold, 2004; Neumann & Gamble, 1995). Furthermore, students have reported feeling unprepared in regards to working with clients who have experienced trauma (Alpert & Paulson, 1990; O’Halloran & O’Halloran, 2001; Pope & Feldman-Summers, 1992). Such was the case in the present study. After viewing the clinical case vignette, both the first and second times, several participants discussed feeling untrained to counsel clients with issues related to generational childhood sexual abuse, which was described in the vignette. Given this, training on counseling trauma populations as well as ways to prevent the potential negative consequences of working with clients who have experienced trauma seems essential for clinicians-in-training.

Participants’ response to the clinical case vignette was a category that emerged during the cross case analysis and thus warrants some discussion. Two participants who both volunteered that they had experienced past trauma, expressed a lack of surprise at the traumatic details in the clinical case vignette and one participant, after viewing the vignette the second time, expressed feeling surprised at the clinician’s reactions toward her client. For example, the participant stated, “I was surprised at her level of shock” at the client’s story. Conversely, two participants who both volunteered that they had not experienced past trauma, reported surprise at the trauma details in the clinical case vignette. This finding could potentially be due to the participants with trauma histories having a better awareness of what trauma may include for survivors. It might be interesting to note that the two participants that reported surprise at the trauma details from the vignette were two of the youngest participants in the study, which is troubling
since research indicates younger clinicians might be more at risk for VT (Adams & Riggs, 2008). It is also interesting that the participants did not report a reaction to the fact that the client was a female perpetrator of childhood sexual abuse. Given this, I am left to wonder about potential reasons for this lack of discussion. It could be due to the additional awareness in United States culture that both males and females perpetrate sexual abuse. It could also illustrate that the participants were very focused on the client’s traumatic story and thus failed to attend to any additional details. It could have also had something to do with the way in which I framed the questions to focus on the clinician’s reaction to the client’s story, not the demographics of the client.

Another finding that emerged regarding participants’ responses to the clinical case vignette included several participants in this study discussing their feelings of sadness, distress, anxiety, and mistrust of others after they viewed the clinical case vignette. This finding could represent a possible natural response that anyone may experience when hearing traumatic stories (Briere & Scott, 2006; McCann et al., 1988; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998); however, it is important to note that since clinicians are more likely to hear details of traumatic stories than someone who is not a clinician, they may be more susceptible to strong reactions to traumatic material, based on the participants’ reactions to the vignette. Moreover, they are attentive and engage with clients on an empathic level which might make them more vulnerable. Over time this exposure and these strong reactions could put clinicians at risk for experiencing VT. It is important to note that the strong reactions participants experienced to the vignette may potentially be even more intense when they are empathically engaging with clients’ traumatic material during an actual counseling
session. These strong reactions to the vignette illustrates that clinicians-in-training, and possibly all clinicians, may be susceptible to VT. Given this potential risk, clinicians-in-training need to be prepared to hear their clients’ traumatic experiences, so they can make sure to protect themselves from the negative consequences of working with trauma populations (Danieli, 1994; Neumann & Gamble, 1995). Given the findings of the participants’ responses to the clinical case vignette, the vignette seemed to help raise participants’ awareness of VT and also functioned as an unintended training tool that provided participants with additional information about VT.

With regard to general level of awareness, the participant who reported having an awareness of VT from a course on Post Traumatic Stress Disorder (PTSD), stated that before she participated in the study she questioned whether a clinician could be negatively impacted by hearing clients’ traumatic stories. After she had attended the psychoeducational workshop on VT and viewed the clinical case vignette twice, she shared that she felt the vignette and the workshop had “opened up [her] mind to the possibility that [vicarious trauma] can happen” and expressed how important it was to “prepare clinicians” for potentially experiencing VT. Given that someone who stated she had heard about the construct of VT had a strong reaction to the clinical case vignette may indicate that limited training is not sufficient to fully raise people’s awareness of VT, whereas additional training, such as the workshop for the particular client described above, could help raise clinicians’ awareness. In sum, the participants’ responses from this study signify a need for clinicians to have an awareness of VT before exposure to the negative consequences of working with trauma populations.
Impact of the VT Psychoeducational Workshop

The second research question asked about the impact of a VT training program on clinicians’-in-training ability to recognize VT in others. The training program was the psychoeducational workshop designed to provide information about VT, specifically VT symptoms, potential risk factors associated with VT, and VT’s impact. Discussion of the study findings related to this second question will thus be organized around these aspects. I will also discuss the constructs of resilience and self care. Study findings regarding VT revealed that while most participants had little knowledge about the construct before attending the psychoeducational workshop, afterward they discussed the different aspects of VT in more detail and were able to provide examples of the symptoms, potential risk factors, and impact of VT that they observed the clinician in the vignette experience.

Symptoms of VT. Pearlman and Saakvitne (1995a, 1995b; Saakvitne & Pearlman, 1996) advocated that training regarding the symptoms of VT is an important component for clinicians to have a greater understanding of VT. The study findings about recognizing VT symptoms suggested that participants gained greater understanding of some of the different potential symptoms of VT after they attended the psychoeducational workshop. Before the workshop they had a difficult time discussing the different categories of symptoms (i.e., physiological, psychological, emotional, interpersonal, and foundational) and gave minimal examples. In contrast, after participants attended the workshop, they discussed the different categories of VT symptoms in more depth as well as provided additional examples of different symptoms.
The category of symptoms described the least by participants was the physiological one, such that three of the seven participants recognized the overall area of physical symptoms of VT and only two participants described limited examples of physiological symptoms. In contrast, the category of symptoms described the most by participants was the foundational one, such that all seven participants’ explained foundational symptoms in greater detail and provided more specific examples after they attended the workshop. The participants may have discussed the foundational symptoms more than the other symptoms due to the foundational symptoms being seemingly more intense. For instance, clinicians questioning their faith and belief in God could be seen as more severe versus having a headache at the end of a counseling session. Physiological symptoms may also be easier to dismiss or explain away, such as feeling exhausted could be attributed to exercising too much or getting less sleep, whereas experiencing changes in worldview may be directly related to hearing a torture survivor share the details of his or her traumatic experiences. Interpersonal symptoms of VT were discussed by six of the participants after they attended the psychoeducational workshop on VT. This category of symptoms seems important to discuss due to a few participants who expressed how important it is for clinicians to have a support network and the notion that a clinician would not have support seemed shocking and even dangerous. One participant expressed this concern after she observed the clinical case vignette twice:

She started to not want to do stuff with her husband, not wanting to go out with friends, not want to attend things, [which] is the biggest danger that I would see because it is through connecting with others that she is gonna be able to stay stable so if your first gut reaction is oh gosh I need to just withdraw and process this then you are cutting yourself off from the lifeline that you would have to be able to unpack it and process it and verbalize it.
Interpersonal and foundational symptoms were discussed in more depth and were mentioned more often by participants after they attended the workshop. This finding could be due, in part, to the intensity that participants felt regarding interpersonal relationships and foundational beliefs, which was illustrated by the intensity and frequency of the participants’ emotional reactions to interpersonal and foundational symptoms, as the above example illustrates.

These findings regarding participants increased recognition of VT symptoms are consistent with Pearlman and Saakvitne’s (1995a, 1995b; Saakvitne & Pearlman, 1996) belief that educating clinicians with regards to symptoms of VT provides a greater understanding of VT. It is important to note that despite the increased ability of the participants to recognize VT symptoms after they attended the psychoeducational workshop, only three actually discussed all five categories of VT symptoms. Therefore, though knowledge of VT symptoms increased post intervention, one psychoeducational workshop is likely not sufficient for educating clinicians regarding the symptoms of VT. The results of this study indicate that professionals training clinicians regarding the symptoms of VT may want to give thought to the emphasis of different categories of VT symptoms as well as specific attention to the ways in which they provide examples of the different types of symptoms.

**Risk factors of VT.** The findings from this study regarding participants recognition of potential risk factors (i.e., ongoing and repeated work with clients who have experienced trauma, clinicians’ personal trauma history, present personal situation, lack of supervision, lack of training on working with clients who have experienced trauma, and work environment) indicated that they were better able to discuss the
potential risk factors after they attended the psychoeducational workshop on VT. This finding is consistent with the literature, which supports the idea that training for clinicians on the potential risk factors of VT would help them to recognize the potential risk factors of VT in others (Patrick, 2007; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998). Before the workshop, two participants did not describe any potential risk factors, one participant described one risk factor, two participants described two risk factors, and two participants described three risk factors. The potential risk factors that were recognized varied among the participants. The participants who described potential risk factors before they attended the psychoeducational workshop on VT discussed four different factors (i.e., personal trauma history, lack of training on working with trauma populations, lack of supervision, and work environment) that could increase clinicians’ risk for VT. For some of the participants, the risk factors reported before they attended the psychoeducational workshop on VT seemed to have had some personal relevance. For instance, one participant questioned if “younger girls’ fresh new lives will leave them enough strength to do this work more easily” or if a clinician who has experienced trauma in her personal life may have the advantage due to having been “tested” and “survived.” This question of a “young” clinician versus a “tested” clinician appeared personally relevant to her since she disclosed that she felt she was a more “tested” clinician having experienced personal trauma. This example illustrates times when participants’ discussion of potential risk factors of VT prompted some self reflection about their own risk for VT. The risk factors discussed before the workshop seemed to highlight previous experiences from the participants’ own lives. This may indicate that clinicians who have experience with
specific risk factors may already have some awareness of what may potentially increase a person’s risk to hearing clients’ traumatic material.

After participants in this study attended the workshop, they described the potential risk factors associated with VT in more depth as well as provided specific examples of the risk factors they observed the clinician in the clinical case vignette to experience. Six participants discussed two potential risk factors, lack of training and lack of supervision, more often and deeply than the other risk factors. For instance, one participant reported that the clinician in the vignette “was unable to be effective and needed further training and supervision.” Additionally, two participants described feeling disappointed and irritated towards the clinician in the vignette for not seeking additional training. For example, the response by one participant to the clinician in the vignette’s wishing that she could get more training was, “Well… do something about it.”

When discussing lack of supervision, a participant expressed that “the big [risk factor] that stood out for me is supervision, not having a good supervisor.” Pearlman and Saakvitne (1995a, 1995b; Saakvitne & Pearlman, 1996) argue that regular supervision when working with trauma is an essential professional responsibility. During the data analysis a finding revealed that none of the participants indicated on the demographic questionnaire any helpful supervision experiences with regards to working with clients who have experienced trauma. This lack of helpful supervision experiences could be due to their novice status because the participants had experienced little supervision, approximately seven weeks, at that point in their training. However, this still seems troubling particularly since six participants reported having at least one practicum client who discussed some form of trauma as a presenting concern. It seems critical that
clinicians have some form of supervision or consultation “for holding and metabolizing the intense… personal responses to trauma” (Saakvitne, 2005, pp. 142-143).

Unfortunately, even after they attended the psychoeducational workshop on VT, the participants still had some difficulty identifying potential risk factors of VT. For instance, none of the participants discussed all six of the potential risk factors for VT. Therefore, though knowledge of VT risk factors increased post intervention, a single training experience, such as the psychoeducational workshop, is probably not enough to ensure that clinicians are prepared to recognize the potential risk factors of VT. The results of this study may indicate that professionals who train clinicians may want to give thought to the emphasis of different risk factors as well as the specific examples provided for different potential risk factors.

**Impact of VT.** The study’s findings regarding participants’ ability to recognize VT’s impact (i.e., personal and professional) indicated that they were better able to discuss the impact of VT after they attended the psychoeducational workshop on VT. According to the literature, negative personal implications of clinicians experiencing VT may include their own personal trauma resurfacing or problems communicating with family and friends, and negative professional consequences of VT may include clinicians feeling unable to empathically connect with their clients or having a difficult time interacting with their colleagues (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a, 1995b). Before they attended the workshop, all but one participant did not identify any potential negative personal consequences of working with trauma. After they attended the workshop all but one of the participants did describe examples of the potential negative personal impacts of VT. Examples they described of the negative
personal consequences were “divorce,” “not be[ing] the best parent,” and “disruption in home life.” A possible reason, in part, for only one participant discussing the negative impact on clinicians’ personal lives before the workshop might be attributed to clinicians, on the whole, being taught to remain objective and not think about their own personal lives while counseling clients. With regards to participants’ ability to recognize the negative professional impact of VT, four of the participants provided examples of negative professional impacts before they attended the workshop. After the workshop, all but one of the participants were able to discuss examples of the potential negative professional consequences of VT. In addition, many of the participants discussed how the impact could be a potential difficulty for themselves. For instance, one participant stated that the “relationship that [she has] already experienced with trauma and with other peoples’ trauma is a backdrop on which [her] clients’ relationships with trauma will be filtered.” These findings are consistent with Pearlman and Saakvitne’s (1995a, 1995b; Saakvitne & Pearlman, 1996) and Cleman’s (2004) belief that education and training for clinicians affords them a greater awareness of VT as well as the ability to recognize the negative consequences of VT in others and in themselves. Given that the intervention increased awareness and participants were able to recognize VT in others as well as in themselves supports that the psychoeducational workshop on VT was reasonably successful. The success regarding participants’ increased ability to recognize the impact of VT is illustrated with the following participant quotation: “Therapists and helping individuals can be traumatized by the trauma cases they hear about and [VT] can affect them in their lives and in their own well being.”
**Resilience and self care.** As noted in Chapter IV, another related area that emerged from participants’ data but that did not specifically answer the research questions, was the nature of the discussion around the constructs of resilience and self care. Findings regarding the construct resilience showed that just one participant addressed the idea of resiliency when discussing her hopes for clinicians to be able to overcome professional obstacles during their careers. Findings that emerged regarding the construct of self care indicated that participants seemed initially to have a lack of knowledge about the construct. Most of the participants did not describe self care and did not provide specific strategies of self care before they attended the psychoeducational workshop on VT. However, after the workshop, all but one of the participants was able to describe the importance of self care, although most of the participants struggled to define what self care may include and provided very few specific self care strategies. This seemed surprising due to a number of specific examples of self care being briefly discussed at the end of the psychoeducational workshop. Moreover, this seemed especially alarming considering the volume of literature written by scholars and researchers stating the importance of self care for clinicians (Berzoff & Kita, 2010; Dass-Brailsford, 2010; Neumann & Gamble, 1995; O’Halloran & Linton, 2000; Osofsky, 2009; Patrick, 2007; Pearlman & Caringi, 2009; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Wicks, 2008). The lack of discussion regarding the construct of resilience and self care by participants may be due to a lack of questions that focused on resilience or self care in this study. The lack of discussion regarding self care could also potentially illustrate that at least the participants’ training program, and perhaps other training programs, do not spend time training clinicians on developing
healthy coping mechanisms. Instead, perhaps training is focused on client care, which was illustrated by three participants reporting that they initially thought VT was a client concern. Training on client concerns should be paramount, yet clinicians’ own welfare should not be overlooked or minimized.

Given the importance of resilience and self care as well as the participants’ difficulties in discussing the two constructs, it seems crucial that training and education specifically regarding these constructs be provided for clinicians. Pearlman and Mac Ian (1995) advocated that clinicians must have self care strategies to maintain “high quality, ethical services” as well as to protect “themselves and their nonprofessional lives” (p. 564). Additionally, according to Harrison and Westwood (2009), “holistic self-care” (p. 207) was found to be a very important component to alleviate the consequences of VT. Holistic self care was described as using different methods or resources to take care of oneself physically, psychologically, emotionally, and interpersonally for both healthy personal and professional lives (Harrison & Westwood, 2009). In addition, participants from their study described self care as not only a necessity but an ethical duty; “if they do not take care of themselves, they are at risk for harming others” (Harrison & Westwood, 2009, p. 212). Considering the difficulties participants in the present study had providing specific examples of self care, a brief presentation on self care during a psychoeducational workshop is not sufficient for educating clinicians about its importance and the ways in which one can protect oneself. Neumann and Gamble (1995) advocated the importance for organizations to provide appropriate education on self care as well as stress to clinicians to practice self care, especially for novice clinicians. Even with understanding the significance of clinicians’ need to integrate self care into their
lives, many professionals do not have an awareness of how self care can prevent VT (Meyer & Ponton, 2006; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996). Given this, continued education regarding VT needs to explicitly state the importance of self care in preventing as well as combating VT (McCann & Pearlman, 1990; Patrick, 2007; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996).

**Researcher’s Journal**

My journal writing throughout the study was extremely helpful for me to focus on my participants’ voices and not get lost in the overwhelming process of data collection and analyses. Specifically, I found the amount of data most overwhelming when first beginning the single case analyses. I found it helpful to write about my feelings of excitement when I found something thought-provoking that a participant expressed about VT or her participation in the study, as well as my feelings of fatigue when the letters began to blur together. Additionally, writing in a journal allowed me time to process and reflect upon my notions and biases regarding VT.

In the beginning, when attending practicum classes to ask for potential participants for this study, I was worried that I would not have any interested students. I found that writing about that concern before visiting the classrooms helped me to remain positive and remember the benefits for the participants. The thoughts I had written in my journal also became helpful when writing this chapter. The ideas that I noted to myself regarding the successful and unsuccessful aspects of the psychoeducational workshop on VT supplied me with a few ideas to include in the interpretation of the findings that emerged from the cross case analysis. For example, one idea that came to me regarding
self care due to the lack of discussion from the participants was the need to have spent
more time in the workshop covering the importance of self care in combating and
preventing VT. Additionally, I found it helpful to have a specific place when I could write
these thoughts and later revisit them when writing Chapter V, which helped to decrease
some anxiety about forgetting an idea. When I reviewed the journal during the writing of
Chapter V, I found myself having a difficult time switching from being immersed in the
data to being able to see the implications of the study. As my advisor stated, “I couldn’t
see the forest for the trees.” This process of struggling to have balance regarding the
participants’ data and what I learned from the study made me wonder about a parallel
process of clinicians who work with clients being unable to see the bigger picture of how
their work with those clients can have negative consequences for themselves.

I also reflected on my own feelings that arose throughout the study. I found a
consistent theme throughout my journal entries, which included feeling overwhelmed by
the amount of data to analyze and interpret. I consistently wondered what to do with all of
the data. My dissertation chair advised that I write on a note card the purpose of my study
and the research questions to help me stay focused, which I found to be helpful at times.
At other times, when I would feel exhausted and the thought of reading another interview
transcript about vicarious trauma was almost painful, I wrote in my journal that I
wondered why I ever thought the purpose of my study and the research questions would
be a good dissertation topic. During the times I felt this way, I reminded myself about
ways I take care of myself and that I had to practice what I preach to my clients: self care
is a necessity. Luckily my questioning of the purpose of the study and research questions
decreased as I moved from the case-by-case analysis to the cross case analysis. In addition
to feeling overwhelmed, I also wrote about feelings of anger and sadness. My anger was most prominently focused on the lack of adequate education provided by graduate training programs on counseling trauma populations and the potential negative consequences. My sadness manifested through the belief that clinicians may currently be vicariously traumatized due to that lack of training. Even now, I find myself saddened by the thought that most of the wonderful women that participated in this study, had they not participated, may possibly have learned about VT only after they had been traumatized from working with clients who have experienced trauma.

In Chapter III, I discussed my background and wrote about the need to continue to process my biases regarding VT throughout the study. I found the journal writing to be particularly helpful in reflecting on these preconceived notions, especially when conducting the analyses. For example, I reflected many times about the importance of setting aside my bias that training on VT is not included in most training programs and, therefore, the participants will likely have no awareness of VT. I wanted to make sure that I was hearing what the participants were saying regarding their awareness of VT instead of confirming what I thought would be uncovered. The journal writing also helped me to reflect on how surprised, yet happy I was to see that one of the participants did report that she had some training on the construct of VT. Another bias I found myself regularly reflecting on included a dialogue about the likelihood of clinicians experiencing VT. I would vacillate between writing about the rewarding aspects that clinicians experience when working with trauma populations, such as vicarious resilience, and the negative consequences that occur. This seemed particularly relevant as I was conducting my data analyses while on my internship and clients who had experienced trauma were
approximately half of my caseload. A good example includes a week where three of my trauma survivors had been physically attacked by previous abusers and I spent a great deal of time with each of them to safety plan and decompress from the abuse. A few weeks later, I met with a trauma survivor who previously had been unable to leave her dorm, but now discussed how free and exhilarated she felt after her stalker had moved out of state to go to another university. Utilizing a journal throughout this study was a useful tool to both help organize my thoughts and process my reactions.

**Limitations**

Some limitations of the study involved my lack of experience as a researcher, my multiple roles, the data collection instruments and clinical case vignette, and the nature of the participant pool. An important potential limitation of the study was my novice status in conducting qualitative research. Because the researcher in qualitative research is one of the main instruments to collect data (Morrow & Smith, 2000), my inexperience at conducting the interviews as well as creating instruments, such as the demographic questionnaire, reflection questions, and research questions, may have impacted the richness of data collected. According to Kvale and Brinkmann (2009), interviews provide an excellent way to gather data; however, due to my inexperience, I believe that my rigidity in asking the interview questions was a hindrance. For instance, the interviews might have provided richer data if I had probed participants for further information when they provided a brief answer to an interview question. Retrospectively, it feels as if my worry about deviating from the questions as well as anxiety about making mistakes inhibited my ability to probe and ask additional questions. My inexperience in conducting
interviews was probably most evident with the constructs of resilience/self care as there was a lack of discussion and description for both constructs. If I had noticed that the finding of resilience and self care was emerging, I may have been able to probe further regarding the discussion of these two constructs when they arose and gained richer and more detailed data.

Another example of a potential data collection and/or data analysis limitation involves the interview questions themselves. They may have been too narrowly focused and did not allow for the research participants to discuss in any extended depth topics outside of VT’s symptoms, risk factors, and impact as well as resilience/self care. Given my research questions, the richness that I was able to gain by focusing on these specific constructs allowed for a more in-depth look at participants’ knowledge regarding symptoms, risk factors, and impact of VT. Another example of my inexperience as a qualitative researcher became evident during the data analysis phase. Some of the questions on the demographic questionnaire were vague or difficult to interpret. For example, the ratings used for the question about impact of spirituality and religion did not allow a complete and rich understanding of this topic. This question might have been better asked in an open-ended format in the first interview. For example, “Please discuss how spirituality and/or religion impact your life.”

In addition to my novice status as a qualitative researcher, another potential limitation of the study could include the multiple roles I played: instrument in collecting data, developer of the workshop, and presenter of the workshop. Since I both developed and presented the workshop, I had impact on the participants learning about VT. While I was the original creator and then disseminator of the presentation, it should be noted that
I did incorporate expert critiques of the content (i.e., didactic components) of the presentation in an effort to make sure of the accuracy of the content. That being said, my multiple roles raise some questions regarding the workshop. How did my role as presenter of the workshop impact the participants’ learning? Was the content presented in a way that participants were able to learn about the different aspects of VT? Did I present the information in a clear enough fashion? Could the presentation delivery (i.e., didactic presentation) have impacted the way participants received the education regarding the symptoms, risk factors, and impact of VT as well as self care? Did my two roles of presenter of the workshop and then data collector impact participants’ ability to ask questions during the workshop, inhibit participant learning in any way, or perhaps impact how they shared information during the rest of the study activities? All of these unanswered questions are limitations to the study. One potential way to eliminate some of these limitations might have been to ask an expert on VT to present the workshop, thereby eliminating a central concern of myself, as a data collection instrument, having multiple roles. In spite of these questions, I was able to gain rich data regarding the participants’ awareness level of VT and the successful impact of the workshop on the ability of clinicians-in-training to recognize VT in others.

While it was not considered a part of the training program, the clinical case vignette may have functioned, at least in part, as an educational/training tool about VT. The vignette was designed to serve as a means by which to assess participants’ awareness of VT (symptoms, potential risk factors, and impact), yet it may have also served to provide viewers with more knowledge about the construct. Given this, the vignette used to assess participants’ awareness of VT may have been an unintended training
component. Thus, it is important to note that other data collection elements other than the psychoeducational workshop could have affected participants’ awareness and knowledge of VT.

A potential limitation of the study also involves the homogeneity of the participants. This homogeneous population allowed in-depth study of a very specific population and context (i.e., Caucasian, heterosexual females who are master’s level clinicians from counseling psychology or counselor education graduate training programs at a Midwestern university); however, it may have been helpful if there had been more demographic diversity among the participants. For instance, how would our understanding of beginning clinicians’ awareness level and knowledge of VT been altered if there had been male participants? The participant population and context limited the ability to generalize the findings of the study to another context. According to Creswell (1998), generalizations are most accurate and helpful when the cases are representative of different contexts. Therefore, the findings that emerged from this study are best used to inform similar training programs about the important need for clinicians to receive education on the construct of VT.

**Implications and Areas for Future Study**

According to Stake (2006), “it would be a mistake if a multicase researcher fail[ed] to disclose whatever generalizations appear evident from the data” (p. 90). Lincoln and Guba (1985) suggested that in the final interpretation the researcher include lessons learned from the case; however, Creswell (1998) urged caution when generalizing from multiple case studies in large part due to the very specific context of those cases.
Therefore, what follows are the implications drawn from the study results, areas for future study, and a cautionary note about the context. With respect to the cautionary note, all seven participants were novice master’s level clinicians from either counseling psychology or counselor education training programs in a Midwestern university setting. Additionally, across most demographic variables except age, the participants were a demographically homogenous sample. All seven of the participants identified as Caucasian, heterosexual females. Given the homogeneous nature of the participants, the findings must be interpreted with caution.

The present study findings illustrated that most participants had no awareness regarding VT and yet all but one of the participants were providing counseling to clients that reportedly had trauma concerns. With the prevalence of trauma survivors in our society, even if participants had not counseled clients with trauma concerns during their training, they would potentially counsel them in their jobs after they graduate. If the participants in the current study are representative of clinicians-in-training, clinicians in general are not being trained on VT and thus may have limited awareness of VT. Since clinicians-in-training are most likely seeing clients who have experienced trauma and yet may have little or no awareness and knowledge about VT’s symptoms, risk factors, and impact, they are susceptible to experiencing VT. Thus, VT training is essential to help protect clinicians from experiencing the negative consequences of working with trauma populations. In addition to clinicians-in-training receiving education regarding VT, clinicians working in the field would benefit by continuing education regarding the symptoms, risk factors, and impact of VT as well as ways to combat any VT symptoms they have experienced.
The success of the intervention in this study implies that education and training regarding VT can help raise clinicians’ awareness and knowledge regarding the construct of vicarious traumatization. Thus, it seems possible that other training programs could include training about VT for their students, especially since the study’s findings illustrated that a 45-minute workshop on VT can have some success at raising participants’ awareness level of VT and knowledge regarding symptoms, risk factors, impact, and self care. Even though more education regarding VT could be more successful at raising awareness level and knowledge regarding VT, a short 45-minute workshop had an impact on increasing clinicians’-in-training awareness level and knowledge of VT. Therefore, it would seem that having at least some form of training for clinicians-in-training before they start their practicum or at the beginning of their practicum experience may be helpful since, according to the participants in this study, clinicians-in-training are likely to see clients who have trauma concerns. Additionally, due to participants discussing physiological symptoms less than foundational symptoms, as well as participants having difficulties describing some potential risk factors more than others, it would seem important for training programs to learn what emphasis is needed for the different aspects of VT symptoms and risk factors for their students.

The present study findings also illustrated that participants discussed lack of supervision as a potential risk factor. Included in their rich responses was the idea that receiving good supervision while training to become a clinician is very important. Thinking about this finding from a developmental perspective, being a novice clinician could account for their reported lack of supervision experiences that have been helpful in supporting their work with trauma survivors. Their level of development, according to
Stoltenberg and McNeill’s (2010) Integrative Developmental Model (IDM), could have been a factor. Participants may have been more focused on seeking their supervisors’ approval that they are good clinicians and gaining instruction on the right ways to do therapy, and not necessarily at the stage of looking at how they are a part of the therapeutic process with their clients. Their responses regarding the necessity of good supervision might also be a matter of the level of anxiety new clinicians experience when engaging in their work (Stoltenberg & McNeill, 2010). Additionally, their expectations for supervisors might be unrealistic, such that they feel their supervisor should provide them with lots of advice. Conversely, the absence of helpful supervision experiences related to trauma work might be a function of the level of experience of the supervisors. Given the participant findings related to the importance of supervisors being able to discuss issues related to working with trauma clients, issues such as VT, perhaps supervisors would benefit by receiving training and education on the symptoms, risk factors, and impact of VT as well as ways to help supervisees manage and combat VT.

Beyond the issues of supervision, it is possible that developmentally these participants were not able to consider that they could be impacted by their clients’ material. Retrospectively, these issues may highlight the importance of them having repeated exposure to VT information at multiple developmental points. For example, VT training could occur in a basic counseling skills course, in a practicum counseling course, and during a field practicum group supervision course. This seems important so that the first time clinicians-in-training learn about VT is not when they are faced with seeing clients who have experienced trauma.
The absence of training on trauma and the negative consequences that potentially occur when working with trauma are concerning, yet also understandable. The vast amounts of knowledge training programs are trying to convey in a relatively short time span create many difficult decisions of what should be included and what goes unaddressed. Thus, it seems hopeful that a short workshop had an impact on increasing clinicians’-in-training awareness level and knowledge of VT, illustrating that even a very small amount of training on VT can help clinicians raise their awareness and knowledge.

To make the most of the training time and given the discussion above regarding symptoms, potential risk factors, and impact of VT, it might be helpful for training programs to assess what symptoms and risk factors to emphasize for their students. Additionally, impact areas that are professional in nature may be more noticeable for clinicians so personal consequences of VT may be important to emphasize. The lack of the participant discussion around self-care may illustrate that training programs need to intentionally focus on coping strategies of their clinicians-in-training. Lastly, since the participants had strong reactions to the clinical case vignette and may have received unintended education regarding VT symptoms, risk factors, and impact from the vignette, training programs may try to include a vignette or other example illustrating how VT can affect clinicians. Related to the participants having strong reactions to the clinical case vignette, it may be helpful to include a debriefing after participants view a vignette. The current study worked to ensure that participants’ safety was taken into account by providing a debriefing at the end of the second interview, a list of mental health resources, and the journal as a self care resource; however, a debriefing session after each vignette would have been an additional way to ensure participants’ safety.
In addition, two participants volunteered that they had previously experienced trauma. Due to issues related to participant confidentiality and safety, questions about previous personal trauma were not asked as a part of data collection, so it is possible that more than those two participants had experienced previous trauma. Scholars and researchers report that past trauma experiences can increase clinicians’ risk for experiencing VT (Bober & Regehr, 2005; Bride & Figley, 2009; Hernandez et al., 2010; Meyer & Ponton, 2006; Patrick, 2007; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996; Saakvitne et al., 1998; Salston & Figley, 2003; VanDeusen & Way, 2006). Therefore, it seems important to discuss with clinicians-in-training how their own trauma histories may potentially increase their risk for experiencing VT. Moreover, training programs need to discuss specific ways that clinicians-in-training can prevent VT to help decrease the potential risk of being vicariously traumatized for those clinicians who have experienced previous trauma. Given the study’s findings that clinicians had difficulty expressing specific examples of self care, discussing healthy coping mechanisms with clinicians-in-training could be an important step in helping decrease clinicians risk of experiencing VT. Thus, my hope is that training programs will choose to incorporate training on trauma and VT into their curriculum so clinicians can be made aware of the potential negative consequences of counseling trauma populations before clinicians are traumatized.

The present study’s findings revealed that, in general, the participants had not received education regarding VT from their training programs; however, some programs may include training on the potentially negative consequences of working with trauma populations. For programs that are providing training on VT for clinicians, sharing what
training is being provided as well as the results of that training could be helpful for other programs that do not have VT training. Future areas of study may include assessing what students’ awareness level and knowledge of VT is after they have received training. The current study’s findings illustrated that training on VT increases participants’ awareness level and knowledge regarding the construct of VT. Thus, future research studies might also seek to investigate the specific content regarding symptoms, risk factors, and impact that should be included in training as well as what examples of different aspects of VT are important to include. In addition, future studies may want to investigate the best time for clinicians to receive training, such as before students see clients or in beginning of their first practicum experience.

Understanding how training on VT has affected prevention for clinicians-in-training also seems important. To focus on prevention, a future study might present training on VT and then conduct a follow-up investigation some time (e.g., 6 months) after the training to see what information about VT has been retained. Additionally, a qualitative longitudinal study that interviewed clinicians every year starting at training and continued for 10 years may be helpful to further investigate ways clinicians are able to prevent VT. Future studies regarding prevention may also want to investigate clinicians working in the field that have experience working with trauma populations to investigate possible ways to prevent VT that may have naturally developed for clinicians over time. I think that it is important to note that the literature includes a debate about whether VT is preventable or rather is an unavoidable normal product of hearing clients’ traumatic stories that clinicians need to learn how to manage (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a, 1995b; Saakvitne & Pearlman, 1996). Given this, future
research studies could investigate the success of training about VT in two different ways, preventing the symptoms and impact of VT for clinicians as well as managing the symptoms and impact of VT for clinicians.

The study’s findings also illustrated that participants had strong reactions to the clinical case vignette and the vignette may have potentially helped to educate clinicians on the different aspects of VT; however, future research needs to be conducted on how helpful a specific example of a clinical case vignette is with regard to educating clinicians on VT. Additionally, this study’s findings showed that a one-time didactic psychoeducational workshop may not be sufficient for educating clinicians regarding the symptoms, potential risk factors, and impact of VT. Given this, it seems important that more research be conducted on what are more successful methods to educate clinicians about VT.
REFERENCES


Appendix A

Script for Discussion with Clinic Director
Script for Discussion with Clinic Director

Hello,

___________  (first clinic director) or

___________  (second clinic director).

My name is Amy Cavanaugh. The reason for my call is to ask for your help with getting a pool of participants for my dissertation research. I am asking for a list of the instructors of record that are teaching practicum courses in your clinic this semester and their contact information, phone number or e-mail. The instructors of record contact information will only be used to contact them to ask permission to recruit participants in their practicum classes. I am looking for beginning clinicians-in-training and hope to recruit participant(s) from the counseling practicum they are teaching. I would need to go into the class to discuss my study with the students.

I am also asking permission to conduct research and to use clinic space to conduct data collection including participants observing clinical case vignettes, engaging in individual interviews, and presenting a psychoeducational workshop.

Answer any questions?

Thank you.
Appendix B

Script for Discussion with Instructor of Record
Script for Discussion with Instructor of Record

Hello,
________________ (Instructor’s of record name).

My name is Amy Cavanaugh and I am a counseling psychology doctoral student. The reason for my call/e-mail is to ask for your help with recruiting a pool of participants for my dissertation research. What I am wondering is if it is possible for me to come into your class on (insert date) to recruit participants for my study. The study has been approved by the Human Subjects Institutional Review Board and by my dissertation chair.

If the instructor indicates that I am able to come into her or his class or would like more information on the process:

   I would need approximately 15 minutes to come into the class to discuss my study with your students. Do you have any questions about the study recruitment?

If the instructor indicates that I am able to come into her or his class:

Can we schedule a time I can come to your class to recruit participants?

   If yes, schedule. Thank you.

   If not, when would be a good time to schedule a visit to your class? Thank you.

If the instructor indicates that I am not able to come into her or his class: Thank you.
Appendix C

Script for Explanation of the Study for Students
Script for Explanation of the Study for Students

Hello, my name is Amy Cavanaugh and I am a fourth year counseling psychology doctoral student. I am working on my dissertation and am here to describe my study and see if anyone would like to learn more about participating in the study. My study includes asking what clinicians-in-training understand about what it means to work with clients experiencing trauma.

[At this time I would pass out a copy of the informed consent document (see Appendix D), a list of mental health resources (see Appendix L), and go over both documents with the potential participants].

Please carefully consider the content of the study and what will be asked of you as a participant when making your decision about whether to be involved in the study. Does anyone have any questions?

I will be available in (room #) during class breaks and after class to privately answer any additional questions and to continue the consent process. If you are not interested in participating in the study, please shred the informed consent document.

Thank you so much for your time
Appendix D

Informed Consent Document
Informed Consent Document

Principal Investigator: Kelly McDonnell, Ph.D.
Student Investigator: Amy Cavanaugh, M.A.
Title of Study: Clinicians’ in training ability to recognize vicarious traumatization: A multiple case study

Hello, I am inviting you to participate in a study about clinicians who work with clients who have experienced or are experiencing trauma. This project will serve as Amy Cavanaugh’s dissertation project for the requirements of the doctorate degree in Counseling Psychology. This consent document will explain the purpose of this research project and will go over all of the time commitments, the procedures used in the study, and the risks and benefits of participating in this research project. Please read this consent form carefully and completely and please ask any questions if you need more clarification.

What are we trying to find out in this study?
The researchers are trying to gain information regarding clinicians who work with clients who have experienced or are experiencing trauma.

Who can participate in this study?
To participate in the study, you must meet the following criteria: (a) be a beginning clinician with 3 months or less of clinical experience and (b) be enrolled and participating in a master’s level clinical practicum course. Approximately 5 to 8 individuals will be invited to participate in the second phase of the study from among those who express an interest in being a part of the study. This invitation will be based on the number of participants that can be included in the study.

Where will this study take place?
Your meetings with the student researcher will take place in the Center for Counseling and Psychological services at Kalamazoo or Grand Rapids, depending on where your practicum is held, or in another confidential room in the building where the clinic is located.

What is the time commitment for participating in this study?
All participants will be asked to complete a demographic questionnaire, which will take approximately 5 to 10 minutes. Participation in both phase 1 and phase 2 of the study will require approximately 5-6 hours.

What will you be asked to do if you choose to participate in this study?
All participants will be asked to complete a demographic questionnaire, which will take approximately 5 to 10 minutes. Those who are invited and decide to participate in phase 2 will be asked to do the following: (a) view/read a 20 minute case vignette (depicting several sessions of a trauma case involving childhood sexual abuse illustrated via a fictitious role-play) and reflect on what you watched/read; (b) write a one page reflection journal on the case vignette; (c) attend a 45 minute psychoeducational workshop presented by the student researcher, Amy Cavanaugh, M.A., about experiences of working with clients who have been traumatized; (d) participate in a 60 minute individual interview with the student researcher; (e) view/read the same 20 minute case vignette and reflect on what you watched/read; (f) write a one page reflection journal; and (g) participate in a final 60 minute individual interview with the student researcher. Both journal
exercises will ask you to take a few minutes to think about your experience of participating in the study and journal any feelings or thoughts that come to mind. The two 60 minute interviews will be audio recorded by the student researcher. You are encouraged to consider if any relationship you have with the researchers would hinder your ability to take part in the study and therefore you may find it is not in your best interest to be a study participant.

What are the benefits of participating in this study?
Ways in which you may benefit from this activity are having a chance to participate in research at the master’s level and gaining a greater understanding of what it means to work with clients who have experienced trauma. Information from this study may help those who train clinicians to better prepare them to work with clients experiencing trauma.

What are the risks of participating in this study and how will these risks be minimized?
Although not anticipated, one potential risk for your participation in this project is that it might elicit negative feelings from watching/reading the clinical case vignette. As this is a potential risk, the student researcher has provided information about mental health professional resources. Additionally, the student researcher will provide information about mental health professional resources at the conclusion of the study. The student researcher will also conduct a short debriefing with you after the final interview.

What are the limits of confidentiality for this study?
The researchers cannot guarantee ultimate confidentiality when other participants are present; however, the student researcher will ask all participants to keep confidential information that is shared by others. The student researcher will also encourage you to consider what you choose to share in a group context. Although the study activities are not counseling, if you discuss harming yourself or others, and/or share information that involves abuse of children or older adults, the student researcher may need to inform any necessary professionals, in accordance with American Psychological Association ethical guidelines.

Are there any costs associated with participating in this study?
A cost to you includes the time commitment, which is approximately 5-6 hours over 3-10 weeks.

Who will have access to the information collected during this study?
All data, including paper documents, audio recordings, and transcripts of the interviews, will be kept in a locked file cabinet in the Principal Investigator’s (PI) office. At the beginning of the study, each participant will be given a code number to use on all documents. For data collected in Grand Rapids, the student researcher will place the informed consent documents in a sealed envelope and will securely transport them to Kalamazoo. All other data collected in Grand Rapids will include participant code numbers and will also be securely transported to the PI’s office in Kalamazoo for storage. The audio recordings will leave Dr. McDonnell’s office only for the purpose of transcription and then will be returned. After the transcriptions are completed, audio recordings will be erased. Any other data that would be removed from Dr. McDonnell’s office for the purpose of data analysis will only include participant code numbers and will be copies of the original documents. Study records will be retained and securely stored for a minimum of 3 years in a locked file cabinet in the PI’s Office. Any presentation or publication of the study will include data in aggregate form and not identify specific participants.
What if you want to stop participating in this study?
You can choose to stop participating in the study at anytime for any reason. You will not suffer any prejudice or penalty by your decision to stop your participation. You will experience NO consequences either academically or personally if you choose to withdraw from this study. You may choose not to participate or you may withdraw from the study at any time without any penalties by letting the researchers know. If you have any questions or concerns about this study, you may contact either Amy Cavanaugh, M.A. at 937-657-4072 or Kelly McDonnell, Ph.D. at 269-387-5107. You may also contact the chair of The Human Subjects Institutional Review Board, Amy Naugle, Ph.D. at 269-387-8293 or the vice president for research at 269-387-8298, with any concerns that you have.

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board as indicated by the stamped date and signature of the board chair in the upper right corner. Do not participate in this study if the stamped date is more than one year old.

By signing this consent document you are indicating that the purpose, conditions, risks, and benefits of study participation have been explained to you. You are also indicating your willingness to participate in the study. Participation means that you will complete the Demographic Questionnaire. You may or may not be invited to participate in phase two of the study.

___________________________________________________
Name (please print)

______________________________________________  ___________________
Signature        Date

______________________________________________  ___________________
E-mail Address        Phone Number
Appendix E

Demographic Questionnaire
Demographic Questionnaire

Participant Code #: ____________  
Date: ____________

*Instructions: Please take a few minutes to answer the questions below by either circling your answer or filling in the blank provided. All information will be used strictly for the purpose of research and will be kept confidential. Thank you.

1. Please self-identify your gender.
   - Female  
   - Male  
   - Transgendered

2. Please self-identify your ethnicity or race (circle all that apply).
   - African American  
   - Alaska Native  
   - Asian/Pacific Islander  
   - Caucasian  
   - Latino/Latina  
   - Native American  
   - Bi-Racial: ________________  
   - Multi-Racial: ________________  
   - Other: ________________________________

3. Please self-identify your sexual orientation (circle all that apply).
   - Bi-sexual  
   - Gay  
   - Heterosexual  
   - Lesbian  
   - Other: ________________________________

4. Age: ________________

5. What best describes your relationship status (circle all that apply)?
   - Dating  
   - Divorced  
   - Married  
   - Partnered  
   - Separated  
   - Single  
   - Widowed

Please turn to the back.
6. What best describes your current academic program?
   Counselor Education: College Counseling
   Counselor Education: Community Counseling
   Counselor Education: Rehabilitation Counseling and Teaching
   Counselor Education: School Counseling
   Counseling Psychology
   Human Resources and Development
   Other: ________________________________

7. Number of credit hours you have completed in your current master’s degree program (not including the current semester):
   _______________________

8. Please rate on a scale of 1 to 6 (1 being low impact and 6 high impact) the degree to which spirituality/religion impacts your life.
   1  2  3  4  5  6
   Low Impact  High Impact

9. Please rate on a scale of 1 to 6 (1 being no preparation and 6 being extensive preparation) how well you feel your academic program has prepared you to counsel those who have been traumatized.
   1  2  3  4  5  6
   No Preparation  Extensive Preparation

10. Indicate the number of clients you have already seen in a counseling session, in CECP 6120 and indicate the number of sessions with each client:

    Number of clients seen in a counseling session in CECP 6120:
    _______________________

    Number of sessions with each client
    Client 1  Client 2  Client 3  Client 4
11. Indicate the number of clients on your current caseload in CECP 6120 for whom you have discussed issues of trauma (please also indicate the type of trauma discussed with each client):

Number of clients: ______ Type of trauma discussed:__________________

12. Have you ever counseled others, formally (e.g., as a clinician) or informally (e.g., as a colleague or family member), regarding trauma they have experienced?

Yes    No

If yes, please circle all of the types of trauma that apply:

- Physical abuse
- Verbal abuse
- Emotional abuse
- Sexual assault or rape
- Childhood sexual abuse
- Military combat
- Natural disasters
- Other:______________________

13. Please describe any supervision experiences you have had as a supervisee that have been helpful in your work with trauma survivors (If you have not had any experiences skip to question 14).

14. Have you heard of the construct vicarious traumatization before today?

Yes    No

If yes, where, when, and how did you hear of the construct?

How do you define vicarious traumatization?

*Please use the back of this page if extra space is needed.*
Appendix F

Clinical Case Vignette
Clinical Case Vignette

Introduction/Narration:
Narrator: Welcome to this clinical case vignette. There are four participants in this vignette: the counselor, the client, the counselor’s internal thoughts, and me, the narrator. The counselor’s internal thoughts and the narrator will not appear on camera. The counselor has her master’s degree in counseling and is working at a private practice with three other clinicians in the community. The counselor is nearing the end of her first year of full time practice. This is the first case she has had referred from Child Protective Services, which will be referred to as CPS. The case involves issues that are new to the counselor. The counselor is married, has a two-year-old child, and is pregnant.

We will begin by watching the counselor read the referral. Next, you will see a compilation of the first three counseling sessions. The counselor has already addressed aspects characteristic of working with a new client, such as introductions, informed consent, confidentiality, and relationship building. As the counselor has accumulated more information than we are able to present here, the vignette will begin by highlighting specific aspects of the first three sessions. Now let’s join the counselor as she is reviewing the case referral.

Compilation of 1st – 3rd sessions:
Narrator: The referral form the counselor received from CPS stated that the individual is a court-ordered client and has been referred for 15 counseling sessions. The client has an open case with CPS and is required to discuss her family issues. The client’s CPS
case worker removed her four children from the home due to an open and on-going investigation concerning inappropriate sexual behavior regarding the client’s children. Currently, CPS is considering terminating her parental rights.

Counselor’s Internal Response: Mandated clients can be difficult to work with, but overall they are good people dealing with difficult issues. I wish there was another counselor here that specialized in working with mandated clients, but I know that I will be okay.

Counselor’s Internal Response: She looks like she has it all together and seems like a nice person. I wonder what has happened to her. I think I can work with her.

Counselor: I received a referral from your CPS case worker, but I’d like to hear in your own words what brings you into counseling.

Client: My children were taken away by CPS. My oldest son, Justin, was caught attempting to remove a girl’s pants in the back of his third grade classroom. Later that same week he was caught masturbating at his desk. They made him talk with the school counselor and he told her that he learned those things from me. I told them that wasn’t true, but they are believing an eight year old boy over me.

Counselor’s Internal Response: I wonder why her son did that, where did he learn those things? He couldn’t have learned it from home, families are safe places for children. I need to make sure to complete a full mental status exam to understand what is happening with the client.

Counselor: Justin’s actions do seem very serious. Tell me more about what has been happening for him recently.
Client: Well, he didn’t learn those things from me. I was just as surprised as the school.

Counselor’s Internal Response: She sounds defensive. This is probably terrifying for her.

Counselor: Sounds like you are upset that your children have been taken away from you.

Client: I’m more angry. My oldest daughter, Julia, supposedly told her counselor that I made her watch while I had sex with my boyfriend. Maybe she came out of her room and saw what was going on but there was no way I made her watch.

Counselor’s Internal Response: Maybe she forgot to lock her door before she had sex and it was a one time thing. Sometimes parents make mistakes, but that doesn’t mean she’s a bad person. Could someone else be hurting her kids?

Client: After they took my kids, my youngest son and daughter told counselors I forced them to do sexual things to each other and I also made them do sexual things to me. They even said I showed them my gun and told them I’d use it on them if they told. I have a gun and my kids have seen it but I never threatened them with it.

Counselor’s Internal Response: I am sure the gun is usually locked up and is just for protection. I may need to ask if the gun is locked up later. Now, all four of her children are saying that she is doing sexual things that are inappropriate.

Counselor: Sounds like you are really surprised that your children are even saying these things.
Client: I am. They won’t even let me talk to my kids. They want them away from me so they can convince them to say all this stuff.

Counselor’s Internal Response: Why won’t they let her talk to her kids? I wonder what is going on with this family. Families should stay together. Mom’s don’t hurt their children. I wish there was another counselor here that had more experience with child abuse issues.

Counselor: You must have a lot of stress and anxiety about what is happening with your children and what you believe people are making them say.

Client: You bet I do. They’re making my kids say things that aren’t true and won’t even let me talk to them.

Counselor: Well, given all that we have talked about, how can counseling be most helpful for you?

Client: I’m just here because the court said I had to, to get my kids back. I’m not sure how this can be helpful, but I want to get my kids back. It would be helpful for me if you could talk to my worker and tell her that I need to talk to my kids.

Counselor’s Internal Response: I wonder if it would be helpful for her to talk to her children. They should be with their mom. It seems like she feels she’s been judged by people and just wants to get her kids back. This sounds like a bad situation. I hope that I can help her. It seems like she’s upset and angry, but am I hearing the complete story? I just feel so confused about what the client is saying and maybe not saying.
Narrator: We are moving forward to a compilation of the sixth, seventh, and eighth sessions. The client has continued to discuss her irritation and anger that her children have been removed from her home. The counselor has received an update from the CPS case worker about the youngest daughter taking off her clothes in the bathroom during recess and mimicking sexual acts with another female student at school. The counselor shared with her supervisor that last night she was talking with her husband about parenting and realized that she didn’t hear him because she was back in the session with her client. She confides to her supervisor that she is worried that she has experienced other times where she felt like she was back in the session with her client. Her supervisor states, “whoa, I’ve never had an experience like that before, I don’t know what to tell you.” After her supervision session, the counselor tells another clinician at her practice that she doesn’t want to go to lunch anymore, but needs to eat while she works at her desk.

Compilation of 6th - 8th sessions:

Counselor’s Internal Response: I can’t stop thinking about what has happened to this woman and her children; it keeps me awake at night. What if I was in her shoes? What if my kids were taken away? I can’t believe that the couple I have been working with talked about having sexual problems because she was sexually abused as a child. I really wish I had someone at work to consult with about both of these cases.

Counselor: At the end of our last session, you seemed really depressed about what was
going on with your children, and you started to talk some about what happened in your
own childhood.

Client: Yeah, I have been thinking about that a lot. Like I told you last time, when I was growing up, my dad was very strict. He wasn’t nice to us. And my mom just took a back seat.

Counselor: Your dad was very strict?

Client: You didn’t dare disobey my father because he would make your life a living nightmare. There was one time where I did disobey and tried to run out of the house. He was faster than me and made me walk circles barefoot in the snow. My feet got frostbite and they still ache from time to time.

Counselor’s Internal Response: Do things like that really happen? I wonder what else happened to her growing up? I really wish I would have gone to that training last year on working with clients who have been abused.

Counselor: That sounds very scary.

Client: Yeah, he wasn’t done with his punishment though. My mother tried to talk him into letting me come in. She was worried about my my feet, would get too bad and someone would notice. Maybe I deserved his punishment.

Counselor’s Internal Response: Wow, it seems like this woman has had a pretty bad childhood. I feel shocked that she was abused and no one helped her. How could a parent do this to their own child? Where would I be now if I had been abused and nobody helped me? I definitely can’t go see that movie tonight, because I heard it was about a woman and her children who are trying to leave an abusive situation.
Counselor: You believed that you deserved his punishment?

Client: This is really hard for me.

Counselor: What do you find yourself struggling to talk about?

Client: I have never told anyone this. Sometimes, my dad would do things to us that were just really bad. I remember this one time he made all of us kids watch him having sex with my mom.

Counselor’s Internal Response: I feel numb. This shouldn’t happen in families. I feel helpless. How can I help her with all that she has been through? I think what people said may really be true, she has hurt her children. My heart is racing and I feel sick to my stomach. I really feel so sad for her, but I think she has hurt her children and I am not sure what to do with my feelings. My husband and I are supposed to have “date night” tonight, but I don’t think I can. I just want to be alone. What am I going to tell my husband? How could he possibly understand what I am feeling?

FAST FORWARD

Narrator: We are moving forward to the twelfth session. In the past few weeks, the client has been talking more about her own childhood sexual abuse. The client reported that she often had to go to parties with her parents when she was in elementary school so that one of her parent’s friends had a date. She reported that she was sexually involved with many of the boys in her class so she could forget what she had to do with her parents, but said that it never really helped her forget. In the eleventh session, the session before this one, the client confirmed that she has been sexually abusing her
own children. She stated that she often has her children have sex with each other to please her boyfriend.

The counselor was told by her doctor that she needs to reduce the amount of stress she experiences at work to have a safe third trimester. The counselor shared her doctor’s concerns with another clinician in the practice where she works. She also told the other clinician that she has been having nightmares regarding this client, which is one of the reasons she feels so stressed. The other clinician asked what else is making her stressed and she reported that she has been fighting with her husband, because he feels she is pushing him away and needs too much time alone. The other clinician told her she needs to try to leave her clients at work and not take them home with her. The morning before the client’s twelfth session, the counselor received an updated report from the client’s CPS worker that the client's son has gonorrhea. The CPS worker also left a message for the counselor to see if she is available to see another woman whose parental rights are being terminated.

12th session:

Counselor’s Internal Response: This has all been really hard for me to hear. I want to help the client, but I am angry that she could hurt her children like that and I feel more pissed off since I heard her son has gonorrhea. I am feeling anxious and unsure how to best work with the client now that I know she has abused her children. I have been thinking about her children and how horrible it must have been for them. How could this happen to her kids, they should be protected by their mom, not sexually abused by her. I am wondering how could God allow children to be abused?
Counselor: Last week, we ran out of time. We said that we would continue today to discuss what happened with you and your children.

Client: I know you probably think what I did was wrong but that’s how I grew up. When I was about five my parents would make all of us, my two brothers and my sister and myself have sex with each other. Sometimes they would join in. I now know my parents were swingers. They would make us watch them have sex with other couples. And there were many times when they would make us have sex with each other, it seemed like to entertain their friends.

Counselor’s Internal Response: That sounds horrible. I don’t even want to believe what she is saying is true…This is devastating. I can’t imagine what I would be like if my childhood had been this way. How can she not see that she is doing the same things to her kids that were done to her? This is too overwhelming for me to hear. I don’t know what to do with this. There are such evil people in the world, who would hurt their own children. How do I leave all this at work and not think about this when I see my own little one.

Counselor: You grew up thinking that having sex with your kids was okay, because that is what happened to you. No one deserves to be treated that way.

Client: Either way, it happened. I am just dirty and disgusting. I used to think no one would want me after that, no one decent anyway. As we grew up, my older brother would make us do sexual things when my parents weren’t home. He was angry all the time and would constantly hit us. He broke my arm once and I had to
tell the doctors that I fell out of a tree. None of us ever told
and we don’t talk about it to this day.

Counselor’s Internal Response: I am feeling unable to control my emotions. I am
wondering if she even cares or is she just trying to manipulate me? Is she telling me this
to make me feel bad for her so I will be more sympathetic so she can get her kids back?
My neighbor said that his kid broke his arm playing, but I wonder if that is even true?

Counselor: I wonder if it has been hard to never talk about what your parents and then
your brother did to you.

Client: Oh yeah, but it is kind of the rule that we just don’t
talk about it, ever. My brother is the dad of one of my kids but
everyone pretended it wasn’t. My son doesn’t even know who his
dad is. You probably think that’s disgusting don’t you?

Counselor’s Internal Response: Woo…I am feeling dizzy…What is wrong with this
family? What would the world be like if this happened to more families? How can God
let this happen to her? Are family members even safe anymore?

Counselor: I think it is really horrible what happened to you; it sounds like you weren’t
able to feel safe and protected within your own family.

Client: I have never felt safe with my family. I don’t talk to my
father anymore but sometimes I see my mother though because she
watches my kids when I’m at work.

Counselor’s Internal Response: My head is pounding…after what her mother did to her
how does she let her watch the kids…Is that what abusive families do? I just want to
shake some sense into her, but I need to try to be empathic.
Counselor: Your mom watches your kids...?!

Client: Oh yeah, she takes the kids to the park and they have a good time with grandma.

Counselor’s Internal Response: You have got to be kidding me. Does she really think they just go to the park? I can’t help this woman. I have to call her CPS worker and let her know that I don’t have any time to see other women like her.

Counselor: A few minutes ago you were talking about growing up and how you thought you were supposed to show that you cared for someone.

Client: Yeah, the only time my dad had anything to do with us was either during sex or punishment. Sometimes my children seemed to like it. They would even be sexual with each other on their own. I walked in several times when this was going on. I didn’t try to stop them because they were doing it by themselves.

Counselor’s Internal Response: How can anyone even think that their kids like having sex with each other, or her!?! I feel like the room is spinning. I cannot believe this!

Counselor: What makes you think that?

Client: I am just saying it can’t be all that bad if they chose to do it themselves.

Counselor’s Internal Response: You’ve got to be kidding me that she would think her kids like having sex. I definitely can not work with another perpetrator!

Client (continuing): and they’d still come to me when they got hurt and wanted me to put a Band-Aid on their boo-boo. So they must not have had a problem with me. I know they love me and I
love them. I just feel close to them when we were all doing that stuff together.

Counselor’s Internal Response: LOVE?! This is how she defines love...this is nuts!
I can’t understand this kind of love! I have to know if she has any idea how wrong this behavior is!

Counselor: Are there pieces of you that question what you have done?

Client: Well, there was one time where Justin tried to resist, but my boyfriend had sex with my son. I kinda knew it was wrong, but was scared to death of what he would do to me and my kids.

Counselor’s Internal Response: I am seeing that little boy being raped and I can’t believe she would do this. I feel sick to my stomach. If this mother could allow this to happen to her little boy, she is no longer a mother; she is more a monster. Are there any good mothers out there? I need to distance myself from this woman. I feel like there is no way that I won’t take home this disgust that this woman let her son be raped? How do other clinicians work with monsters like her?

Counselor: Help me understand how you allowed your son to be raped?

Client: The kids would get on my boyfriend’s nerves a lot and I was always trying to calm him down.

Counselor’s Internal Response: Get on his nerves...you gotta be kidding me! I never want to work with a child abuser ever again!

Counselor: The kids got on his nerves...so your boyfriend raped your son.

Client: Raped?????? It just got out of hand. This was supposed to be something they just did at home. I didn’t know Justin was gonna do this to other people at school.
Counselor’s Internal Response: She is teaching her kids to do this to other kids at school. So that means that my children are not safe because there are other kids out there who have been abused like her kids. I can’t be with my kids 24/7, so how do I keep them safe?

Narrator: This is the end of the clinical case vignette.

THE END
Appendix G

Reflection Questions
Reflection Questions

Participant Code #:___________

Date:___________

*Instructions: Please take a few minutes to reflect on the vignette you just watched/read. Please respond to the following reflection questions as thoroughly as possible. There are no “right” or “wrong” answers. All information will be used strictly for the purpose of research and will be kept confidential. Thank you.

1. As you think about the clinician and her work with this client, please describe what stood out for you about this case.

2. As you think about the clinician and her work with this client, please describe the thoughts and feelings you experienced.

Please turn to the back.
3. As you reflect on the clinician’s experience of engaging with the client and her traumatic story, what specifically about vicarious traumatization did you identify?

4. As you reflect on the internal voice of the clinician, please describe the thoughts and feelings you experienced.
Appendix H

Journal Exercise
Journal Exercise

Participant Code #:___________

Date:___________

Please take a few minutes to think about your experience of participating in this study. Use the space provided below to journal any feelings or thoughts that come to mind. There are no “right” or “wrong” answers. Thank you.
Appendix I

Interview Questions
First interview:

1. Please take a few minutes to tell me what you learned from attending the psychoeducational workshop.

2. As you reflect upon the workshop, what feelings and thoughts did you experience?

3. When you hear the term vicarious traumatization, what are the first thoughts that come to your mind?
   Potential Prompt: What other thoughts do you have when you hear the term vicarious traumatization?

4. How much have you learned about vicarious trauma?

5. Please tell me your thoughts about what occurs for a clinician when working with a client who has been traumatized?

Second interview:

1. Please describe one main message that you learned about this topic from participating in the study.
   Potential Prompt: What other messages have you learned from participating in the study?

2. As you reflect on your experiences throughout the study, what was the most helpful experience? Please explain.

3. As you reflect on your experiences throughout the study, what was the least helpful experience? Please explain.

4. Please describe what you have learned about the symptoms of vicarious traumatization, by participating in the study.

5. Please describe what you have learned about the risk factors of vicarious traumatization, by participating in the study.

6. Please describe what you have learned about the impact of vicarious traumatization, by participating in the study.

What else you would like to add?
Appendix J

VT Psychoeducational Workshop
VT Psychoeducational Workshop

Welcome, the psychoeducational workshop today will include a presentation on the definition, symptoms, risk factors, and impact of VT. The workshop will conclude with a brief presentation about self care followed by a question and answer period regarding all of the material presented.

First we will define VT:

McCann and Pearlman (1990) defined Vicarious Traumatization (VT) as “a process through which the therapist’s inner experience is negatively transformed through empathic engagement with a client’s trauma material” (p. 279). VT is not a single occurrence of experiencing a client’s traumatic material, but a collective effect of working over time with a client or many clients who have experienced trauma (McCann & Pearlman; Pearlman & Saakvitne, 1995a). More importantly, VT does not reflect a shortcoming in a therapist, but is a normal risk associated with counseling trauma clients (Pearlman & Saakvitne, 1995b).

Next, we will discuss the VT symptoms that clinicians may experience:

(a) **Physiological:**

Physiological symptoms may include clinicians feeling an increased heart rate or body temperature as well as a lack of energy. Other physiological symptoms may include teeth grinding or increased headaches and/or stomachaches (Pearlman & Saakvitne, 1995a; Pearlman & Saakvitne, 1995b; Rosenbloom, Williams, & Watkins, 1999). Physiological symptoms are important warning signs for clinicians, because they illustrate that clinicians are experiencing
consequences due to listening to clients’ traumatic material (Pearlman, 1999; Pearlman & Saakvitne; Pearlman & Saakvitne).

(b) **Psychological:**

Examples of psychological symptoms of VT could possibly include flashbacks (e.g., a male survivor of childhood abuse hears his mother yelling at him when visiting his mother’s house) (Rosenbloom et al., 1999) and/or ruminations (e.g., thinking repeatedly about an argument with your partner) (Allen, 2005). Psychological symptoms could also include increased sensitivity to seeing or hearing about violence, hyperarousal, or hypervigilence. Hyperarousal refers to clinicians’ state of increased physiological awareness (e.g., hearing becomes more sensitive to the sounds around them) (Allen). Hypervigilence refers to clinicians’ amplified awareness of their surroundings (e.g., noticing exact landmarks when walking outside) (Rosenbloom et al.).

(c) **Emotional:**

Emotional symptoms of VT may include increased feelings of fear, sadness, or anger (McCann & Pearlman, 1990), lack of feelings (e.g., numbness) or intense feelings (e.g. extreme sadness).

(d) **Interpersonal:**

Clinicians experiencing interpersonal symptoms may have difficulty connecting with others, such as having problems communicating with a partner about what they are thinking/feeling or wanting to isolate themselves from the other people in their lives (McCann & Pearlman, 1990; Pearlman & Saakvitine, 1995b).
(e) **Foundational:**

Foundational symptoms of VT can include clinicians experiencing changes in their spirituality, self, or worldview (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a; Pearlman & Saakvitne, 1995b). Clinicians that view themselves as spiritual, such that they believe in a higher Being, may question how that higher Being could allow hundreds of people to be killed by a natural disaster. Thus, clinicians may have strong feelings of demoralization because of changes to their spiritual beliefs and values (Pearlman & Saakvitne). Clinicians might also question their sense of self and begin to doubt their professional competence and their ability to help their clients, which can lead clinicians to begin to experience a loss of professional identity as a competent practitioner (Horner, 1993). Another effect of VT may be clinicians’ questioning the way they view the world, such that family and home may no longer be considered a safe place that offers unconditional love and support.

Now, we will discuss potential risk factors that may increase clinicians’ chances of experiencing VT:

(a) **Ongoing and repeated work with clients who are experiencing trauma:**

Clinicians who repeatedly work with clients who are experiencing trauma are more likely to experience VT (Bober & Regehr, 2005; McCann & Pearlman, 1990; Meyer & Ponton, 2006; Pearlman & MacCann, 1990; Pearlman & Saakvitne, 1995a; Pearlman & Saakvitne, 1995b; Sexton, 1999). This risk includes repeated and/or ongoing exposure to graphic material such as hearing about the cruelty people commit against one another (e.g., assault) or the
atrocities that people face (e.g., losing a house due to a mudslide). Repeated and on-going trauma work may lead to additive exposure to clients’ graphic traumatic material, which poses a risk in part because of clinicians’ difficulties in empathically engaging with their clients. When clinicians work with clients who have experienced trauma they are more likely to be at risk for experiencing VT based on repeatedly hearing about the horrible acts that individuals commit, which can include hearing the actual details of clients’ traumatic stories (Patrick, 2007; Pearlman & Saakvitne; Pearlman & Saakvitne). When working with clients with a trauma history, talking about the traumatic event can be very therapeutic for clients and often facilitates healing for those clients. Perlman (1999) stated that clients telling their traumatic stories can be therapeutic (e.g., empowering and cathartic) because of their voices previously going unheard and/or their stories being trivialized. Clients discussing their traumatic stories can be therapeutic, yet clinicians listening to clients’ traumatic material increase their risk of VT. Therefore, we need to address how clinicians can continue to help their clients grow, while protecting themselves from being impacted by VT.

(b) **Clinicians’ personal trauma history:**

Another potential risk factor for experiencing VT includes clinicians’ personal trauma history (Bober & Regehr, 2005; Figly, 1995; Meyer & Ponton, 2006; Patrick, 2007; Pearlman & Saakvitne, 1995a; Pearlman & Saakvitne, 1995b; Salston & Figley, 2003). Salston and Figley (2003) stated that clinicians may have a tendency to “overgeneralize” (p. 170) their own trauma incidents with
those of their clients. Additionally, raising clinicians’ unresolved personal trauma history, such as memories of childhood abuse, is a risk when listening to clients’ traumatic material (Patrick; Pearlman & Saakvitne; Pearlman & Saakvitne; Salston & Figley; Sexton, 1999). Clinicians’ unresolved trauma can be harmful to both clinicians and clients when it impedes the therapeutic process because it may stop clients’ ability to grow when for example, clinicians focus on their own trauma versus being present with their clients’ concerns (Sexton). Therefore, clinicians may find it helpful to work on resolving their own trauma through personal therapy to help decrease or alleviate the risk of raising their own unresolved trauma while listening to their clients’ traumatic material (Patrick; Pearlman & Saakvitne).

(c) **Present personal situation:**

The major stressors in clinicians’ lives are clinicians’ present situation and personal stressors, such as being pregnant, experiencing relationship difficulties, or dealing with the death of a loved one (Pearlman & Saakvitne, 2005b), which can possibly increase their risk of being vicariously traumatized by adding to the stress that is impacting clinicians. The different stressors in clinicians’ lives can impact their ability to focus in session as well as their overall desire to be at work (Pearlman & Saakvitne 2005a). Sexton (1999) suggests that “major life stressors will make [clinicians] more vulnerable” to VT.
(d) **Lack of supervision:**

Lack of supervision (e.g., lack of opportunity to discuss difficult clients) is one possible professional stressor. The importance of regular supervision when working with trauma is a vital professional responsibility for one’s own self care (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a; Pearlman & Saakvitne, 1995b; Salston & Figley, 2003). Furthermore, Sexton (1999) stated that receiving supervision is not only helpful, but an ethical duty. According to Pearlman and Saakvitne and Sexton, consideration of all parts of the relationship between clinicians and clients, awareness of any possible countertransference, and a thorough knowledge and understanding of VT should be integral components in supervision. It is important to note that for clinicians who are not mandated to receive counseling, peer supervision or case consultation is extremely important to help decrease the risk of experiencing VT. Peer supervision and case consultation allows clinicians to decrease feelings of isolation and allows time to process the effects of listening to clients’ traumatic material (Salston & Figley; Sexton).

(e) **Lack of training on working with clients who have experienced trauma:**

This can include clinicians having limited or no specific training working with client trauma concerns, which can lead clinicians to feel overwhelmed or confused of how to work best work with a client experiencing trauma (Bober & Regehr, 2005; Meyer & Ponton, 2006; Patrick, 2007; Pearlman & Saakvitne, 2005b).
(f) **Work environment:**

Clinicians’ work environments are another possible professional stressor. For example, clinicians that are considered the expert on trauma may be assigned all of the trauma referrals that agency receives, which in turn, creates a large caseload of clients experiencing trauma for those clinicians. Negative work environments can also include having inadequate space to work and/or being isolated from other colleagues who work with clients experiencing trauma. Balancing their work environment with their home environment is one way for clinicians to keep perspective of the stressors of their job (Cerney, 1995; Salston & Figley, 2003). Additionally, knowing and enforcing their boundaries helps clinicians from feeling as overwhelmed by work pressures (e.g., reducing the number of hours spent working and decreasing large client caseloads) (Cerney; Sinclair & Hamill, 2007).

Next, we will discuss the possible impact on a clinician who has experienced VT:

(a) **Professional:**

Understanding VT is important because clinicians cannot protect themselves if they are not aware of VT. In addition, if they are not aware that they are being impacted by VT, they may also be unaware of any impact being vicariously traumatized may have on their work with clients. For example, clinicians’ counseling skills may be impaired such that they lose their ability to feel empathy regarding clients’ presenting issues. Other professional negative implications include experiencing feelings of decreased professional competency or choosing to limit the number of clients experiencing trauma on

(b) **Personal:**

Personal negative implications of clinicians experiencing VT can include their own personal trauma resurfacing or mental health concerns such as experiencing depression or facing substance abuse (e.g., alcoholism or abusing prescription medications). Other personal negative implications include interpersonal difficulties such as divorce, parenting issues (e.g., struggles to feel close with children or feeling overprotective of children), or domestic violence (e.g., neglect/abuse of children or verbally abusing a partner) (Pearlman & McCann, 1990; Pearlman & Saakvitne, 1995a; Pearlman & Saakvitne, 1995b).

Lastly, we will conclude with a very brief discussion regarding self care.

Examples of self care: setting boundaries, using relaxation techniques, arranging fun activities/time, practicing meditation, developing a mentoring relationship, developing and strengthening a social network, exercising, eating nutritionally, and developing an awareness of one’s spirituality. The psychoeducational workshop on VT concluded with a short period during which students asked questions regarding the material presented.

Any questions regarding the material presented?
Appendix K

Vignette Evaluation Form for Expert Raters
This evaluation form is a rubric to help identify specific examples of VT found in the trauma vignette. The form includes 3 dimensions of VT: Symptoms, Risk Factors, and Impact/Consequences. Each dimension will be included on the following pages.

Instructions: Please read the accompanying vignette and identify the examples you find of the three dimensions (i.e., symptoms, risk factors, impact/consequences) by highlighting the specific content that addresses each of these areas and label it accordingly (with symptoms, risk factors, and/or impact/consequences). For example, when you highlight a risk factor, write risk factor and the specific type of risk factor, such as personal trauma history.

On this evaluation form, please include any specific examples of additions and/or revisions that you feel are needed to portray a particular symptom, risk factor, and/or impact/consequence. Thank you for your time and expertise.

I. Vicarious Traumatization (VT) Symptoms:

Physiological

Examples: Increased heart rate, lack of energy, teeth grinding, increased headaches/stomachaches

Comments regarding specific additions needed to portray the Physiological VT symptoms:

Psychological

Examples: Flashbacks, ruminations, increased sensitivity to seeing/hearing violence, hyperarousal.

Comments regarding specific additions needed to portray the Psychological VT symptoms:

Emotional

Examples: Lack of feelings or increased feelings of hopelessness, disappointment, frustration.

Comments regarding specific additions needed to portray the Emotional VT symptoms:
**Interpersonal**

Examples: Difficulty connecting with others, isolation

Comments regarding specific additions needed to portray the **Interpersonal** VT symptoms:

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**Foundational**

Examples: Changes in spirituality (e.g., losing their spiritual connections), identity (e.g., question their sense of self), worldview (e.g., question the way they view the world)

Comments regarding specific additions needed to portray the **Foundational** VT symptoms:

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Additional comments regarding the **VT symptoms**:

---

**II. Risk Factors for experiencing VT**

**Ongoing & repeated work with client’s experiencing trauma**

Examples: Large number of clients experiencing trauma on caseload or additive exposure to client’s graphic traumatic material

Comments regarding specific additions needed to portray the **ongoing & repeated work with client’s experiencing trauma**:

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**Personal trauma history**

Examples: Overgeneralizing a client’s traumatic experiences with the clinician’s own traumatic experiences or raising issues related to the clinician’s personal trauma history.

Comments regarding specific additions needed to portray the **personal trauma history**:
Present personal situation
Examples: Major life stressors in the clinician’s life (e.g., being pregnant or the death of a family member)

Comments regarding specific additions needed to portray the present personal situation:

Present professional situation:
Lack of supervision (e.g., lack of opportunity to discuss difficult clients, supervisor with little or no experience working with trauma population)

Comments regarding specific additions needed to portray the lack of supervision:

Lack of training on working with trauma (e.g., clinician having limited/no training related to working with client trauma concerns)

Comments regarding specific additions needed to portray the lack of training on working with trauma:

Work environment (e.g., being isolated from other colleagues, productivity valued over client care)

Comments regarding specific additions needed to portray the work environment:

Additional comments regarding the Risk Factors for experiencing VT:
III. Impact/Consequences of VT:
*It is important to note that the impact and subsequent consequences of VT for the clinician often overlap with the symptoms of VT. For instance, a flashback is often a psychological symptom of VT. The flashback can simultaneously have a negative impact for the clinician, which could include the clinician’s inability to empathize with a client’s traumatic material for fear of experiencing a flashback.

**Professional**
Examples: clinicians’ counseling skills may be impaired such that they lose their ability to feel empathy regarding clients’ traumatic material, experience feelings of decreased professional competency, choosing to limit the number of clients experiencing trauma on their caseloads.

Comments regarding specific additions needed to portray the professional impact of VT:

**Personal**
Examples: A clinician’s own personal trauma resurfacing, experiencing mental health concerns (e.g., depression, facing substance abuse concerns), interpersonal difficulties (e.g., lack of communication with partner, separation/divorce), parenting issues (e.g., struggling to feel close with children, feeling overprotective of children).

Comments regarding specific additions needed to portray the personal impact of VT:

Additional comments regarding the Impact/Consequences of VT:

IV. Overall Comments, Suggestions, & Revisions
Please include any additional constructive comments, suggested changes and/or revisions for the Trauma Vignette (use additional pages as needed).
Appendix L

Mental Health Resources
Mental Health Resources

Kalamazoo:

- **University Counseling and Testing Center**
  - **269-387-1850**
  2513 Faunce Student Services
  Kalamazoo, MI 49008
  - Provides mental health services for students currently enrolled at Western Michigan University (WMU) for no fee.

- **Gryphon Place**
  - **269-381-4357 (HELP) or 211 (from a land line telephone)**
  1104 S. Westnedge Ave.
  Kalamazoo, MI 49008
  - Provides a 24 hour crisis line and referral service.

- **Kalamazoo Community Mental Health & Substance Abuse Services**
  - **269-373-6000 or Toll Free 888-373-6200**
  418 W. Kalamazoo Avenue
  Kalamazoo, MI 49001
  - Fees are based on a sliding fee scale.

- **Pine Rest Christian Mental Health Services**
  - **269-343-6700**
  1530 Nichols Road
  Kalamazoo, MI 49006
  - Provides mental health services for individuals with a mental health or substance abuse problem.

Grand Rapids:

- **Kent County Community Mental Health Cornerstone Access/Crisis Center**
  - **616-336-3909**
  833 Lake Drive SE
  Grand Rapids, MI 49548
  - Provides services for mental health concerns and substance abuse issues.

- **Pine Rest Christian Mental Health Services**
  - **616-455-9200 or Toll Free 800-678-5500**
  300 68th Street SE
  Pine Rest Main Campus
  Grand Rapids, MI 49548
  - Provides mental health services for individuals with a mental health or substance abuse problem.
Appendix M

Debriefing Session
Debriefing Session

1. Discuss Self Care Strategies:
   - Set boundaries (relational and task-oriented)
   - Use relaxation techniques (e.g., breathing, yoga)
   - Use visual imagery
   - Practice meditation
   - Develop a mentoring relationship
   - Develop a social network
   - Exercise
   - Awareness of spirituality

2. The discussion of self care strategies will be followed by a Question and Answer period.

3. Conclude the debriefing session with any other participant issues related to the study.

   1. Ask participants to self-report how they are feeling.
   2. Remind participants of the mental health resources sheet they received at the beginning of the study. Provide another copy of the mental health resources list upon participants’ request.
Appendix N

VT Informational Packet
VT Informational Packet

**Definition of VT:**

McCann and Pearlman (1990) defined Vicarious Traumatization (VT) as “a process through which the therapist’s inner experience is negatively transformed through empathic engagement with a client’s trauma material” (p. 279). VT is not a single occurrence of experiencing a client’s traumatic material, but a collective effect of working over time with a client or many clients who have experienced trauma (McCann & Pearlman; Pearlman & Saakvitne, 1995a). More importantly, VT does not reflect a shortcoming in a therapist, but is a normal risk associated with counseling trauma clients (Pearlman & Saakvitne, 1995b).

**VT symptoms:**

**Physiological:** Physiological symptoms are important warning signs for clinicians, because they illustrate that clinicians are experiencing consequences due to listening to clients’ traumatic material.

Examples include:

- Increased heart rate or body temperature
- Lack of energy
- Teeth grinding
- Headaches and/or stomachaches.

**Psychological:**

Examples include:

- Flashbacks
- Ruminations
- Increased sensitivity to seeing or hearing about violence
- Hyperarousal
- Hypervigilence

**Emotional:**

Examples include:

- Increased feelings, such as fear, sadness, or anger
- Lack of feelings, such as numbness
- Intense feelings, such as extreme sadness

**Interpersonal:**

Examples include:

- Difficulty connecting with others
- Wanting to isolate themselves from the other people in their lives
- Not enjoying social activities

**Foundational:**

Foundational symptoms of VT can include clinicians experiencing changes in their spirituality, self, or worldview.

Examples include:

- Questioning spirituality or religion
- Questioning sense of self
- Questioning the world and experiencing changes in worldview

**Potential risk factors of VT:**

Ongoing and repeated work with clients who are experiencing trauma:
Clinicians who repeatedly work with clients who are experiencing trauma are potentially more likely to experience VT. This risk may include repeated and/or ongoing exposure to graphic material.

Clinicians’ personal trauma history:

Counseling clients who have experienced trauma can potentially raise clinicians’ unresolved personal trauma history. Unresolved trauma can be harmful to both clinicians and clients when it impedes the therapeutic process because it may stop clients’ ability to grow when for example, clinicians focus on their own trauma versus being present with their clients’ concerns. Therefore, clinicians may find it helpful to work on resolving their own trauma through personal therapy to help decrease or alleviate the risk of raising their own unresolved trauma while listening to their clients’ traumatic material.

Present personal situation:

Major stressors in clinicians’ personal lives, such as being pregnant, experiencing relationship difficulties, or dealing with the death of a loved one, can possibly increase the risk of being vicariously traumatized by adding to the stress that is felt when hearing traumatic stories. The different stressors in clinicians’ lives can impact their ability to focus in session as well as their overall desire to be at work.

Lack of supervision:

The importance of regular supervision when working with trauma is a vital professional responsibility for one’s own self care. Consideration of all parts
of the relationship between clinicians and clients, awareness of any possible countertransference, and a thorough knowledge and understanding of VT should be integral components in supervision.

Lack of training on working with clients who have experienced trauma:

This can include clinicians having limited or no specific training working with client trauma concerns, which can lead clinicians to feel overwhelmed or confused of how to work best work with a client experiencing trauma.

Work environment:

Negative work environments can include having inadequate space to work, being isolated from other colleagues who work with clients experiencing trauma, or be labeled the expert on trauma, which could result in a large caseload of clients experiencing trauma. Balancing their work environment with their home environment is one way for clinicians to keep perspective of the stressors of their job. Additionally, knowing and enforcing their boundaries helps clinicians from feeling as overwhelmed by work pressures.

VT’s Impact:

Professional:

Examples include:

- Losing ability to feel empathy regarding clients’ presenting issues
- Experiencing feelings of decreased professional competency
- Limiting the number of clients experiencing trauma on caseloads
Personal:

- Resurfacing of personal trauma
- Experiencing mental health concerns
- Having interpersonal difficulties
Appendix O
Reference List Handout
Reference List


transference and vicarious traumatization in psychotherapy with incest survivors.

Webb (Ed.), Play therapy for children in crisis: Individual, group, and family

W. Norton & Co.

counselors of working with sexual violence survivors. Psychology of Women
Quarterly, 19, 49–54.

amongst psychologists and professional counselors working in the field of sexual
abuse/assault. The Australasian Journal of Disaster and Trauma Studies, 2, no
pagination specified (electronic).

trauma: A comparison of clinicians who treat survivors of sexual abuse and sexual
Appendix P

Script to Introduce Single Case Narrative Feedback
Script to Introduce Single Case Narrative Feedback

At the end of the second interview:

I wanted to let you know what will happen now that we just finished our second and last interview. I will analyze all of the different information you have shared and write a report. I would really like to get your feedback and comments regarding this report and would like to ask if I can contact you in 6 months to possibly one year from now?

If yes: Thank you, what is the best way to contact you? Is there another way that I can contact you, for whatever reason, the first way is unsuccessful? Thank you so much.

If no: Do you have any concerns or questions that I can answer regarding this process and what a follow up would entail? (Answer questions or concerns appropriately)
Appendix Q

Script for Single Case Narrative Feedback
Script for Single Case Narrative Feedback

I will contact the participants however they have indicated that they prefer I do so. If, I do not receive a response within approximately ten days after the first response, I will make a second attempt; however, if I do not receive a response within approximately five days after the second attempt, I will try an alternative method.

E-mail script:
Hello, Participant’s name. I wanted to thank you so much for your participation in my study. I am excited to let you know that I have been able to compile all of your answers into a narrative summary. I am writing to ask for your comments. Does this summary accurately reflect your experience of the study? I would really appreciate your comments on the summary. Please send me any comments you have by (a date that gives the participant ten days to respond). Thank you so much for you help and participation!

Phone script:
Hello, Participants name. This is Amy Cavanaugh. I am excited to let you know that I have been able to compile all of your answers into a narrative summary and I am calling to ask what would be the best way for me to send you a copy of the summary for your comments and to see if the summary accurately reflects your experience. (Answer any questions appropriately and double check mailing address or e-mail address for accuracy). Thank you so much for your time.
Phone script for voicemail message:

Hello, Participant’s name. This is Amy Cavanaugh. I am excited to let you know that I have been able to compile all of your answers into a narrative summary and I am calling to ask what would be the best way for me to send you a copy of the summary for your comments and to see if the summary accurately reflects your experience. Please call me at 937-657-4072. I look forward to hearing from you.
Appendix R

Human Subjects Institutional Review Board
Letter of Approval
Date: June 29, 2009

To: Kelly McDonnell, Principal Investigator
   Amy Cavanaugh, Student Investigator for dissertation

From: Amy Naugle, Ph.D., Chair

Re: HSIRB Project Number: 09 04 25

This letter will serve as confirmation that your research project titled "Clinicians’ in Training Ability to Recognize Vicarious Traumatization: A Multiple Case Study" has been approved under the full category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: June 17, 2010