The Lived Experiences of African American Counselors: An Exploration of Their Reactions to Trauma Survivors

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THE LIVED EXPERIENCES OF AFRICAN AMERICAN COUNSELORS: AN
EXPLORATION OF THEIR REACTIONS TO TRAUMA SURVIVORS

by

Zanovia P. Tucker

A dissertation submitted to the Graduate College
in partial fulfillment of the requirements
for the degree of Doctor of Philosophy
Counselor Education and Counseling Psychology
Western Michigan University
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Doctoral Committee:

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Nearly 83% of Americans are exposed to a traumatic event (Benjet et al., 2016). Given this, every counselor will more than likely work with trauma survivors (Trippany et al., 2004). Because of the high percentage of exposure to trauma, mental health professions who service individuals who experience trauma are at risk for secondary trauma (Ivicic & Motta, 2016), vicarious traumatization (Culver et al., 2011), and shared trauma (Hope & Edward, 2013).

African American counselors have not been recognized in the counseling literature; thus their work with trauma survivors and their training experiences remain relatively unknown. Most of the research pertaining to Black counselors’ training experience discusses the lack of racial representation in their graduate programs (Walker et al., 2001), the challenges they face navigating White spaces (Rasheem & Brunson, 2018), isolation as a Black student (Haskins et al., 2013; Rasheem & Brunson, 2018), and multicultural training competence (Bowie et al., 2011). The purpose of this phenomenological study was to explore the lived experiences of African American counselors, in Chicago, and their reactions to working with trauma survivors. Specifically, this study explores the unique experiences of African American counselors through the lens of trauma theory.

To guide this study, there was one overarching research question and five sub-questions. The overarching question was: How do practicing counselors who serve clients...
from Chicago’s 11 most violent neighborhoods experience and make personal and professional meaning of their work with trauma clients? The sub-questions were: (1) What are the clinical experiences of African American counselors in Chicago? (2) What experiences do African American counselors have working with clients who have experienced trauma? (3) What experiences do African American counselors have with secondary traumatic stress, vicarious traumatization, and shared trauma? (4) How do these experiences shape their interactions and responses to their trauma? (5) How do African American counselors draw upon their counselor education training to work with trauma clients? Where do they draw upon services outside their training?

Eight African American counselors who work in or with clients from 11 of the most violent neighborhoods in Chicago participated in this study. The researcher conducted semi-structured interviews, which revealed 10 themes. When asked about their clinical experiences, African American counselors in this study described their diverse work experiences, awareness, and understanding. They also described how challenging, complex, and rewarding it was to work with trauma survivors. When asked about their experience with secondary traumatic stress, vicarious trauma, and shared trauma, African American counselors in this study described their personal impact and clients’ well-being. Additionally, they described how their awareness of their clients increased, as did their self-care practices. When asked about their counselor education training, African American counselors in this study described their limited preparedness and the need for more trauma training, specifically urban trauma training. Implication for counselor education and future research was discussed.
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Zanovia P. Tucker
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CHAPTER I
INTRODUCTION

Nearly 83% of Americans are exposed to a traumatic event (Benjet et al., 2016). Trauma can result from an event or a series of events. These events include, but are not limited to violence, sexual abuse, and natural disasters. Every counselor, no matter where they work or what population they choose to work with, will more than likely work with trauma survivors (Trippany et al., 2004). Because of the high percentage of exposure to trauma, mental health professionals who service individuals who experience trauma are at risk for secondary trauma stress (Ivicic & Motta, 2016), vicarious trauma (Culver et al., 2011), and shared trauma (Bell & Robinson, 2013). This study explored the lived experiences of African American counselors in Chicago and their reactions to working with trauma survivors.

Types of Trauma in Counselor Experience

Mental health professionals are at risk of secondary traumatic stress (STS), vicarious traumatization (VT), and shared trauma (ST) by way of being exposed to the traumatic stories of their clients, working long hours, working many years helping trauma victims, and having a history of trauma experience similar to their clients (Baum, 2010; Figley, 1995; Sommer, 2008). Secondary traumatic stress, which is used interchangeably with the term compassion fatigue (Figley, 1995), describes the negative effects of secondary exposure to traumatic events. Essentially, secondary traumatic stress occurs when a client’s traumatizing event(s) becomes a traumatizing event for the counselor who is servicing the client (Figley, 1995). When counselors are exposed to the traumatic event(s) of their clients, their abnormal symptoms can mirror those of their client, including intrusive imagery (Courtois, 1996; Chrestman, 1999; Danieli, 1988; McCann & Pearlman, 1990) and functional impairment (Dutton & Rubinstein, 1995; Figley,
Intrusive imagery includes flashbacks of client’s traumatic event, nightmares, and flooding (Courtois, 1996). Functional impairment occurs with symptoms such as the counselor’s inability to arrive at appointments on time, increased isolation, and decreased self-care habits. Secondary traumatic stress can occur simply by knowing about a traumatizing event experienced by a significant other. The stress occurs from helping or by wanting to help the traumatized individual (Figley, 1993).

Counselors who work with trauma survivors are also at risk of vicarious traumatization (VT), or a “significant disruptions in one’s sense of meaning, connection, identity, and worldview, as well as in one’s affect tolerance, psychological needs, beliefs about self and other, interpersonal relationships, and sensory memory” (Pearlman & Saakvitne, 1995b, p. 151). Although secondary traumatic stress and vicarious traumatization focuses on the traumatization of a mental health professional exposed to a traumatic event by way of their clients, VT is a cumulative process during which a counselor experiences negative psychological effects as a result of working with trauma victims overtime (McCann & Pearlman, 1990). Also, VT is experienced only during a therapeutic relationship. VT symptoms typically occur after being exposed to various clients and their traumatic stories. Each of the clients’ stories reinforces the therapist gradually changing beliefs and assumptions about themselves and the world (McCann & Pearlman, 1990). According to Rasmussen (2005), “VT emphasizes the way the therapist’s experience of the self is altered in terms of identity, worldview, spirituality, self-capacities, ego resources, psychological needs, and the sensory system” (p. 20).

Culver and colleagues (2011) conducted a study about mental health professionals’ experiences with vicarious traumatization post-Hurricane Katrina. In this study, 73% of the participants reported anxiety, 62% reported suspiciousness, and 46% reported increased
vulnerability when working with individuals who were victims of Hurricane Katrina. VT “disrupts the therapist’s sense of safety, trust, esteem, intimacy, and self-control” (Pearlman & Saakvitne, 1995, p. ). This disruption can result in blurred boundaries in the therapeutic relationship and can possibly harm the clients they serve.

Trauma can be experienced in different ways. Mass traumas, such as Hurricane Katrina, the Virginia Tech shooting, and the terrorist attack on September 11th, affect entire communities. Because these are large-scale events, the counselors living in the communities are being exposed to the same trauma as their clients (Day et al., 2017). According to Day et al. (2017), “mass trauma that affects many people has ramifications for individuals, the groups affected, the larger community, and the clinicians who attempt to help them” (p. 269). Thus, mass trauma is associated with shared trauma (ST). *Shared trauma* is a concept often used in the social work profession to describe mental health professionals’ exposure to the same collective trauma as their clients (Tosone, 2011). During shared trauma, clinicians are prone to experiencing posttraumatic stress, having a lack of boundaries, professionally and personally, and increased self-disclosure (Tosone et al., 2012). Although this concept has been used previously in relation to natural disasters and terrorist attacks, this concept can be applied to traumatic events such as recent school shootings (Tosone et al., 2012). Shared trauma does not imply that clinicians respond to trauma the same way that their clients do as in the case of STS or VT; however, it implies that the clinician and their clients are impacted by the same traumatic event.

**Background**

With violent crimes increasing by 4.1% in 2016 compared to 2015 (Federal Bureau Investigation, 2016), counselors and other mental health professionals may find themselves working in environments that are consumed with violence. Chicago, for example has been
reported to have more murders than cities with higher populations (Department of Justice, 2016). In 2016, there were 924 homicides and of this amount, 87% of those homicides were gun related (Cook County Medical Examiner Annual Report, 2016). Additionally, of those 924 homicide cases, 644 of the victims were Black, and 832 were males between the ages of 18 and 24 years (Cook County Medical Examiner Annual Report, 2016). The following year, there were 840 homicides; of this amount, 88% of those homicides were gun related (Cook County Medical Examiner Annual Report, 2017). Of the 840 homicides in Chicago in 2017, 589 of the victims were Black, and 680 were males between the ages of 15-24 (County Medical Examiner Annual Report, 2017). Chicago had a decline in homicide by more than 100 victims (as of June 2017), which was the largest decline in almost 15 years (Armentrout, 2017). Although there was a 15% decline in murders in Chicago in 2017, in the first six months they saw more than 400 murders (Armentrout, 2017).

Chicago is composed of 77 communities, of which 11 were rated as “the most violent” by the Chicago Police Department (Urban labs Crime Lab, 2018). Sixty-nine percent of the total Black, non-Hispanic population, in Chicago, live within communities on the south side of Chicago (Naylor et al., 2016), which is where most of the violence occur in the city. These neighborhoods represented 20% of the city’s population, but accounted for 55% of Chicago’s gun-related violent crimes (Urban Labs Crime Lab, 2018). Since it is a city with high incidence of violent crime and the researcher wants to explore STS, VT, and ST in African American counselors who work with trauma survivors, this study took place in the inner-urban city of Chicago.
Statement of the Problem

Research indicates that significant numbers of mental health professionals experience secondary traumatic stress (STS), vicarious traumatization (VT), and/or shared trauma (ST), in events such as personal relationships, therapeutic relationships, and natural disasters; yet the literature does not discuss the unique experiences of African American counselors who work in heavily violent neighborhoods. Hence, despite the experiences of these counselors in the counseling profession, their work with trauma survivors and their training experiences remain relatively unknown.

Most of the literature related to Black counselors’ clinical experiences explores the experiences of counselors-in-training (Haskins et al., 2013; Lu et al., 2017). This literature primarily examines the lack of racial representation in their graduate programs (Walker et al., 2001), the challenges they face navigating White spaces (Rasheem & Brunson, 2018), isolation as a Black student (Haskins et al., 2013; Rasheem & Brunson, 2018), and multicultural training competence (Bowie et al., 2011).

Very little is known about African American counselors’ perception of the preparedness they received through their counselor education graduate training programs to work with trauma survivors. Trippany and colleagues (2004) found that counselors are likely to deliver mental health services to trauma survivors; however, they lack evidence-based knowledge and training needed to do so (Cook & Newman, 2014). Trauma-focused assessment, evidence-based literature, and psychotherapy skills are not fundamental components of the standard curricula in graduate-level education (Deprince & Newman, 2011).
Purpose Statement and Research Questions

The purpose of this study was to explore the lived experiences of African American counselors, in Chicago, and their reactions to working with trauma survivors. The overarching research question was, How do practicing counselors who serve clients from Chicago’s 11 most violent neighborhoods experience and make personal and professional meaning of their work with trauma clients? Additionally, there were five sub-questions that help to guide this study. They are listed below.

1. What are the clinical experiences of African American counselors in Chicago?
2. What experiences do African American counselors have working with clients who have experienced trauma?
3. What experiences do African American counselors have with secondary traumatic stress, vicarious traumatization, and shared trauma?
4. How do these experiences shape their interactions and responses to their trauma clients?
5. How do African American counselors draw upon their counselor education training to work with trauma clients? Where do they draw upon services outside their training?

Significance of the Study

This study was important because there were virtually no studies in counselor education literature that have explored the lived experiences of African American counselors. This study helped to highlight the unique experiences of African American counselors; namely their experiences working and living in some of the most violent neighborhoods in Chicago. Exploration of African American counselors’ experiences in the literature is relatively sparse. The literature provides an abundance of knowledge about the clinical and training experiences of
Caucasian counselors (Thompson, Amatea, & Thompson, 2014; Thompson et al., 2015); yet information regarding the experiences of Black counselors, who represent 900 members out of only 13,600 American Counseling Association members who voluntarily disclosed their racial/ethnic background (out of 55,000 members) was largely unknown (David Kaplan, personal communication, February 21, 2018). The counseling profession could be better informed about the experiences of African American counselors to promote inclusivity and the diversity in experiences of the profession.

Therefore, the findings from this study have particular relevance to the counseling profession, since the Council for Accreditation of Counseling and Related Educational Programs (CACREP) requires master’s- and doctoral-level students to be trained in trauma (CACREP, 2016). After the terrorist attack on September 11, 2001, CACREP wanted to focus on the counselor’s role in disaster and trauma response (Webster & Mascari, 2009). Accordingly, the 2009 CACREP standards included trauma as a practice area for competency. The information gleaned from this research could promote curriculum development in the areas of traumatology. The counselor education profession could benefit from this understanding by exploring these concepts because counselors work in environments that experience traumatic events constantly.

**Definition of Terms**

*Secondary Traumatic Stress*—The natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other-the stress resulting from helping or wanting to help a traumatized or suffering person (Figley, 1993a).

*Vicarious Traumatization*—Relates both to the graphic and painful material trauma clients often present, as well as the therapist’s unique cognitive schemas or beliefs, expectations, and assumptions about self and others (McCann & Pearlman, 1990).
**Shared trauma**— Refers to situations in which helper and helpee, psychotherapist and client, are exposed to the same communal disaster (Baum, 2010).

**Violent crime**— Composed of four offenses: murder and nonnegligent manslaughter, forcible rape, robbery, and aggravated assault. Violent crimes are defined as those offenses which involve force or threat of force (Federal Bureau of Investigations, 2010).

**Homicide**— Murder and nonnegligent manslaughter is the willful killing of one human being by another (Federal Bureau of Investigations, 2013).

**Summary**

There has been a lack of research pertaining to the lived experiences of African American counselors, their perceived preparedness to work in violent neighborhoods and serve trauma survivors, and their clinical experiences working with trauma survivors. Several studies conducted in the past few decades reveal that mental health professionals who work with trauma survivors overtime are subject to experiencing secondary traumatic stress, vicarious traumatization, and/or shared trauma (Bride, 2004; Cohen & Collens, 2013; Rasmussen, 2005; Tosone et al., 2012) Mental health professionals included in these studies include social workers, psychologist, and nonprofessional trauma counselors.

There are three significant aspects of research within the mental health literature that have not been explored with Black counselors. These areas are: (1) Black counselors’ exposure to servicing individuals who are exposed to traumatic events, (2) Black counselors’ clinical experiences, and (3) Black counselors’ training experiences. Black counselors’ experiences within the profession are important aspects of research since there is little information about their experiences currently. Most research about the experiences of Black mental health professionals can be found in the social work and the counseling psychology literature (Merriman & Joseph,
2018; Wagaman et al., 2015). However, Black counselors might have unique experiences within the counseling profession that have not been included in the literature. Therefore, this study explored the lived experiences of African American counselors, in Chicago, and their reactions to working with trauma survivors.

Chapter I highlighted the rationale for conducting this dissertation research. The next chapter provides a written section on trauma as the theoretical concept used in this study, as well as a review of the literature on secondary traumatic stress, vicarious traumatization, shared trauma, the clinical experiences of counselors, social workers, and counseling psychologists and their experiences working with trauma survivors. Chapter II also explores the clinical training of Black counselors in counselor education, social work, and counseling psychology. Chapter III is the methodology section. In that chapter, the researcher discusses the phenomenological approach for this study, such as research design, participants and sampling, data collection procedures, and the method to be used to analyze the data. Chapter IV presents the results from the data analysis. It also includes a report on the descriptive statistics gathered from demographic information and direct quotes from the individual interviews conducted by the researcher. In the last chapter, the researcher offers conclusions drawn from the data analysis, explores the implications the study has for counselor education, and suggests areas for future research.
CHAPTER II
LITERATURE REVIEW

Since the purpose of this study was to explore the lived experiences of African American counselors in Chicago and their reactions to working with trauma survivors, this chapter provides a review of the literature related to counseling and trauma. It begins with a brief history of trauma, then provides definitions of the concepts needed to understand this research. Next, the research on the clinical experiences of counselors, including counselors’ clinical experiences while working with trauma survivors is presented. The chapter concludes with a discussion of the existing literature on counselor’s training experience within their graduate programs, their perceptions of their graduate training, and how they perceived their training has prepared them to work with trauma survivors.

History of Trauma

The earliest literature on trauma dates back to the late 1800s, with the work of Pierre Janet and Sigmund Freud. Both individuals developed similar theories related to the etiology of hysteria, mostly related to psychological trauma, particularly sexual trauma (Herman, 1992a). Hysteria was often described as a nervous disease. However, Janet and Freud had different views regarding hysteria. Janet conceptualized hysteria as the dissociation of feelings and memories related to traumatic experiences, while Freud believed that people who experience hysteria were believed to be struggling with dealing with repressed wishes, particularly childhood sexual wishes (Van Der Kolk, 2014). This idea marked the start of Freud’s psychoanalysis theory.

It was Freud’s continual look at neurosis that led him to realize there were stressful events that contributed to people experiencing neurosis. At the time, individual experiences with World War I, child abuse, and other fatal accidents and injuries led to traumatic neurosis
Freud described the core of post-traumatic stress disorder (PTSD) symptoms several decades prior to the release of the revision of the Diagnostic and Systematic Manual of Mental Health Disorders (DSM-III-R; American Psychiatric Association [APA], 1987), which listed PTSD as a mental disorder. Freud asserted that his patients had dreams that repeated their traumatic event (i.e., intrusive imagery), that they were having physical attacks as if they were presently in the traumatic situation (i.e., physiological hyperactivity), and that his patients were living as if the traumatic event was not over (i.e., reliving the event; reoccurring thoughts). The literature on trauma increased following World War I and during the Vietnam War. Clinicians during times of war noticed that returning soldiers were displaying symptoms that have not been considered and/or included the DSM (APA, 1952). It was not until the release of the DSM-III in 1980 that trauma was recognized as a mental illness (APA, 1980). The DSM-III classified trauma as an event existing “outside the range of usual human experience” (APA, 1980, p. 236).

Prior to the release of the DSM-III and its definition of PTSD, the DSM-I (APA, 1952) described stress disorders as Gross Stress Reaction (GSR). GSR was defined as a stress syndrome, which is a response to physical or mental stress. At the time of the release of the DSM-I (APA, 1952), mental stress was commonly a result of World War II (1939-1945). Criteria for GSR included: (a) acute reactions to unusual stress, (b) prolonged or persistent reactions to an alternative diagnosis considered by a clinician (this implied that the client had a pre-morbid condition and included psychosis, neurosis, or character disorders), (c) happens in people who were considered normal, (d) must alleviate in days to weeks, and (e) if symptoms persist, another diagnosis must be made (Andreasen, 2010).

Following the DSM-I (APA, 1952), the DSM-II (APA, 1968) was released. In the newest edition of the DSM, GSR was omitted and was classified as “adjustment reaction of adult life”
(APA, 1968), which included criteria such as depression related to unwanted pregnancy and fear of military combat. These criteria did not address people who had been affected by warfare (Wilson, 1995). Between the DSM-I and the DSM-II there had been more traumatic events across the world and the United States (i.e., Korean War, Vietnam War); yet the DSM-II did not include criterion related to stress disorders. Andreasen (2010) asserted that the omission on GSR in the DSM-II was done “without any explanation” (p. 68) and that “the most plausible explanation for the omission is that the concept was closely linked to warfare and combat, and the DSM-II was written in a peaceful era. Consequently, between 1968 and 1980 no official diagnosis for stress disorders was available” (Andreasen, 2010, p. 68).

It was not until the DSM-III (APA, 1980) that PTSD was included as a mental diagnosis. PTSD was defined as an anxiety disorder because emotional distress and physical instability were among the primitive factors related to trauma. The criteria for PTSD in the DSM-III was: (a) the person has experienced an event outside of usual human experience, (b) the traumatic event is persistently re-experienced, (c) persistent avoidance of anything associated with the trauma or numbing, (d) persistent symptoms of increased arousal, and (e) duration of disturbance of at least one month (APA, 1980). However, as researchers continued to study trauma further, they recognized that the traumatic experiences people experienced were not inclusive (Jones & Cureton, 2017). So, the DSM-IV and DSM-IV-TR were updated to be more inclusive of the wide range of traumatic experiences or events individuals can experience, such as loss, natural disasters, and accidents (APA, 2000). Because of the expansion of the criteria of trauma in the DSM-IV and DSM-IV-TR, trauma diagnosis increased by 59% (Breslau & Kessler, 2001). Currently, the DSM-5 (APA, 2013) includes the most extensive definition for trauma to date, including trauma-related criteria for minors under the age of 6-years-old.
The DSM-5 (APA, 2013) became more explicit in terms of its definition of trauma and stressor related disorders, as well as in its extension of the symptomatic profile, where the symptoms structure went from three to four. The criterion for trauma in the DSM-5 includes: (a) exposure to actual or threatened death, serious injury or sexual violence, (b) presence of intrusion symptoms such as recurrent, involuntary, and intrusive memories of traumatic event, recurrent distressing dreams related to the traumatic event(s), dissociative reactions where the individual feels or acts as if the traumatic event(s) were recurring, intense or prolonged psychological distress at exposure to internal or external reminders the resembles the traumatic event(s), or physiological reactions to internal or external reminders that resemble the traumatic event, (c) persistent avoidance of stimuli associated with the traumatic event(s), (d) negative alterations in cognitions and mood associated with the traumatic event(s), (e) alterations in arousal and reactivity associated with the traumatic event(s), (f) duration of criteria B-E is more than one month, (g) the disturbance causes clinically significant distress and impairment in social, occupational, and other important areas, and (h) disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition (APA, 2013).

An additional requirement to meet PTSD criteria in the DSM-IV-TR (APA, 2000), was that individuals must experience stressor reactions such as fear, horror, or helplessness; however, this criterion excluded the range of psychological responses that are experience by those who often encounter traumatic events, like survivors of sexual and partner violence, military, and first responders (Friedman et al., 2011). So, this criterion was eliminated when the DSM-5 was produced. The expansion of the definition of trauma (PTSD) over the past few decades was a
much-needed adjustment as the world progressed in its knowledge of trauma. Trauma is now defined:

as exposure to actual or threatened death, serious injury or sexual violence in one or more of four ways: (a) directly experiencing the event, (b) witnessing, in person, the event occurring to others, (c) learning that such an event happened to a close family member or friend, and (d) experiencing repeated or extreme exposure to aversive details of such events, such as with first responders. Actual or threatened death must have occurred in a violent or accidental manner; and experiencing cannot include exposure through electronic media, television, movies or pictures, unless it is work-related. (APA, 2013)

Due to the increase of community and school violence and wars overseas, exposure to traumatic events has become an epidemic in the United States (Jones & Cureton, 2017). Nearly 80% of clients seen in community mental health clinics have experienced at least one incident of trauma during their lifetime, representing about five out of every six clients (Breslau & Kessler, 2001; Jones & Cureton, 2017). Individual trauma results from an event or series of events that is experienced by an individual as “physically or emotionally harmful or threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being” (U.S. Department of Health and Human Services [DHHS], 2018, p. 45).

Injuries and violence affect all Americans regardless of what they look like, what age they are, or where they are from. Injuries or violence such as falling, homicides, and gang violence "kill more Americans ages 1 to 44 than any other cause, including cancer, HIV, or the flu” (DHHS, 2018, p. 45). As such, clinicians are likely to work with trauma survivors no matter their specialty or work environment (Trippany et al., 2004).
The U.S. Department of Health and Human Services (DHHS) (2003) declared trauma as a high priority following incidents such as Hurricane Katrina and the wars in Iraq and Afghanistan. These incidents resulted in thousands of trauma survivors seeking help. Clinicians who took on these clients, as well as those experiencing subsequent traumatic incidences, found themselves experiencing negative reactions to helping trauma survivors. Due to the high percentage of exposure to trauma, clinicians’ reactions to trauma survivors can result in secondary traumatic stress (Figley, 1995), vicarious traumatization (McCann & Pearlman, 1990) and/or shared trauma (Altman & Davies, 2002).

**Clinicians Exposure to Clients’ Trauma**

Mental health professionals’ experiences working with trauma survivors has been widely studied (Culver et al., 2011; Finklestein et al., 2015). Early writings describe clinician’s experiences of secondary traumatic stress, vicarious trauma, and shared trauma after major events such as the Holocaust, the Persian Gulf War, and the terrorist attack on 9/11 (Figley, 1993; McCann & Pearlman, 1990; Tosone, 2011). Secondary traumatic stress and vicarious trauma have been widely discussed in the counseling and psychology literature; however, shared trauma is a concept that has been used in the social work literature. This section will describe each concept used for this study and its effects on mental health professionals.

**Secondary Traumatic Stress**

*Secondary traumatic stress* (STS) is a concept that has been used to describe the negative effects of secondary exposure to a traumatic event(s) (Figley, 1995). The symptoms related to STS have been closely related to the symptoms of post-traumatic stress disorder. However, other researchers have conceptualized secondary traumatic stress to include “a broader range of psychological, cognitive, and interpersonal reactions” (Robinson-Keilig, 2010, p. 11). In this
study, STS is used to understand how engaging with individuals who have suffered from trauma can have negative effects on Black counselors who work and live in Chicago.

Secondary traumatic stress, often used interchangeably with compassion fatigue, describes how mental health professionals experience stress as a result of caring for someone who is suffering from a traumatic event(s) and/or wanting to help someone who is experiencing a traumatic event(s) (Figley, 1993). This includes family members, friends, and other people who have a relationship with trauma survivors (Dutton & Rubinstein, 1995; Figley, 1995). Mental health professionals who experience this level of stress are impacted physically, psychologically, and socially (Robinson-Keilig, 2010).

**Physical Impact**

Mental health professionals who experience secondary traumatic stress often experience symptoms related to symptoms related to PTSD. Through trauma exposure, PTSD can negatively impact an individual’s physical health. PTSD has been associated with increased unhealthy behaviors and negative health perceptions (Godfrey et al., 2013; Lauterbach et al., 2005; Pacella et al., 2013; Rauch et al., 2006; Thordardottir et al., 2015).

Godfrey et al. (2013) examined the differences across physical health indicators and health behaviors of community members and U.S. military veterans with and without PTSD. They found that the participants with PTSD had poor health and health behaviors. The participants with PTSD experienced obesity, poor eating habits, and alcohol use more than those who did not have PTSD. This study shows the link between PTSD and negative physical health.

Pacella et al. (2013) conducted another study that examined the association between physical health and PTSD symptoms, as well as moderators of this relationship, through meta-analysis of 62 studies. Requirements for these studies to be included in the meta-analysis were: (a)
participants must have been 18 years and older, (b) studies must had administered PTSD or post-traumatic stress symptoms (PTSS) assessments, and (c) they must have included outcome assessments such as general health symptoms (e.g., somatic symptoms), medical conditions, physical health-related quality of life (HR-QOL), musculoskeletal pain, etc. The metanalysis revealed that the participants of the studies who had PTSD and high PTSS experienced general health symptoms, general medical conditions, and poorer physical health-related quality of life. PTSD and PTSS was also associated with greater frequency and severity of pain, cardio-respiratory symptoms, and gastrointestinal complaints. Their study also supported that there is a significant relationship between PTSD and negative physical health outcomes. Furthermore, PTSD has been associated with “sleep disturbances, more physical symptoms, increased somatic symptom severity, hypertension, heart disease, stomach ulcer, gastritis, and arthritis” (Lee et al., 2018, p. 229).

Lee et al. (2018) conducted a cross-sectional study of 539 clinical social workers to record the prevalence of secondary traumatic stress in the United States and to examine the relationship between exposure to client trauma, STS, and the perceived health of social workers. They found that clinicians experience intrusive symptoms most frequently and many of them reported arousal and avoidance symptoms, which are all symptoms of PTSD. They also determined that exposure to traumatized client populations indirectly influenced clinical social workers physical health perceptions by way of STS. The indirect effect can be determined by the amount of cases the clinical social worker have with PTSD. Their cross-sectional study was unable to determine causality; however, they concluded that higher levels of STS was associated with lower levels of health perceptions.
The literature reviewed does not explicitly state how negative physical health can affect counselors’ work with trauma survivors; however, one can imagine an increase of absenteeism. Clinicians who may be experiencing gastrointestinal issues and pain may be at risk for chronic absences and abandonment of their clients. Furthermore, the therapeutic relationship can be affected by the clinicians’ absenteeism, as well as the lack of sleep and alcohol use they may be experiencing. Clinicians are potentially at risk of damaging the clinician-client relationship. Healthy therapeutic relationships are the cornerstone for effective counseling.

**Psychological Impact**

An individual’s psychological health is equally at risk as their physical health. To illustrate, Makadia et al. (2017) evaluated (a) the extent of exposure to trauma work among 564 clinical psychology trainees (which consisted of an overwhelming number of White, female participants, 507 female and 531 White), and (b) the relationship between the amount of exposure to trauma and psychological symptoms, trauma symptoms, and disrupted beliefs. The reasoning behind the study was that in previous research it was unclear how much the level of stress related to clinical work contributes to trauma symptoms or disrupted beliefs due to the exposure to trauma work. The results indicated that greater amounts of exposure to trauma work and greater levels of stress of clinical work were related to greater levels of trauma symptoms. These symptoms included intrusion, arousal, and avoidant behavior (Makadia et al., 2017).

Perez et al. (2012) examined the mediating role of trauma symptoms such as reexperiencing, avoidance, hyperarousal, and depressive symptoms in relationship between trauma exposure and physical health symptoms among 516 Spanish female undergraduate students. The results indicated that group of female students who were exposed to trauma reported more physical health symptoms. The results also showed that hyperarousal and
depressive symptoms mediated the relationship between trauma exposure and physical health symptoms. The exposure to trauma is significantly correlated with negative physical and psychological health (Perez et al., 2012)

Other studies included personal trauma history as a variable to see if it may impact the development of secondary traumatic stress in mental health professionals. For example, Ivicic and Motta (2016) evaluated the impact personal trauma history, experience, trauma exposure, and supervision had on the development of secondary traumatic stress in mental health professionals by assessing their ability to recall words related to traumatic experiences. The purpose of this multiple regression study was to evaluate the combined impact of personal trauma history, experience, exposure, and supervision on the development of secondary traumatic stress in mental health professionals, while expanding the accuracy of therapist recall. The study consisted of 88 mental health professionals, which included social workers, counselors, psychologists, and creative arts therapists who had worked with individuals who experienced natural disaster, assault with a weapon, domestic violence, physical and/or sexual abuse (adult or child), terrorist attack, neglect (child), and placement in the foster care system. Eighty-one percent of the participants were White and 79.5% female.

To carry out this study, the researchers used several assessment tools, including the Stroop procedure, which is an unbiased measure of secondary trauma used to recall words related to traumatic experiences (Ivicic & Motta, 2016). The modified Stroop measure consist three types of stimuli: trauma-related words (e.g., neglect), neutral words (e.g., finger), and color zeros. The participants were to name the colors and not the words. The measurement consisted of the extent to which the trauma-related words will cause delay in naming the color that was presented to them and neutral words the participants to identify.
The researchers also used the Secondary Trauma Scale to assess for symptoms related to secondary traumatic stress; the Life Events Checklist to assess for personal trauma history; the Job Satisfaction Survey to assess for job satisfaction; a supervision scale to assess for the perceived quantity and quality of supervision that the participants had; and a demographics questionnaire (Ivicic & Motta, 2016). They hypothesized that those who were exposed to trauma experiences would have a delay in recalling the words related to a traumatic experience. The results of this study supported their hypothesis. Also, the study found that working with clients with traumatic backgrounds has a negative emotional effect on mental health professionals. The researchers concluded that there is a relatively high level of secondary trauma among mental health workers. Individuals who are exposed to secondary traumatic stress experience cognitive impairments, and this study is an example of research which documents that (Ivicic & Motta, 2016).

Cieslak and colleagues (2013) also found personal trauma history to be a factor in the risk for secondary traumatic stress among mental health professionals. They surveyed 224 psychologists (45%), counselors (31%), and social workers (23%) working with military patients. They assessed the prevalence of STS and investigated their personal trauma, work-related trauma, and the relationship between indirect exposure to trauma and STS. Regarding the personal trauma history, the participants’ personal history of trauma, having an excessive number of clients, and too much paperwork was positively associated with STS.

Symptoms of STS among health professionals include insomnia, nightmares, irritability, hypervigilance, intrusive thoughts, and re-experiencing the client’s traumatic event (Bride, 2007). Negative emotions such as anger, frustration, and helplessness have been reported, along with health professional’s disruption in their worldview (Steed & Downing, 1998). These
negative effects can have an impact on the personal and professional lives of health professionals (Steed & Downing, 1998).

**Social Impact**

Secondary traumatic stress has also been associated with having a negative impact on mental health professionals’ social lives. Symptoms of PTSD can cause problems within family and romantic relationships (Milenkovic et al., 2013). Milenkovic et al. (2013) investigated whether the presence of PTSD symptomatology is related to specific family problems among 94 male military veterans (combat and non-combat). The study indicated that there is a relationship between PTSD and family dysfunction, as there were high PTSD scores associated with family dysfunction. In addition, arousal, intrusion, and avoidance were more frequent in participants with disturbed family function. It was concluded that military veterans with symptoms of PTSD are more likely to experience family dysfunction.

Monson et al. (2009) also found that military veterans who experience symptoms of PTSD displayed issues within intimate partner relationships and relationship dissatisfaction. This is common in the literature regarding military veterans. Other studies discuss how emotional numbing interferes with intimacy (Riggs et al., 1998), marital, parenting, and poor family functioning (Ahmadzadeh & Malekian, 2004; Manguno-Mire et al., 2007; Ruscio et al., 2002; Taft et al., 2008), and social isolation and poor subjective well-being (Price & Stevens, 2012) among military veterans. Although these studies highlight the negative social impact among military veterans who experience PTSD symptoms, PTSD symptoms, as previously stated, are reported by a significant amount of mental health professionals who experience secondary traumatic stress, which means mental health professionals’ social lives can be negatively impacted due to secondary traumatic stress.
Symptoms of secondary traumatic stress can be sudden and happen after a single encounter with a traumatic story. Symptoms of STS are parallel to the symptoms of post-traumatic stress disorder (PTSD) (Bride, 2007; Figley, 1995). These symptoms include avoidance, intrusion, and/or arousal (American Psychiatric Association, 2013). According to the DSM-5, avoidance symptoms include persistent avoidance to any stimuli that is associated with the trauma that a person has experienced, and a lack of responsiveness (APA, 2013). Avoidance occurs when someone is trying to avoid the thoughts and feelings associated with the trauma they have experienced. People who experience the symptoms of avoidance often avoid people, places, conversations, and other activities that may remind them of their traumatic experience (APA, 2013).

Intrusion symptoms include recurrent thoughts, memories, or dreams, whereby the traumatic event is replayed over and over (APA, 2013). The flooding of these event(s) in a person’s mind may occur in the form of flashbacks and hallucinations, which makes the persons feel as though they are reliving the traumatic event (APA, 2013). While the person is experiencing these intrusive thoughts, it can cause psychological distress and physiological reactivity. Arousal symptoms include irritability and anger, self-destructive and reckless behavior, hypervigilance, problems concentrating, elaborate startled response, and difficulty falling and staying asleep (APA, 2013).

Mental health professionals are not the only professionals who are affected by secondary traumatic stress. Studies (Covey et al., 2013; Ludick & Figley, 2017; McCann & Pearlman, 1990) have shown that secondary traumatic stress is not specific to mental health professionals since it can affect those in close contact with trauma survivors. Other professionals include firefighters, nurses, funeral directors, and those who simply just want to help (Bride, 2007).
However, mental health professionals are especially vulnerable to STS because their empathic engagement and their level of exposure when engaging with trauma survivors (Figley, 1995).

**Vicarious Traumatization**

The terms *secondary traumatic stress* and *vicarious trauma* both focus on the effects of trauma on mental health professionals by way of their clients’ stories; however, vicarious trauma is the product of the therapeutic relationship (Boulanger, 2018), and the effect of vicarious trauma is a cumulative process (McCann & Pearlman, 1990). Mental health professionals who are exposed to their clients’ traumatic stories over time are at risk of vicarious trauma.

The term vicarious trauma was first used in the literature in the early 1990s when describing clinicians’ experiences while working with survivors of childhood sexual abuse (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). The term was initially used to conceptualize indirect trauma as it applied to mental health therapists (McCann & Pearlman, 1990). The concept was later expanded to include other types of trauma workers (e.g., nurses, medical officers, firefighters).

Vicarious trauma (VT) is described as a “way the therapist’s experience of the self is altered in terms of identity, world view, spirituality, self-capacities, ego resources, psychological needs, and the sensory system” (Rasmussen, 2005, p. 20) when working with clients who have experienced trauma. VT disrupts the therapist’s sense of safety, trust, esteem, intimacy, imagery, sense of power, and sense of control (McCann & Pearlman, 1990b; Pearlman & Saakvitne, 1995). The therapist often experiences a heightened sense of vulnerability because of hearing stories about violence, paranoia, traumatic images of their client’s story, as well as suspiciousness of other people motives (McCann & Pearlman, 1990). Additionally, therapists who experience vicarious trauma had a high change of experiencing disruption in their imagery.
Therapists experience their clients story in the form of flashbacks, dreams, or intrusive thoughts (McCann & Pearlman, 1990). These disruptions in imagery are associated with feelings of sadness, anger, and anxiety, which mirrors the feelings of the therapist’s client(s) (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). McCann and Pearlman (1990) believed that the imagery that is most painful to the therapist center around the therapist’s most important areas of need. For example, if the therapist’s most salient need is safety, they will recall images that threatens their safety (McCann & Pearlman, 1990).

In a study conducted by Finklestein et al. (2015), the researchers investigated PTSD and vicarious trauma symptoms among 99 mental health professionals who worked in communities with high levels of trauma related to rocket attacks. Most of the study included social workers working and living along the Gaza Strip and in Sderot, which is in Israel. PTSD symptoms of intrusion, avoidance, and hyperarousal were measured by how frequently the participants experienced each symptom in the past month. Participants also reported the extent to which they experienced vicarious reactions. The authors found that mental health professionals working in Sderot, which was severely affected by the rocket attacks, reported higher levels of vicarious trauma and PTSD than those who work in communities boarding Gaza, which experienced lower levels of trauma related activity. Therefore, mental health professionals who were exposed to trauma primarily and vicariously were at higher risk to experience psychological distress. Although this study took place in a war-torn area, it can be assumed that those who experience repeated trauma primarily and vicariously, such as gun violence, are at higher risk for psychological distress (Finklestein et al., 2015).

Mental health professionals who work in impoverish communities often lack support from their organizations, which seems to be an ongoing issue with clinicians who are at risk for
developing psychological distress. Because of this, this study will focus on Black counselors’ experiences working with trauma survivors who live in violent and impoverish areas so that the counseling profession can better understand their experiences with STS, VT, and ST, and to discuss ways to help these professionals with their symptoms. For example, Michalopoulos and Aparico (2012) explored the role of personal trauma history in the development of vicarious trauma symptomatology among 160 social workers. Eighty-nine percent of this study was female, 77% where White, and 92% of the participants had a history of trauma. Through an administered survey on personal trauma history, vicarious trauma, and social support, the authors found that personal trauma history did not predict vicarious trauma; however, they did find that an increase in social support could predict less severe vicarious trauma. They concluded that personal connections can protect against the development of vicarious trauma symptoms. Mental health professionals who have support from their organizations and colleagues have clear boundaries, better self-care habits, and the ability to distinguish between their professional and personal lives (Bell & Robinson, 2013).

The theoretical framework used to understand vicarious trauma is the Constructivist Self-Development Theory (CSDT), a developmental theory that explains the impact of trauma on an individual’s psychological development, self-schema, and how these individuals interact with their environment (McCann & Pearlman, 1990b). CSDT was initially developed to understand the differences in recovery for adult trauma survivors. The authors of this theory were committed to studying and treating adult survivors of sexual assault, childhood sexual and physical abuse, war, domestic violence, other crimes and other life stressors (McCann & Pearlman, 1990b). CSDT proposes that people can construct their realities as they interact with their environment. Their realities are the foundation of how they understand new experiences.
According to McCann and Pearlman (1990), “CSDT focuses on the interaction between the person and the situation, with particular focus on the self in development” (p. 3). Therapists’ response to their clients’ traumatic stories are formed by the interactions between the important aspects of the traumatic story and the therapists’ psychological needs (Robinson-Keilig, 2010). CSDT proposes that traumatic disruptions can occur within a therapist in different areas, including self-capacities, ego resources, psychological needs, and cognitive schemas. Self-capacities refer to an individual’s ability to manage strong emotions while maintaining positive self-esteem. Ego resources refer to an individual’s ability to maintain healthy relationships, and their ability to establish and maintain healthy boundaries when interacting with others.

An individual’s psychological needs are at the core of who they are as a person. They differentiate one individual from another. Psychological needs motivate the behavior of a person and how they interact with other people (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). Cognitive schemas, on the other hand, are “related to an individual’s core psychological needs such as safety, trust, esteem, control, and intimacy” (Robinson-Keilig, 2010, p. 14). Cognitive schemas refers to an individual’s beliefs, assumptions, and expectations related to their psychological needs (McCann & Pearlman, 1990). McCann and Pearlman (1990) asserted that cognitive schemas develop overtime through the process of assimilation and accommodation, of which the therapist is either consciously aware or not. Robinson-Keilig (2010) asserted:

For therapists, empathic engagement with clients and exposure to traumatic material serves as the impetus for disruptions to a therapist’s self-capacity, ego resources, frame of reference and core psychological need areas. It is the position of CSDT that this process is psychologically painful and can have a profound and lasting impact on the therapists’ identity, emotions, relationships, interpersonal life, and their ability to meet their own
basic psychological needs. However, the way that the therapist experiences disruptions depends in part upon which aspects and core psychological needs areas are most salient to the therapist. (p. 17)

While vicarious trauma and secondary traumatic stress both focus on the experiences of mental health professionals’ secondary exposure by way of their clients’ stories, vicarious trauma alters mental health professionals’ sense of self and how they view the world. In this study, vicarious trauma was used to understand how Black counselors’ (working and living in Chicago) livelihood were affected by engaging in therapeutic relationships with individuals who have suffered from a traumatic event(s).

**Shared Trauma**

Shared trauma is often used in the social work literature to describe the experiences of clinicians who have experienced the same collective disaster as their clients (Tosone, 2011). Clinicians who work with clients after personally experiencing the same mass traumatic event, such as Hurricane Katrina and the terrorist attacks on 9/11 are at risk for experiencing shared trauma. However, this phenomenon can also be applied to local events of a traumatic nature, such as neighborhood gun violence (Tosone et al., 2012). For the purposes of this study, shared trauma will be used to understand how African American counselors can be affected by the same collective trauma as their clients when they work and live in the same community as their clients.

Shared trauma occurs suddenly and is an unavoidable situation in which a mental health professional goes through a traumatic experience that is the same as that of his or her client. “Trauma can have many causes: natural disasters, political oppression and persecution, violence, terrorism, genocidal atrocities, an individual’s physical or verbal abuse” (Sampson, 2016, p. 344). Any of these experiences may result in a disruptive environment that threatens the mind
and the well-being of anyone involved, “shattering the mind, creating rifts in consciousness or fault lines in the psyche” (Stuthridge, 2012, p. 238).

The concept “shared trauma” was not used in the literature until early 1990s; however, researchers were describing this phenomenon early in the 1940s. In 1942, Schmideberg, a psychoanalyst, wrote about a communal disaster of repeated bomb explosions on civilians in London. She wrote about what was later called the “London Blitz” and its impact on her, her patients, and their therapeutic relationship (Baum, 2010). In 1991 when the termed was coined, a sociologist, Killian, wrote an article describing the impact that different communal disasters (i.e., natural disasters, explosions) had on the population within the community (Killian, 1952). Killian (1952) looked at the problems that service providers had as a professional and an individual. Schmideberg (1942) focused on the joint exposure of client and psychotherapist to the same disaster, while Killian focused on the professional’s double exposure, as a professional and individual (Baum, 2010).

There are a few terms used in the literature to describe this phenomenon: shared trauma, shared reality, and shared traumatic reality. All of the terms describe the “affective, behavioral, cognitive, spiritual, and multi-modal responses that clinicians experience as a result of dual exposure to the same collective trauma as their clients,” (Tosone et al., 2012, p. 233). Like vicarious trauma, these reactions can alter the clinician’s worldview. Unlike vicarious trauma, clinicians who experience shared trauma are more prone to posttraumatic stress, blurring of professional and personal boundaries, and increased self-disclosure (Tosone et al., 2012). According to Baum (2010), shared traumatic reality involves all the following features: (1) the disaster is a collective trauma, that is, a traumatogenic event that can potentially traumatize the entire community, (2) the communal disaster is a current one, (3) both the client and
psychotherapist belong to that community, even if they have been there only for a short time, and (4) the clinician suffers double exposure both as an individual member of the community and as a professional providing services (Baum, 2010).

Mental health professionals might live in the community in which their clients live, and might also be affected by the same communal disasters. The literature does not specifically explore how far and/or how close a clinician might live to be a part of a communal disaster. Baum (2010) conceptualized that shared trauma may occur communally due to disaster that causes trauma to a large group, a community, or an entire nation as it impacts an entire population simultaneously (Bell & Robinson, 2013). Nuttman-Shwartz (2015) asserted that shared trauma is a matter of mental health professionals living and working in the same community as the people they serve. So, based on these assertions, distance from the communal disaster is not the concern as it relates to shared trauma. Instead, it is a matter of the effects the communal disaster has on clinicians who service clients and live in the community.

Baum (2010) described several ways clinicians can be affected personally and professionally when experiencing shared trauma. They include: (a) blurred boundaries within clinicians’ professional work, causing a change in workplace and a change in role boundaries, (b) blurred boundaries between the professional and personal lives of clinicians, (c) intrusion of the clinicians’ professional life into their personal life, (d) interruption in social life, (e) blurred boundaries within therapeutic relationship, (f) disruption in cognitive functioning within, and (g) heightened sense of threat. Clinicians who are affected by a collective disaster often have to leave their workplace and provide services at the site where the incident may have occurred, or at the site where the victims have been evacuated. These sites may be unorganized and full of devastation. Lev-Wiesel et al. (2009) found that mental health professionals who had to leave
their normal work sites to provide assistance at other work sites after a disaster reported greater levels of emotional distress. In addition, Baum (2010) discussed how clinicians experience a change in their role where they have found themselves performing duties other than what they were trained to do because of the higher level of need-based tasks after a collective disaster. He also asserted that the helping professionals who assisted after the terror attack on 9/11 were torn between assisting the victims who were affected by the attack, or their own families who were also a part the community. Their commitment to the profession, and their commitment and loyalty to their families were tested. This could possibly cause emotional distress. Furthermore, the clinicians were also a part of the community that was stricken by the terrorist attacks on 9/11; however, they still had to provide services. Clinicians are less likely to be able to separate their experiences as a clinician from their experiences as a citizen of the community in which they live in.

Baum (2010) asserted that the clinicians who experience shared trauma might affect the ongoing relationship between the clinician and the client in many ways. First, the clinician and the client may be responding to and processing through the traumatic event at the same time. The client story about the traumatic event can potentially have a negative impact on the clinician, causing countertransference. Moreover, clinicians who experience the same communal disaster as their client may feel like their experience is one in the same (Tosone & Bialkin, 2003). This awareness can create new directions both in the therapeutic relationship and the clinician’s personal self. The clinician can experience more stress, be preoccupied, and be more defensive than other times when they may not have experience the same collective trauma. When the client perceives the change, they may lose confidence in the clinician’s ability to help them (Baum, 2010).
Bauwens and Tosone (2010), for example, wanted to understand the long-term impact the terrorist attack on 9/11 had on 481 social workers’ professional and personal lives. Participants lived and worked in the affected area, and the researchers explored what qualities enabled participants to cope with their own traumatic stressors while assisting others. Like most studies mentioned earlier, this study was overwhelmingly heterogenous, with 90% of the participants being White and 80% being female. They worked an average of 30 hours per week, serving a diverse population of trauma survivors (e.g., sexual abuse, multiple traumas, intimate partner violence). Most of the participants provided services during 9/11 and worked with adults who had a history of childhood sexual abuse.

Clinicians in the Bauwens and Tosone (2010) study reported feeling more vulnerable, having continued hypervigilance and traumatic memories, feeling unprofessional, and feeling ill-equipped to provide services post-9/11. They also reported professional and clinical growth, which included: (a) changes in boundaries wherein they allowed themselves to become more connected with their clients, (b) skill development, (c) self-care, (d) political activism, and (e) connectedness, which included being more compassionate and transparent with their clients. They also reported making a conscious decision to improve their work situation after the shared traumatic experience of 9/11. Those who answered the open-ended questions had more traumatic symptoms, had more resiliency, and reported being currently affected by the events of 9/11. The effects of the terrorist attack on 9/11, even 6 years later, had both negative and positive effects on social workers that lived and work in the affected area. Although the clinicians in this study experienced these negative reactions during their work with clients, they also used this situation as an opportunity to grow professionally and to improve their work situation after the shared traumatic experience of 9/11 (Bauwens & Tosone, 2010).
Through narrative inquiry, O’Neill (2010) explored how working with trauma survivors affected helping professionals who provided some form of psychological support to trauma survivors in an isolated community in Canada. The eight participants of the study reported that large caseloads, limited social life, and community problems affected their work with trauma survivors. The community lack of resources, issues with poverty, and violence subjected the participants to feeling ill-prepared to work effectively with their clients. O’Neill (2010) found that they lacked training and access to training to work with trauma survivors. Furthermore, the participants of this study experienced feelings of isolation. Working in a small community and not being able to confide in anyone about the experiences with working with traumatized individuals left them feeling isolated. Their experience with isolation was also related to the lack of supervision they received. The helping professionals were negatively affected by their work with traumatized in that they experienced hypervigilance, loss of compassion, guilt, sleeplessness, and emotional and physical depletion. They described their experiences with secondary trauma as being “haunted, injured, and taking on client issues” (O’Neill, 2010, p. 140). Although the participants in this study experienced the negative effects of trauma work, they also experience some positive effects. They experienced increased compassion, knowledge on how to effectively help their clients, and enrichment during their work with trauma survivors.

The positive psychological effects of working with trauma survivors is often referred to as posttraumatic growth (Bauwens & Tosone, 2010; Tedeschi & Calhoun, 1996; Tedeschi et al., 1998; Tosone, 2011; Tosone et al., 2014). It is a term used to describe how mental health professionals may experience some sort of personal and professional growth when working with trauma survivors. Tedeschi et al. (1998) described the positive psychological effects of working with trauma survivors as the development of positive meaning gained from a traumatic
experience. There are five areas that result in growth after a trauma: (a) new possibilities, (b) relating to others, (c) personal strength, (d) appreciation for life, and (e) spiritual change (Tedeschi & Calhoun, 1996).

In discussing areas that result in growth after a trauma, new possibilities describe new opportunities, rather than a new job or new relationships (Calhoun & Tedeschi, 2006). Relating to others is described as having intimacy and/or increased compassion for those who may be struggling in life. Personal strength can be described as how people identify their strength after a traumatic event they may not have seen otherwise. Appreciation for life is described as the increased sense of gratitude for life and how people’s priorities change to the more meaningful things in their life. Lastly, spiritual change can be characterized as a deepening of spirituality (Calhoun & Tedeschi, 2006). Indeed, some of the clinicians in the Bauwens and Tosone (2010) study experienced post-traumatic growth (PTG) in that they grew in their clinical skills, became political activists, took better care of themselves, and were able to connect with their clients because of their shared experience with the terrorist attack on 9/11.

Satkunanayagam et al. (2010) also explored post-traumatic growth in their study of 12 (5 women, 7 men) clinicians working with trauma survivors in Sri Lanka during civil conflict. Through interpretative phenomenology, they explored the struggles and rewards of these clinicians’ trauma work, and the notion that individuals are changed in some way by the work they do with survivors of traumatic events. The researchers wanted to understand the experiences the clinicians had that contribute towards raising awareness and transferable participant-defined knowledge. They reported that the participants were affected by the traumatic stories of their clients by experiencing a sense of frustrations because of their inability to change the social injustices (civil war) their clients were experiencing. However, the positive side of the trauma
work included how they were able to give their clients some kind of relief, and identifying their purpose in engaging in trauma work (Satkunanayagam et al., 2010). The participants experienced personal transformation while supporting people who have experienced the traumatic events in Sri Lanka. The work they were conducting created a greater awareness of shared humanity.

Spelvins et al. (2010) also explored vicarious experiences through a qualitative inquiry of eight interpreters working in a therapeutic setting with asylum seekers and refugees who were trauma survivors. The participants consisted of six women and two men, representing five different ethnic groups (i.e. French, Iraqi, Iranian, British, and African) who work in the north west of England and spoke several different languages. Fifty to 90% of the interpreters’ work was therapeutic work with asylum seekers and refugees who had experienced multiple traumas. Given that interpreters are needed to meet the mental health needed to meet the mental health needs of refugees and asylum seekers now more than ever, the researchers of this study thought an exploration of the vicarious experiences of the interpreters was much needed. They found that interpreters did experience some distress in their work with trauma survivors. They also found that the interpreters experienced post-traumatic growth. They experienced a sense of growth in their personal and professional lives because of their work with trauma survivors (Splevins et al., 2010). Spelvins et al.’s (2010) study was different than other studies mentioned previously regarding the population that was studied; however, this study, like the others, shows that helping professionals, no matter their professional titles, who work with trauma survivors are at risk of experiencing vicarious trauma as well as post-traumatic growth.

For the purposes of this study, the researcher explored the reactions of Black licensed professional counselors who work in the most violent neighborhoods in Chicago. Shared trauma, as a phenomenon, was explored within the lived experiences of those who also live in the most
violent neighborhoods in Chicago, and who have experienced the same collective trauma of gun violence. Gun violence exposes the entire community to the same threat and injury.

**Summary**

The literature over the past few decades have continued to clarify the effects of vicarious trauma, secondary traumatic stress, and shared trauma on clinicians who work with trauma survivors. For example, Cohen and Collens (2012) conducted a meta-synthesis of several qualitative studies (e.g., O’Neill, 2010; Satkunanayagam et al., 2010) done over a decade focused on the impact trauma work has on individuals who work with traumatized clients, within the framework of vicarious trauma. These studies have found that the impact of trauma work on trauma workers can potentially increase their level of distress and their experience of negative somatic and emotional responses. Trauma workers in turn become less compassionate, isolated, and experience feelings of danger (Cohen & Collens, 2013). Studies focusing on secondary traumatic stress often discussed military veterans who were diagnosed with PTSD, and how it affected them physiologically, psychologically, and socially. Furthermore, studies that focused on shared trauma often discussed how mental health professionals experienced that same communal disaster as their clients. These communal disasters are often described as wars, terrorist attacks, and natural disasters.

None of the studies (Bauwens & Tosone, 2010; Godfrey et al., 2013; Michalopoulos & Aparicio, 2012; Milenkovic et al., 2013; Tosone, 2011) focused on neighborhoods who experience gun violence. Most of the participants in each study were social workers and psychologists. Also, the racial demographics of the participants were not always clear. Furthermore, in the studies that included racial demographics, most of them consisted of over
50% White females. The experiences of licensed professional counselors, specifically African American counselors, and their reactions to trauma survivors remain unclear.

**Theoretical Concept**

Before the writings about the etiology of hysteria produced by Pierre Janet and Sigmund Freud began, their teacher, Jean Martin Charcot, a French physician, wrote and studied hysteria with traumatized women. Women comprised most of the patients with hysteria during Charcot’s time (Ringel & Brandel, 2012). According to Ringel and Brandel (2012), “Hysterical symptoms were characterized by sudden paralysis, amnesia, sensory loss, and convulsion” (p. 106). It was believed that hysteria originated in the uterus; thus the treatment for hysteria was a hysterectomy. However, Dr. Charcot understood that hysteria was not physiological, but psychological (Ringel & Brandel, 2012). He “describe both the problems of suggestibility in these patients, and the fact that hysterical attacks are dissociative problems-the results of having endured unbearable experiences” (van der Kolk et al., 1996, p. 50). Pierre Janet and Sigmund Freud continued the research on hysteria. However, Janet and Freud had different views regarding hysteria. Janet conceptualized hysteria as the dissociation of feelings and memories related to traumatic experiences, while Freud believed that people who experience hysteria were believed to be struggling with dealing with repressed wishes, particularly childhood sexual wishes (van der Kolk, 2014).

It was Freud’s continual look at neurosis that led him to realize that there were stressful events that contributed to people experiencing neurosis. Freud described the core of post-traumatic stress disorder (PTSD) symptoms several decades prior to the release of the revision of the Diagnostic and Systematic Manual of Mental Health Disorders (DSM-III-R; APA, 1987), which listed PTSD as a mental disorder. It was not until 2013, with the release of the DSM-5
(APA 2013), where the definition of trauma became more explicit, it became more explicit in stressor related disorders and its extension of the symptomatic profile, where the symptoms structure went from three to four. The criterion for trauma in the DSM-5 includes: (a) exposure to actual or threatened death, serious injury or sexual violence, (b) presence of intrusion symptoms such as: recurrent, involuntary, and intrusive memories of traumatic event, recurrent distressing dreams related to the traumatic event(s), dissociative reactions where the individual feels or acts as if the traumatic event(s) were recurring, intense or prolonged psychological distress at exposure to internal or external reminders the resembles the traumatic event(s), or physiological reactions to internal or external reminders that resemble the traumatic event, (c) persistent avoidance of stimuli associated with the traumatic event(s), (d) negative alterations in cognitions and mood associated with the traumatic event(s), (e) alterations in arousal and reactivity associated with the traumatic event(s), (f) duration of criteria B-E is more than one month, (g) the disturbance causes clinically significant distress and impairment in social, occupational, and other important areas, and (h) disturbance is not attributable to the physiological effects of a substance (e.g. medication, alcohol) or another medical condition (APA, 2013). Trauma is now defined as:

exposure to actual or threatened death, serious injury or sexual violence in one or more of four ways: (a) directly experiencing the event, (b) witnessing, in person, the event occurring to others, (c) learning that such an event happened to a close family member or friend, and (d) experiencing repeated or extreme exposure to aversive details of such events, such as with first responders. Actual or threatened death must have occurred in a violent or accidental manner; and experiencing cannot include exposure through electronic media, television, movies or pictures, unless it is work-related. (APA, 2013)
Additionally, People of Color experience stress in systems in which they occupy, whether that is institutional or cultural encounters with racism (Landrine & Klonoff, 1996; Utsey, 1999; Utsey & Ellison, 2000). The race-based stressors can have an impact on their physical and psychological health. According to Carter (2007), race-based traumatic stress injury refers to the emotional or physical pain or the threat of physical and emotional pain that results from racism in the forms of racial harassment (hostility), racial discrimination (avoidance), or discriminatory harassment (aversive hostility). The target may and does experience significant emotional reaction(s), and symptom clusters emerge that reflect that reaction, but the racial component or encounter(s) is important in recognizing and connecting the racism to the emotional distress and pain. (p. 88)

Carter (2007) reported that People of Color could experience high blood pressure, risk of heart disease, PTSD, hypervigilance, depression, avoidance, activism, commitment to being strong, and anxiety as signs and symptomology of race-based traumatic stress. His research lead to what we know now as race-based traumatic stress theory.

Furthering the research about race-based traumatic stress, Polanco-Roman et al. (2016) found that emerging adults who experience racial discrimination that is possibly traumatic may be more vulnerable to dissociative symptoms. These symptoms include depersonalization/derealization, gaps in awareness and memory, sensory misperception, and cognitive-behavioral reexperiencing (DSS; Carlson et al, 2016). As noted, racial discriminatory experiences may be perceived as threatening to the integrity and safety of the affected individual. Thus, racism is a potential source for traumatic stress, which he referred to as race-based traumatic stress. Specifically, race-based events may yield emotional and psychological injury that negatively impacts mental health through
eliciting traumatic stress, as they are often perceived as negative, unexpected, ambiguous, repeated, and out of the individual’s control. (Polanco-Roman et al., 2016, p. 609)

Clinical Experiences of Mental Health Professionals

The clinical experiences of mental health professionals who experience secondary traumatic stress (STS), vicarious traumatization (VT), and shared trauma (ST) are often related to their practice and perceived preparedness to work with trauma survivors. Each term is used in discussion about how the impact of each secondary trauma can affect the therapeutic practice of mental health professionals. This section will focus on the clinical experiences of mental health professionals and how their psychological well-being can negatively impact their clinical work, as well as what their experiences are like working with vulnerable populations.

Clinical Experiences With STS

The clinical experiences of mental health professionals vary among matters of work conditions, personal resources, and working with certain populations as it pertains to secondary traumatic stress. To understand how contextual factors may contribute to compassion fatigue and burnout, and to help address the challenges counselors experience when servicing clients with traumatic backgrounds, Thompson et al. (2014) surveyed 213 mental health professionals to explore how gender, years of experience, perceived working conditions, personal resources of mindfulness, use of coping strategy, and whether compassion satisfaction predicted compassion fatigue and burnout. They found that the more positive the clinicians were about their work environment, the less likely they were to experience compassion fatigue and burnout. Women, which accounted for 76% of the participants in the study, were more likely to experience compassion fatigue than men. Also, the more experience they had as a clinician, the less likely they would experience compassion fatigue. The findings suggest that counselor working
conditions and perceptions of personal resources are predictive of counselor burnout and compassion fatigue (Thompson et al., 2014).

Dagan et al. (2015) also examined how personal resources (i.e., coping strategies), social support, and workload contributed to secondary trauma in 217 social workers in Israel. The therapists’ personal resources and professional environment were significantly correlated with secondary trauma. The more the therapists were able to perceive and cope with information they lack the knowledge of without entering a state of anxiety (i.e., tolerance of ambiguity), the lower the level of secondary traumatization. Likewise, therapists who felt incompetent in their clinical work but could persist through the process without becoming anxious were more likely to experience lower levels of secondary trauma. Also, the more trauma cases the therapist had the more likely were to experience secondary trauma (Dagan et al., 2015). Therefore, therapists’ ability to maintain a healthy lifestyle is also crucial to their mental health wellness.

Lawson and Myers (2011), for example, examined the professional quality of life of 506 professional counselors who were members of the American Counseling Association (ACA). Professional quality of life (PQOL) focuses on compassion fatigue, which is a byproduct of “bearing witness to the suffering of others and results in a reduce ability or capacity to be present with feelings of powerlessness, isolation, and confusion” (Lawson & Myers, 2011, p. 164). PQOL includes the aspect of compassion satisfaction as well, which is “the pleasure you derive from being able to do your work well” (Stamm, 2005, p. 5). They found that counselors who engage in healthy self-care habits (e.g., healthy relationships, personal therapy, etc.) are more likely to experience compassion satisfaction in their professional careers.

McCormack and Adams (2015) wanted to study that how the medical model, which “negates the interpersonal relationship and the very factors which promote personal growth, may
affect opportunities for growth in therapists and their clients working with complex traumas” (p. 194). This phenomenological study explored subjective interpretations of four (two psychiatric consultants, one clinical psychologist, one psychologist/clinical manager) senior trauma therapists working in inpatient settings. All participants reported vicarious exposure to traumatic patient narratives (e.g., sexual abuse, serious illness, community violence). The participants experienced vicarious psychological distress through complex and severe inpatient traumatic stories. Working within the medical model led the participants to develop a sense of self-doubt, guilt, and sense of failure. This was because the dynamics of the medical model—horrible stories, acute treatment timeframe, the artificial therapeutic relationship, as well as a diagnose-treat-discharge approach to patient care, left the participants feeling incompetent and complicit in their patients’ distress. The authors asserted that over time, the participants experienced loss of therapeutic integrity working within the medical model framework. The participants perceived little recovery and growth in their clients. The authors concluded that, without professional organizational support, clinicians within the inpatient settings may be at risk of poor self-actualization and chronic psychopathology as they try to make sense of their distress from vicarious traumatic exposure (McCormack & Adams, 2015).

While the literature often discusses the negative reactions mental health professionals experience during their clinical experiences when working with trauma survivors, some studies have focused on the growth that mental health professionals (MHP) experience while working with trauma survivors. Satkunanayagam et al. (2010) explored the lived experiences of 12 MHPs using a phenomenological approach and how their engagement in trauma work can be a struggle and/or some sort of reward. The participants in this study asserted that they were negatively affected by their patients’ traumatic stories, rooted in their experience during the civil war. They
experienced a sense of frustration because of their inability to change the social injustices that their clients were experiencing. The positive side of their trauma work included that they were able to give their clients relief, and that they identified their purpose in doing so (Satkunanayagam et al. 2010). The mental health professionals experienced both a negative emotional impact and positive personal satisfaction while working with trauma survivors.

McKim and Smith-Adcock (2014) studied both sides of vicarious trauma. They asserted that mental health professionals working with trauma survivors often experience both psychological stress (compassion fatigue) and benefits (compassion satisfaction). They arrived at this conclusion from their study of the influence of workplace conditions and the individual characteristics of 98 mental health professionals on their compassion fatigue and compassion satisfaction. The study consisted of 74% female and 92% White counselors, social workers, and psychologists who provided care for trauma survivors in domestic and international contexts. They found that the lack of control over the workplace (e.g., caseload selection), over-involvement with clients, and secondary exposure to clients with serious trauma symptoms were significantly related to the counselors’ compassion fatigue. The counselors’ perceived control of the workplace, personal trauma history, and years of clinical experience were all significantly related to their compassion satisfaction. In other words, the more control participants had over their caseload, time for self-care, and opportunities to diversify their work activities, the more likely they were to experience compassion satisfaction. The less control they had over their work environment, the more likely they were to experience compassion fatigue (McKim & Smith-Adcock, 2014).
Clinical Experiences With ST

PTSD criteria are not sufficient for describing what clinicians experience when engaging in trauma work, and STS and VT are both descriptions of clinicians’ experience with indirect exposure not shared trauma. With these gaps in mind, Bauwens and Tosone (2010) wanted to understand the long-term professional and personal impact of 9/11 on clinicians living and working in the affected area. They surveyed 481 social workers (90% White 80% female; average age 61 years), which spent an average of 30.90 hours a week treating trauma clients. Even 6 years later, the effects of 9/11 had both negative and positive effects on social workers that live and work in the affected area. Clinicians became more vulnerable, hypervigilant, and felt ill prepared to provide services after the event. However, some clinicians experienced post-traumatic growth (PTG). They grew in their clinical skills, became political activists, took care of themselves better, and were able to connect with their clients because of their shared experience with the terrorist attack on 9/11.

In their recent phenomenological study, Day et al. (2017), asked eight (four men, four women) mental health professionals (e.g., counselors, social workers, marriage and family therapy, medicine, psychology) to describe their shared traumatic experiences during the shooting at Virginia Tech. The participants either worked on campus or the surrounding campus area. The authors wanted to address the gap in the literature regarding potential professional challenges and benefits when clinicians are exposed to the same traumatic event as their clients. They found that the participants had never responded to a community-based traumatic event of this magnitude before, so they faced many challenges during that time, including turnover and burnout, lack of information regarding crisis management, and extended community recovery.
efforts. Also, four of the participants in this study reported being so focused on their clients that they neglected to take care of their own needs.

Together these studies suggest that clinicians who work and live in the same community as their clients and share experiences with the same traumatic event can potentially experience psychological distress. Also, clinicians who have not been prepared to work in communities that have experiences mass trauma(s) can potentially experience burnout, cause harm to clients, and leave their jobs.

**Working With Vulnerable Populations**

Mental health professionals work with vulnerable populations have been documented in the literature broadly regarding helping professionals. For the purposes of this study, the researcher revisits what the literature says about mental health professionals’ clinical experiences while working with vulnerable populations.

**Low-income Clients**

Conversations about clinical experiences surrounding trauma are mostly focused on its negative emotional impact, or the positive, personal growth of mental health professionals; however, the clinical experiences of mental health professionals who work with vulnerable populations are equally important. Working with low-income clients is different from the traditional training that is provided to clinicians. Liu et al. (2007) suggested that counselors should be aware of their upward mobility bias, which assumes that “individuals are constantly interested in upward social mobility, achievement, and success” (p. 197). When this is the attitude of the counselor, the counselor can easily label those who are not subscribing to that bias as lazy or unmotivated (Liu et al., 2007). Also, some clinicians assume that the right medication and therapeutic approach will improve the lives of low-income clients (Smyth et al., 2006).
When clients do not live up to this idea, the clients, “blame themselves for their suffering, and are taught, once again, to feel ashamed of their situations and emotional distress” (p. 492).

Clinicians who are not familiar with the experiences of low-income clients’ risks labeling, mistreating, and exercising their social class privilege (Smith, 2005), which can lead to harming their clients more.

Furthermore, psychologists have reported overstepping ethical boundaries to advocate for their low-income clients. In a study conducted by Borges (2014), participants shared that they use their personal resources (e.g., food, money) to advocate for clients from marginalized backgrounds. This act is often seen as clinicians having blurred boundaries; however, the participants in Borges’s (2017) study saw their clients’ situations as unjust and believed they were positioned to help those who trusted them. The participants asserted the key attributes of working with clients in poverty are:

- possessing a values-based commitment to working with marginalized groups,
- possessing experience with, knowledge of, and empathy for the devastating realities of living in poverty,
- possessing a high degree of self-awareness related to poverty,
- possessing a willingness to be deeply affected by the work and to cope with negative feelings.

(Borges, 2014, p. 197)

In another study of income bias, Thompson et al. (2015) wanted to explain the contributing factors for disparities in treatment attendance and outcomes for clients with lower incomes as opposed to high incomes among nine licensed mental health professionals (MHP) using grounded theory methodology. Participants expressed their knowledge of poverty and its environmental factors. They also discussed their own biases working with low-income clients and the need for MHP to work with low-income clients instead of assuming they are difficult to
work with. The researchers reported how the participants’ biases were challenged, but also how they gained a new respect for this population. The researchers suggested training programs to incorporate more literature in their classrooms pertaining to litigation, resources and others educational tools that low income clients can benefit from (Thompson et al., 2015).

Working with client from low-income neighborhoods seems to have its own challenges. It is important to include the experiences of mental health professionals who work in low-income neighborhoods in the counseling so that counseling programs can better prepare mental health professionals to work in these kinds of environments. Traditional, middle-class psychotherapy may not be effective for low-income clients (e.g., Foss, 2012; Kim & Cardemil, 2012).

**Lesbian, Gay, Bisexual, and Transgender Clients**

Individuals who identify as lesbian, gay, bisexual, or transgender have been subject to an unfortunate amount of homophobia in the counseling profession, particularly that which implies that homosexuality can be reversed (Kowszun, 2006; Mair & Izzard, 2001). Homosexuality had been included in the DSM (APA, 1952) as a mental disorder, but in 1973, it was removed after an APA majority vote that affirmed homosexuality was normal. Because of the long history pathologizing and depathologizing of homosexuality, some LGBT individuals may be skeptical of seeking counseling and have negative experiences when they do (e.g., King & Barlett, 1999; Mair & Izzard, 2001; Platzer, 1998); however, generally LGBT individuals are more likely to seek counseling than their heterosexual counterparts (Burckell & Goldfried, 2006). It can be assumed that counselors may have a difficult time engaging LGBT individual in counseling because of the deeply rooted idea that homosexuality is not normal.

Owen and Baines (2014) wanted to explore the gap in the literature as it pertains to the clinical experiences of novice therapists working with LGBT individuals, and to clarify the
extent to which their formal training had prepared them for this client group among 16 (five male, 11 female) counselors from various backgrounds, ethnicities (13 White British, one African Caribbean, 2 British Asian), and sexuality (13 heterosexual or predominantly heterosexual, one gay, two bisexual). The authors found that the participants were engaged with learning by drawing on their own lived experiences or learning from their clients. In this process of learning, the participants were confronted with their lack of knowledge and skill when working with their LGBT clients’, found it difficult to find strategies to help their clients, and were working through their own internalized homophobia while counseling LGBT individuals. The authors concluded that in order for counselors’ clinical experiences with LGBT individual to be more positive and to assure competent care, training programs must adopt a more gay-affirming curriculum (Owen-Pugh & Baines, 2014).

Military Clients

Like LGBT individuals, serving military clients (active duty or veteran) warrants a different therapeutic approach. Individuals who have served in the military are governed by a different set of norms, values, and traditions (Coll et al., 2013) than their civilian counterparts. When military individuals return home, they experience a cultural shock like what immigrant individuals experience. To better understand a civilian understanding of military culture, Coll et al. (2013) tested the relationship between a clinician’s military cultural awareness, attitudes about the wars in Iraq and Afghanistan, and self-efficacy in working with the veteran population. Two-hundred ninety-three people participated in this study. Of these, 74 were male and 219 were female. Seventy percent had experienced working with veterans and 30.4% had completed one or more continuing education courses in military social work/military counseling. Sixteen percent of the participants were veterans themselves, and 10% were military spouses.
The authors found military cultural awareness and clinician self-efficacy scores were not significantly correlated (Coll et al., 2013). Participants who identified as veterans reported higher levels of self-efficacy than did non-veterans. Also, the highest mean efficacy score was among those individuals who identified themselves as veterans. Experience with working with veterans made a difference in both cultural awareness and self-efficacy, but not in attitudes about war. Further, the participants who reported continuing education courses in military social work or counseling scored significantly higher in military cultural awareness and self-efficacy. The findings in this study suggest that those who are military veterans and those who have sought out continuing education in military courses are better prepared to service military veterans than those who have not.

The authors concluded that it is important for counselors to seek an understanding of the worldviews of military veterans, which supports the ethical mandate of professional organizations such as the American Counseling Association (ACA), the National Association of Social Workers (NASW), and the American Psychological Association (APA) (Coll et al., 2013). Additionally, Coll et al.’s (2013) study “validates the significance of seeking appropriate training with emphasis on issues relating to working with military personnel” (p. 46). To Illustrate, Voss Horrell et al. (2011) focused on the unique issues in treating military veterans, particularly combat veterans who had recently returned from tours in Iraq and Afghanistan or had served in other capacities in Operating Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) campaign. The primary difference with working with OEF/OIF veterans compared to veterans from earlier wars is the availability of treatments targeting symptoms of PTSD. Clinicians now have the advantage of recognizing symptoms of PTSD (Voss Horrell et al., 2011). The aim of the
The study was to identify potential patient, clinician, and organization factors that are likely to affect clinicians working with this clinical population.

There are many challenges that clinicians face when servicing OEF/OIF veterans, including vicarious trauma, secondary traumatic stress, compassion fatigue, and burnout (Voss Horrell et al., 2011). Also, OEF/OIF veterans are less likely to attend counseling sessions, they are less likely to complete homework assignments, and their progress in sessions is slow or nonexistent. Clinicians may find themselves becoming discouraged when they do not see progression with their clients. Furthermore, several factors related to the clinician may serve as risks or protective factors when working with OEF/OIF veterans. These factors include training, personal trauma history, supervision, self-care activities, military affiliation, spiritual and religious views, level of social support, and theoretical orientation.

Organizational support may also serve as a risk or protective factor (Voss-Horrell et al., 2011). Organizations that support the clinicians’ effort to maintain a balanced caseload (i.e., different kinds of clients), caseload size, support staff, and available resources can help minimize the risk of vicarious trauma, secondary traumatic stress, compassion fatigue and burnout. Lastly, Voss Horrell et al. (2011) also discussed the importance of civilian clinicians becoming oriented with the military culture. Understanding the worldview of military veterans assists clinicians in understanding how to treat their clients.

Working with vulnerable populations such as low-income clients, LGBT individuals, and military veterans can be much different from working with those who identify as middle-class, heterosexual individuals. It is imperative that helping professionals take into consideration the unique experiences of individuals who do not identify with the dominant culture. The lack of clinical experiences with vulnerable populations can be detrimental to their mental health, and
the sole job of the mental health professional is to aid those who are experiencing distress, not to contribute to the stress because of their lack of experience.

It is important to discuss how important clinical experiences are in practice. For instance, Pignotti and Thyer (2012) surveyed 400 Licensed Clinical Social Workers across the United States to determine the extent of their usage of Novel Unsupported Therapies (NUSTs), as well as their usage of conventional therapies that lacked support and empirically supported therapies (ESTs). They wanted to know the possible reasons social workers did or did not select interventions that had the best research evidence for the client’s problem.

Prior to this study, most studies focused on evidence-based interventions (Pignotti & Thyer, 2012). NUSTs were defined as interventions that lack adequate empirical support and make unsupported claims for their efficacy (e.g., Myers-Briggs Type Indicator, attachment therapy, and EMDR for conditions other than PTSD). Conventional Unsupported Therapies (CUST) are interventions that are widely accepted, but lack empirical support (e.g., Dream Interpretation, Genogram, Psychoanalysis, Psychodrama), and ESTs are interventions that are empirically supported (e.g., Dialectical Behavior Therapy, Cognitive Behavior Therapy). They found that 97% of the participants reported using empirically supported treatment. However, 75% of the participants provided some form of NUSTs, which they defined as a relatively new treatment that was not widely accepted or taught in their graduate training. Sixty percent reported using CUSTs.

The authors concluded that “one’s positive clinical experience, theoretical preferences, personality style and emotional compatibilities were more influential in these psychotherapies’ choice of interventions than favorable research reports in peer reviewed journals” (Pignotti & Thyer, 2012, p. 343). They also stated that clinical experiences were valued over research
evidence. The clinical experiences of mental health professionals are more valuable in clinical practice than research evidence. Research evidence can be skewed, interpretation of findings can be biased, and research studies can possibly not be representative of the population the social workers may be serving (Pignotti & Thyer, 2012).

**Black/African American Clients**

The literature related to Black clients often discusses the barriers Black clients face when seeking and/or are engaged in mental health services. African Americans have faced numerous negative experiences in the mental health profession including misdiagnoses, overmedication, and inadequate attention paid to cultural and societal influences (Curtis-Boles, 2017). These issues have caused African Americans to mistrust the mental health services that are offered to them, especially when the therapist is White (Ridley, 2005). Mistrust is a major barrier to Black people utilizing mental services (DHHS, 2001). Historical and current experiences in a White-dominated world have led to Black people mistrusting White people and White institutions. Terrell et al. (2009) defined cultural mistrust as “the belief acquired by African Americans, due to past and ongoing mistreatment related to being a member of that ethnic group, that Whites cannot be trusted” (p. 299)

The literature related to Black clients often discusses how race plays a part in Black clients seeking therapy. A study by Sanders-Thompson et al. (2004), conducted focus groups of 201 African Americans (134 women, 66 men) about their perceptions of psychotherapy and psychotherapists. One of the significant findings in this study was that the African American participants reported that race should not matter, but it does as it relates to psychotherapy and psychotherapists. They reported that stereotypes affect therapist attitudes towards African American clients, as well as the treatment of African American clients. The participants went on
to say that some things are easily overlooked in therapeutic relationships that include African American clients: “ethnic minority reading material in the waiting room, diversity of the art in therapy and waiting rooms, and ethnic minorities who work for and with the therapist, affected their perceptions.” (Sanders-Thompson et al., 2004, p. 25) They also reported that therapists seemed overwhelmed or unwilling to address these certain issues, which can limit disclosure and participation in the therapeutic process. The researchers concluded that it is important for therapists to become aware and address their concerns and anxieties about working African American clients might have regarding offending or alienating clients, and they must understand and respond appropriately to clients who react negatively to discussions of race in therapy (Sanders-Thompson et al., 2004)

Summary

Overall, there are many studies (e.g., Dagan et al., 2015; Thompson et al., 2014; Thompson et al., 2015) within the literature that explore the work conditions of clinicians, their personal resources, and their experiences working with a certain demographic of people. This information has been limited in exploration within counselor education. Moreover, the studies within the counselor education literature about mental health professionals and trauma lack inclusivity and diversity of experiences as it pertains to race, geographical location, and communal disasters. There is a lack of representation of the Black community wherein the literature does not reflect Black counselors and their work within the Black community with high violent crimes. Little is known about the experiences of Black counselors who work in high crime neighborhoods.
Training Experiences of Counselors

Much like the social work profession, the counseling profession could implore the narratives of counselors in practice to provide students with the knowledge and practical experiences needed to work in various professional environments (Golia, 2015). Golia (2015) asserted that the clinical experiences within training is a pedagogic tool faculty members use to provide guidance and context to students’ questions related to practice. The use of narratives in training as it pertains to the clinical experiences of faculty members is imperative in the development of novice clinical social workers (Golia, 2015). The author contended that the practical experiences of their professors were beneficial as they became novice clinical social workers.

It appears that mental health professionals’ clinical experiences are a determinant of their training experience. To be an effective mental health professional, one must have adequate training in their respective professions to serve a wide-ranging client population. When discussing the experiences of mental health professionals, the perceived preparedness to work with trauma survivors often comes up. There are discrepancies across studies that include the use of participants from various helping professions. The training of each profession is different. Many studies have mainly used psychology students to examine counselors’ reactions to trauma survivors (Adams & Riggs, 2008; Baker, 2012).

It is important to include counselor education training in the conversation to better serve the profession with evidence-based trauma training. Also, it is important to include trauma in the current curriculum for counselor education programs. Trauma training is pivotal to all doctoral and master’s programs, including counselor education. The Council for Accreditation of Counseling and Related Educational programs (CACREP) recognized its importance to the
master’s and doctoral study within the counseling discipline by asserting that the primary function of these programs is to train students in the areas of trauma-informed care and the effects of trauma on diverse populations (CACREP, 2016).

Pearlman and Saakvitne (1995) supported this idea and asserted that counselor educators and supervisors within graduate programs have a responsibility to educate future counselors about VT, as it will be difficult for them to avoid it in their work with trauma survivors. Sartor (2016) sought to determine if the presence of VT could impact self-efficacy in working with traumatized clients. They found that MHPs with higher levels of VT had lower levels of self-efficacy. Also, 66% of the participants indicated they were not prepared to work with trauma clients by their graduate programs. Building the self-efficacy of counselors in training through supervisory feedback, clinical supervision, and evaluation (Larson et al., 1992) can increase future counselors perceived preparedness to provide effective treatment to trauma survivors (Sartor, 2016).

Lu et al. (2017) using qualitative inquiry explored counselor education trainees’ experiences of exposure to trauma cases among eight doctoral level students who completed their master’s level training the United States. The researchers asserted that there was a significant amount of research about the psychological affects counselors experience when working with trauma survivors; however, little was known about the experiences of counselors-in-training who also were providing counseling to trauma survivors. They found that the participants of this study experienced adverse emotional reactions of fear, self-doubt, and decrease self-efficacy when they first encountered their trauma clients. Like practicing mental health professionals, trauma work can impact the professional and personal lives of counselors-in-training. The authors suggested that training in trauma could increase self-efficacy and
eliminate adverse emotional reactions when encountering clients’ traumatic experiences for the first time. Since there were no publications before this study that provided specific suggestions on how to protect students from the potential negative impact of trauma work, Lu et al. (2017) suggested: (a) theoretical frameworks in relation to trauma and vicarious trauma, (b) consideration of what students should expect to encounter when working with trauma cases, (c) clinical skills for trauma counseling, and (d) self-care and coping strategies (Lu et al., 2017).

Trauma training consists of preparing mental health professionals to address traumatic experience, as well as implementing evidence-based practices.

Turkus (2013) identified a multifaceted model for the training of trauma therapists that includes education, clinical practice, research, and self-reflection. The education component of the model is intended to develop a standard for trauma training consisting of “knowledge about differential diagnosis, assessment instruments, the neurobiology of both trauma and resilience, and medication management to complement psychotherapy” (Turkus, 2013, p. 3). Turkus (2013) contended that clinicians need to be exposed to a range of professional expertise through professional reading and continuing education. The clinical practice component of the model refers to becoming familiar with how to treat complex traumas such as dissociative disorder and PTSD. The author included that treating these kinds of trauma takes more than a series of therapeutic techniques to maintain a healthy and effective therapeutic relationship. Clinicians must be able to pace themselves through the therapeutic process. The research component refers to clinicians implementing evidence-based research in the practice with trauma survivors. The author stated that research offers validation to clinical practice. Lastly, the self-reflection component of the model refers to clinicians taking time to reflect on their clinical practice, professional development, and supervisory sessions (Turkus, 2013). Turkus (2013) asserted,
“self-reflection is essential to the process of becoming a competent therapist” (p. 8). This multifaceted model speaks to the development of a trauma therapist. It was concluded that each facet is essential for mastery of the competent practice of trauma psychotherapy. Because of the limited information about trauma training in counselor education programs, the following sections will discuss trauma training in various psychology and social work programs, which are programs closely related to counselor education.

Training in Psychology

Exposure to traumatic events puts individuals at risk for psychological distress, physical impairment, and social consequences (Godfrey et al., 2013; Perez et al., 2012; Milenkovic et al., 2013). Mental health professionals are likely to encounter trauma-related issues in their work. Therefore, trauma-related training is necessary in graduate education, as well as professional continuing education (Courtois & Gold, 2009). Courtois and Gold (2009) asserted that there is a need for the inclusion of trauma in the curriculum for all mental health training programs, as well as a need for mental health professionals to be knowledgeable and able to deliver specialized training to trauma survivors. DePrince and Newman (2011) released a Special Issue Editorial: The Art and Science of Trauma-Focused Training and Education that presented articles focused on practices, theory, and data from various training/education settings (e.g., Veteran Affairs (VA) settings, classroom) and on diverse forms of trauma (e.g., child abuse/neglect, military, violence against women, disaster). They found that many stakeholders had an interest in developing high quality education and training practices in undergraduate and graduate level programs rather than waiting until postgraduate and seeking continuing education.

In addition, Cook et al. (2011) reported findings from a survey conducted by the American Psychological Association Practice Organization (APAPO), which assessed the
number of hours per month that 263 practicing psychologists estimated they spent treating trauma survivors, and their interest in additional clinical training on trauma-related issues and topics. The study was homogenous, with 90% White participants and 53% male. The APAPO wanted to best prepare and meet the need of the expanding population of trauma survivors seeking mental health services. They needed more information regarding psychologists’ current practice patterns, background training to provide services, and interest in additional training. To do that, they had to gather more information. The APAPO found that the psychologists who were represented in this study worked an average of 14 hours a week with trauma survivors. Eighty-one percent of those who worked some or often with trauma survivors expressed interest in additional training.

Makadia et al. (2015) evaluated exposure to trauma work among 56 clinical psychology trainees in order to explore the relationship between the amount of exposure to trauma and psychological symptoms, trauma symptoms, and disrupted beliefs. They found that greater amounts of exposure to trauma work and greater levels of stress of clinical work were related to greater levels of trauma symptoms. The authors concluded that secondary traumatic stress was a potential risk for clinical psychology trainees, and found that quality training was significantly related to lower levels of trauma symptoms. They suggested that “training courses should (a) focus on quality of trauma training as it may be protective; and (b) advocate coping strategies to reduce stress of clinical work, as the level of stress of clinical work may contribute to trauma symptoms” (Makadia et al., 2015, p. 1059). Most psychologists do not have former training in trauma (Cook et al., 2011). For example, Cook et al. (2017) conducted a national survey on all North American doctoral programs in psychology programs to confirm the status of trauma-related training. Of the 398 programs, 151 responded to the survey. Only 31% of psychology
programs offer trauma psychology as a course and as a field experience. Psychology programs do not have the capacity in their curriculum or the resources to include trauma as an elective (Cook et al., 2017). Sixty-four percent of the programs reported that incorporating trauma-focused training into an already existing curriculum would be a more effective approach than creating an entire course. Although the psychology programs in this study expressed that they do not have the capacity to implement trauma-related training in the curriculum, trauma related issues are crucial to the development of mental health professionals. As stated before, the prevalence of traumatic events has increased over the past few decades, and these events are associated with mental health issues that people are seeking out assistance for (Cook et al., 2017). Furthermore, mental health professionals are less likely to experience STS, VT, ST if they receive specialized training during their graduate programs (Adams & Riggs, 2008; Courtois & Gold, 2009). Clinicians reported less competency in the area trauma-informed and trauma-focused care; therefore, their perceived ability to effectively work with trauma survivors is limited.

Many clinicians’ experience with trauma clients occurs during their practicum and field experience in graduate training, and evidence suggest that novice clinicians are more likely to experience difficulties (Pearlman & Mac Ian, 1995) because the literature investigating vicarious trauma among graduate students in clinical and counseling psychology was scarce, Adams and Riggs (2008) explored the vicarious trauma in relation to history of trauma, experience level, trauma-specific training, and defense style among 129 clinical and counseling psychology students in their graduate training programs. The graduate students completed the Trauma Symptom Inventory (TSI; Briere, 1995; Briere et al., 1995), Defense Style Questionnaire (DSQ; Bond & Wesley, 1996), and an experience questionnaire.
The TSI is a widely used self-report instrument of 100 items describing trauma symptoms (Adams & Riggs, 2008). For this study, only five subscales totaling 42 items were selected to represent vicarious trauma (e.g., intrusive experience, dissociation). The DSQ is most widely used self-report defense mechanisms. The DSQ identifies a hierarchy of four basic defense styles: (a) maladaptive action style consists of the most immature defense (e.g., inability to control impulses), (b) image-distorting style consists of defense involving splitting the image of self and others into good or bad, (c) self-sacrificing style reflects a need to maintain an image of self as kind, helpful and never angry, and (d) adaptive style represents positive coping strategies and consists of the most mature defense mechanisms (e.g., suppression, humor, and sublimation). The results indicated trauma symptoms were significantly associated with defense style. Over half of the study reported the self-sacrificing defense style.

Trauma-specific training was also related to trauma symptoms (Adams & Riggs, 2008). Seventy-four percent of the participants reported some formal training in trauma, while 38.7% reported minimal training, and 35.6% reported substantial training; however, a quarter of the participants reported working with trauma clients with no prior training in trauma. The authors concluded that novice therapists are more vulnerable to vicarious trauma. They reported higher levels of impairment when working with trauma clients. Although some of the participants reported some training, one-time lectures or class discussion are not enough to prepare students for trauma-related work. “Students need substantial trauma-specific training in the context of a full semester of coursework or multiple intensive workshops in order to protect themselves against the potential negative impact of trauma counseling” (Adams & Riggs, 2008, p. 32).
Training in Social Work

Much like the literature related to trauma training in psychology programs, social work programs have called for the need for trauma training. Butler et al. (2017) investigated the impact of trauma-related content, stress, and self-care on trainees in mental health training programs. They examined the risk factors (e.g., trauma exposure in training) and protective factors (e.g., self-care effort and importance) in relation to burnout (BO), health status (HS), secondary traumatic stress symptoms (STSS), and compassion satisfaction (CS) among 195 students in a graduate social work program. The participants of this study represented an overwhelmingly amount of non-Hispanic, White (81.7%), female (87.7%) social work students, all of which reported trauma exposure in their field placements and/or casework, which was associated with higher levels of STSS and BO. The participants also reported that higher field stress levels predicted higher BO and STSS, which is associated with a greater likelihood of decline in health status. Higher self-care efforts were also associated with compassion satisfaction.

The authors concluded that clinical training involving trauma content is both rewarding and stressful and can possibly cause distress to trainees (Butler et al., 2017). Although trauma training is essential to clinical training, the authors suggested using a trauma-informed approach within clinical training programs. These findings are important in that it echoes the importance of trauma training in graduate training programs; however, while doing so mental health educators must also teach and inform students how to care for themselves while engaging in trauma-related work. It should also be noted that older students who worked with trauma survivors during their work had higher levels of compassion satisfaction. It can be assumed that
older have more life experiences, which can be associated with better coping strategies and work satisfaction (Butler et al., 2017).

Carello and Butler (2015) suggested guidelines for trauma training, which is referred to as trauma-informed educational practices. These guidelines include student characteristics, content presentation and processing, assignment requirements and policies, instructor behavior, student behavior, classroom characteristics, and self-care. The authors suggested that instructors: (a) become familiar with the implications of trauma for learning, as well as signs and symptoms of trauma, re-traumatization, and VT, (b) check-in with students during class to check for emotional disturbances, (c) critically examine rationales and objectives for assignments and see if assignments can be adjusted to respect personal boundaries, (d) use neutral language and self-reflection to normalize the students’ experiences, (e) provide referrals ahead of time that include information for the college counseling center and other student support services, (f) be aware of student behavior and respond accordingly, (g) solicit student feedback and suggestions for improving classroom safety and comfort, and (h) teach, model, and practice self-care practice.

According to Carello and Butler (2015), the process of preparing the classroom environment for trauma training is equally important as preparing students for trauma work. The environment in which the students learn in can potentially carry over into their work in various settings, which can possibly increase self-care habits and compassion satisfaction.

Several authors have found that trauma-related training can be beneficial in trauma work. For example, Finklestein et al.’s (2015) study aimed to investigate the reporting of PTSD and VT symptoms among 99 mental health professionals working in communities with high levels of trauma. The authors found that MHPs working in communities with high levels of trauma reported higher levels of vicarious trauma and PTSD than those who work in communities who
experienced lower levels of trauma related activity. They concluded that mental health professionals who were exposed to trauma primarily and vicariously were at higher risk to experience psychological distress.

Although the researchers found PTSD and VT to be highly correlated with high levels of trauma, the regression model indicated that variations appeared to be directly related to the professional role of the worker (Finklestein et al., 2015). Specifically, education and professional support with “VT presents an important insight into potential resilience mechanisms for the professionals” (Finklestein et al., 2015, p. 29). They proposed that it would be enough for MHPs to receive “training and supervision to enhance their sense of professional competence, particularly in the context of concurrent exposure to primary trauma and VT” (Finklestein et al., 2015, p. 30).

While most of the above studies focused on the benefits of trauma training when engaging in trauma work (e.g., Butler et al., 2017; Cook et al., 2017; Makadia et al., 2017), Adam and Riggs (2008) noted that clinical supervision should focus on novice counselors and trainees coping styles and personal wellness to reduce the risk of vicarious trauma, rather than focusing on trauma training. The idea is that novice counselors and trainees have a better chance at avoiding secondary trauma if they practice healthy coping strategies and wellness.

Although one of the most common barriers to offering trauma courses is related to focusing on other specialty and programs requirements (Simiola et al., 2018), a consistent theme across the literature is that trauma training is an important component in the development of mental health professionals. Trauma training increases self-efficacy and limits the risk of secondary trauma. Furthermore, most of the literature discusses trauma training in psychology programs and includes participants from various professions. Although the studies include
participants from the helping professions, training in counselor education is uniquely different in
course content and accreditation standards (Evans & Gladding, 2010). Moreover, research in
needed to explore counselors’ training experience within counselor education graduate programs,
their perceptions of their graduate training, and how they perceived their training has prepared
them to work with trauma survivors.

**Conclusion**

Secondary traumatic stress, vicarious trauma, and shared trauma are all concepts related
to the counselors’ reactions to trauma survivors. These traumatic reactions vary in cause and
symptoms. Secondary traumatic stress occurs when hearing about the traumatic experiences of
close friends or relatives, while vicarious trauma is the product of a therapeutic relationship.
Shared trauma is when the counselor experiences the same communal traumatic event as their
clients. The symptomology related to each traumatic reaction can range from blurred boundaries
within a therapeutic relationship to PTSD.

In the current literature, there is evidence that mental health professionals’ clinical
experiences are related to their training in their graduate programs, organizational support,
workload, self-care habits, and psychological well-being. The factors that have the most support
thus far in the literature as influential in relation to STS, VT, and ST are age, gender, years of
counseling experience, exposure to trauma clients, and types of trauma. Most of the literature
includes mostly White, older aged (50 years and up) women who are psychologists, social
workers, or psychology and social work students.

Very little is known about what factors influence the development of secondary traumatic
stress, vicarious trauma, and shared trauma and clinical and training experiences of African
American counselors. Aside from studies conducted on counselors working in communities after
and/or during natural disasters and wars, very little is known about African American counselors living and working in highly violent communities, specifically communities ridden with gun violence. The literature has thus far failed to include an entire population of counselors with unique experiences. African American counselors’ intersectionality of race, social class, and experiences will bring a wealth of information to the counselor education literature.

There is an increased of interpersonal and intrapersonal violence within the home and community. Because of these incidents, there has been a heightened awareness of traumatic events and their negative effects on the population who reside within these communities. Because of the heightened awareness, individuals are seeking mental health treatment more now than before. Also, reliable assessments for traumatic exposure and PTSD have been made available (Wilson & Keane, 2004). This increase in mental health services has begun to put a demand on mental health programs to train their students to service trauma survivors. Research shows that trauma training is not an integral part of the counseling curriculum; however, there is a need for counselors to be knowledgeable and be able to deliver specialized training to trauma survivors.
CHAPTER III

METHODOLOGY

This chapter details the methods and procedures used to conduct this study. As mentioned in Chapter I, the purpose of this study was to explore the lived experiences of African American counselors who work in Chicago and to understand their reactions to working with trauma survivors. This chapter includes the study design, researcher’s reflection, site of potential study participants, participants, sampling, data collection, data analysis, and trustworthiness.

**Study Design**

This qualitative research was designed as a phenomenological study to explore the lived experiences of African American counselors in Chicago, with an emphasis on their clinical and training experiences. A phenomenological approach was appropriate because the research focuses on a phenomenon (Creswell, 2013); that is the experiences of African American counselors who work in the most violent neighborhoods in Chicago, and it seeks to understand the essence of their experiences. This methodology takes into consideration the lived and subjective experiences of the participants in this study, which includes their work with trauma survivors and their graduate training experience.

According to van Manen (1990), the purpose of phenomenological methodology is to “reduce individual experiences with a phenomenon to a description of the universal essence” (p. 177). The characteristics of a phenomenological study specifically, a hermeneutic phenomenological study includes: (a) bracketing out the researcher’s experiences with the phenomenon, (b) analyzing the data by reducing the information to significant statements or quotes, and (c) combining the statements into themes by developing textural and structural categories, integrating both textural and structural elements to convey an overall description, and
reducing that description to thematic statements that portray the essence of the experience (Moustakas, 1994). Hermeneutic phenomenology offers descriptive, reflective, and interpretive modes of inquiry of an individual’s description of his or her experience in the world and assumes human existence is meaningful and of interest in the sense that we are always conscious of something (van Manen, 1990). The researcher focused less on interpretation and more on the description of the participants’ experiences working with trauma survivors, their training experiences, and the meaning that the participants make of such experiences.

**Researcher’s Reflection**

As a researcher engaged in qualitative inquiry, I was the primary instrument in the data collection (Creswell, 2013). It was especially important to recognize my assumptions and biases in qualitative research because the data was filtered through my lens (Heppner & Heppner, 2004). As such, it was crucial that I controlled my assumptions and biases through memoing throughout data collection and analysis and journaling after each interview.

I was born and raised in the inner-urban city of Chicago. I lived and worked in the North Lawndale neighborhood, which has been labeled one of the most violent neighborhoods in the city. North Lawndale has an estimated 35,276 residents, with 47.4% in poverty, 26% in extreme poverty, and 25% low-income (Farooqui, 2015). Growing up in North Lawndale, I witnessed violence, including gun violence. I witnessed people selling and using drugs. It was rough growing up in this environment, and witnessing these events was traumatic for me. I can no longer go into places without knowing where exits are and/or without looking over my shoulder because of living in this kind of environment. I have been amid gunfights. I have also watched someone die from gunshot wounds to the chest. All of which has contributed to how vigilant I am in public places.
I identify as an African American woman who is currently pursuing her doctorate at a CACREP-accredited program in counselor education and supervision. I hold the following credentials: Board-Certified Counselor (NCC), Licensed Professional Counselor-Illinois (LPC), and Limited Licensed Professional Counselor-Michigan (LLPC). I have 5 years of experience as a counselor and worked as an intern therapist in Chicago’s North Lawndale neighborhood, in which I grew up. It was challenging for me to manage my clients’ anger, suspicion, and their inability to receive someone caring for them because of their past experiences of being misunderstood, disrespected, and underrepresented. CACREP requires training or studies in trauma; however, as a student in a counselor education program, there was a lack of trauma-related studies or training experiences that I acquired, which left me feeling incompetent to work with those who were trauma survivors. Because of my lack of training, I felt ill prepared to work with individuals who have suffered trauma, especially in high crime areas.

Since I closely identify with the group of participants that I sought for this study, it was almost impossible to avoid holding any biases coming into this study; however, it was important to me not to project my feelings and experiences onto my participants. To establish the trustworthiness of my study, I used memoing to write down my predispositions, assumptions, comments, thoughts, and reactions that may have conflicted with the study (Creswell, 2013).

I was interested in hearing stories about their experiences as African American counselors in Chicago who work with trauma survivors and their training experiences. Although we may share similar experiences, I captured my opinions, reactions, and concerns by journaling after each interview and memoing throughout data analysis; thus making these elements of my own thinking transparent to me so I can bracket them in appropriate ways. It was important to me to explore the lived experiences of African American counselors, in general, so that their
experiences are well documented in the literature. Also, I wanted to go back to my hometown, to conduct this study. I hope that this study contributes to the already progressive counseling literature and provoke curriculum change and policies in the future.

**Site of Potential Study Participants**

This study took place in Chicago, a city that is currently plagued by overwhelming violence. Chicago is the largest city in the American Midwest (Smith, 2016) and the third most populous city in the United States, with an estimated 2,725,153 people. Thirty-one percent of the city’s population are non-Hispanic White, and 37% are non-Hispanic Black (Naylor, Kassim, & Kim, 2016; United States Census, 2016). Established as a city in 1837, Chicago was known as a trading post during the westward expansion in the United States (Chicago History, 2018). The Michigan and Illinois Canal served as a connecting point between the Mississippi River and the Great Lakes. The increase of job opportunities and the influx of people from various racial and ethnic backgrounds through this connection point contributed to Chicago becoming known as a “multicultural city that thrives on the harmony and diversity of its neighborhoods” (Chicago History, 2018, p. 1).

Chicago, as the third most populous city in the United States, has a numerical murder rate that has been higher than the largest city in the country, New York City. As of 2016, Chicago had 30,126 violent crimes even though the population is 2,725,153. By comparison, New York City had 49,124 violent crimes and has a population of 8,566,917. According to Cook County Medical Examiner, in 2016 there were 924 homicides and, of this amount, 87% of those homicides were gun related (Cook County Medical Examiner Annual Report, 2016). Additionally, of those 924 homicide cases, 644 of the victims were Black, and 832 were male between the ages of 18 and 24 years (Cook County Medical Examiner Annual Report, 2016).
The following year, there were 840 homicides. Of this amount, 88% of those homicides were gun related (County Medical Examiner Annual Report, 2017). Of the 840 homicides in Chicago in 2017, 589 of the victims were Black, and 680 were male between the ages of 15 and 24 years (County Medical Examiner Annual Report, 2017). Chicago had a decline in homicide by more than 100 victims (as of June 2017), which was the largest decline in almost 15 years (Armentrout, 2017). Although there was a 15% decline in murders in Chicago in 2017, in the first six months they saw more than 400 murders (Armentrout, 2017).

Chicago is composed of 77 communities, 11 of which the Chicago Police Department rated as the “most violent” neighborhoods in the city (Urban Labs Crime Lab, 2018). These neighborhoods are located within six police districts: District 6, District 7, District 9, District 10, District 11, and District 15, and the neighborhoods are: Englewood, Garfield/Humboldt Park, Austin, Auburn Gresham, North Lawndale, and Bridgeport/McKinley Park/Brighton Park/New City/Gage Park. Police departments created these districts to make patrolling communities more manageable. Each police district has a headquarters and a commanding officer to oversee police operations (Sugden et al., 1999). The neighborhoods within these six police districts makeup a high percentage of African-Americans (Farooqui, 2014; Thompson et al., 2014, see Table 1). In 2016, these six police districts only represented 20% of the city’s population but accounted for 55% of Chicago’s gun-related violent crimes (Urban Labs Crime Lab, 2018).

Given the overwhelming violence in Chicago, there is a high chance that counselors and other mental health professionals work with survivors of trauma. These counselors’ repeated exposure to servicing trauma survivors could result in counselors experiencing trauma as well. This study aimed to learn more about such experiences.
Table 1

*Neighborhood Demographics*

<table>
<thead>
<tr>
<th>Districts</th>
<th>Neighborhoods</th>
<th>Black/African American Population</th>
<th>Reported Crimes</th>
</tr>
</thead>
<tbody>
<tr>
<td>District 7</td>
<td>Englewood</td>
<td>35,474 (98.8%)</td>
<td>393,000</td>
</tr>
<tr>
<td>District 11</td>
<td>Garfield/Humboldt Park</td>
<td>83,394 (56.9%)</td>
<td>424,000</td>
</tr>
<tr>
<td>District 15</td>
<td>Austin</td>
<td>62,013 (56.3%)</td>
<td>290,000</td>
</tr>
<tr>
<td>District 6</td>
<td>Gresham</td>
<td>71,466 (99.0%)</td>
<td>382,000</td>
</tr>
<tr>
<td>District 10</td>
<td>North Lawndale</td>
<td>82,851 (49.0%)</td>
<td>283,000</td>
</tr>
<tr>
<td>District 9</td>
<td>Bridgeport/McKinley Park/Brighton Park/New City/Gage Park</td>
<td>115,002 (32.8%)</td>
<td>330,000</td>
</tr>
</tbody>
</table>

*Note.* Rough estimates; neighborhoods include more than one zip code and partial zip codes. Reported crimes are from data.cityofchicago.org 2016 reports. Reported crimes include all crimes reported to the police, including battery.

**Participants**

Participants for this study identified as African American female, male, or other counselors working in and/or with clients from one of the 11 most violent neighborhoods in Chicago. I needed eight to 10 participants for this study to reach saturation (Creswell, 2013).

Participants who participated in this study had to: (a) have obtained Licensed Professional Counselor or Licensed Clinical Professional Counselor credentials, (b) be between the ages of 22 and 99 years old, (c) work in and/or with clients from one of the 11 most violent neighborhoods identified by the Chicago Police Department, (d) identify as an African American counselor who was actively engaged in counseling for at least a year, and (e) work within private practice, community agencies (private and not-for-profit), church, or hospital settings.

Individuals in counselor education programs are trained differently than those who are trained in counseling psychology programs or social work programs. Counseling psychology programs focuses on addressing physical, emotional, and mental health issues, as well as on...
assessment and psychological testing (American Psychological Association, 2008), while social work programs focus on social policy, psychotherapy, and child welfare (National Association of Social Workers, 2020). Counselor education programs focuses on training individuals in psychopathology to directly help clients (CACREP, 2016). Also, obtaining a degree and/or license to work within these helping professions varies. Individuals who are interested in becoming a Licensed Psychologist must first receive a doctoral degree in the field of psychology or other related programs (Dittman, 2020). Social workers are not required to receive a graduate degree to work in the field of social work (Council on Social Work Education, 2020). Counselors are required to obtain a master’s degree in counselor education to obtain a license to practice (CACREP, 2016).

This study focused on Black counselors who have obtained an LPC/LCPC, as to keep the integrity of the experiences of counselors who were trained specifically in a counselor education program. Counselors who had dual licensure (e.g. Licensed Professional Counselor/Licensed Psychologist) were not accepted to participate in this study.

**Sampling**

To gain access to the participants, the researcher used purposeful sampling to select participants for this study. Purposeful sampling means that the researcher selects participants and the location for their study; therefore, the participants’ can purposefully inform an understanding of the research being conducted (Creswell, 2013). The snowball recruitment method was also used to recruit participants. The researcher engaged in snowball sampling by using the following procedure: (1) I reached out to a former supervisor who works in one of the neighborhoods the study took place, (2) I asked the counselor to provide my flyer to potential participants for this study, and (3) I continued this process at various agencies in all 11 neighborhoods.
Recruitment

I submitted an HSIRB protocol to the Associate Director of Research Compliance at the university two weeks prior to recruiting African American counselors from community agencies, hospitals, churches, and private practices within 11 Chicago neighborhoods: Englewood, Garfield/Humboldt Park, Austin, Auburn Gresham, North Lawndale, and Bridgeport/McKinley Park/Brighton Park/New City/ Gage Park. Approval was initially obtained on June 13, 2019. On July 15, 2019, I obtained post-approval to revise data collection to add additional questions to my interview protocol. On January 29, 2020, I obtained my final post-approval to clarify eligibility criteria and add additional questions (Appendices A and B).

Subsequent to obtaining HSIRB approval, I reached out to a former counseling supervisor whom I worked with while interning in Chicago to help obtain participants for this study. I developed a flyer that included information about the study and my contact information and provided my former counseling supervisor with the flyer (see Appendix C). Through the snowball technique, I asked the counseling supervisor if she were aware of any Black counselors who hold an LPC or LCPC license in the state of Illinois, and who she would recommend to participate in the study. If so, I asked the counseling supervisor to provide the other counselors with the flyer. The counseling supervisor provided the flyer to counselors in their mailboxes who met the requirements for the study and on the agency’s information board.

I also went to multiple counseling agencies represented in 11 of the most violent neighborhoods in Chicago to speak with counselors and receptionist of each facility. I gained permission to leave a flyer with the receptionist for counselors who could not be reached, and the snowball techniques continued at each site until saturation was met for this study. The participants contacted me via email if they were interested to learn more about the study.
Research Questions

The purpose of this study was to explore the lived experiences of African American counselors in Chicago, and their reactions to working with trauma survivors. To obtain information about the lived experiences of African American counselors in Chicago who work with trauma survivors and their clinical and training experiences, the researcher developed questions based on research about the clinical and training experiences of mental health professionals, and according to what the researcher wanted to gain from this study. The overarching question was, *How do practicing counselors who serve clients from Chicago’s 11 most violent neighborhoods experience and make personal and professional meaning of their work with trauma clients?* There were five sub-questions that guided the study. They are listed below.

1. What are the clinical experiences of African American counselors in Chicago?
2. What experiences do African American counselors have working with clients who have experienced trauma?
3. What experiences do African American counselors have with secondary traumatic stress, vicarious traumatization, and shared trauma?
4. How do these experiences shape their interactions and responses to their trauma clients?
5. How do African American counselors draw upon their counselor education training to work with trauma clients? Where do they draw upon services outside their training?

Data Collection Protocols and Procedures

The researcher collected data using one-on-one interviews with a semi-structured, open-ended interview protocol. She recorded the interviews via voice recorder and the recordings were
transcribed by a transcription service after the interview. A summary of the transcription was sent to each participant for member checking to ensure the trustworthiness of the data analyses. The participants were asked to read through the summary of their transcript and email the researcher back once they thought the summary represented what they said during their interviews, or if they believed the transcript should be changed. The audio voice recordings and the typed transcripts were saved and secured on a password-protected laptop and an encrypted flash drive. Participants were asked to approve their transcript summary and return via email with their approval by a specific date.

Because the researcher closely identified with the participants, it was almost impossible to avoid bias; however, she tried to avoid biases by avoiding “leading questions” when constructing questions for the interview. After each interview, the researcher used reflexive memo writing and voice memoing to describe her emotions and reactions during the study and after each interview. Memo writing was also used to write down ideas about the salient ideas, significant meanings, and evolving patterns of ideas that emerged during the data analysis process, bracketing off experiences from those of the interview partners (Creswell, 2013; Marshall & Rossman, 2016). The researcher also kept a log trail (audio) throughout this study to keep track of her day-to-day activities while working towards completion of this study. This allowed the researcher to keep track of how she conducted this research, what she might leave out of the study, and what she could add. The log trail was also used as another way to minimize the researcher’s biases and it would facilitate the way this study could be replicated. The log trail included raw data, data reduction, and notes about the analysis. To further address biases, the researcher used member checking, which helped ensure the trustworthiness of data analysis (Creswell, 2013).
Forms of Data

Follow-up questions were added to allow for a more in-depth interview. The participants were asked questions that allowed them to elaborate on their experiences, rather than engaging in an interview that consist of close-ended questions. The researcher sought detailed information about the participants’ experiences. The goal of these follow-up questions was to have participants reflect on and provide insights into their experiences and the meaning they derived from such experiences.

The interviews were conducted through semi-structured, in-person interview, phone or video-recorded using Zoom or Skype. Zoom and Skype are videoconference systems, which allowed the researcher to conduct and record the audio of the videoconference. The interviews took 34 to 85 minutes to complete, with an average interview lasting 48 minutes. The researcher began the interview with introductions. The interviews started off with more conversational questions, which helped the participants to start telling a story about their personal experiences. The researcher hoped the interview would become more in-depth through the utilization of probing. Probes seek clarification or to expand on the respondent’s answer (Guest et al., 2013).

To further establish credibility, the participants engaged in member checking before the researcher finalize transcripts (Mertens, 1998).

Data Analysis

The researcher used thematic analysis for this study. The process involved: (a) coding categories to align with my research questions, (b) pulling codes that fit in more than one of the coding categories, and (c) putting the codes that do not fit into a “holding category.” Next, the researcher analyzed the codes assigned to each category of sub-themes to create a story out of the
categories. This captured the essence of the participants’ experience and the meaning they made of those experiences relative to the study.

Analysis Steps

The general approach to analyzing data included highlighting significant statements in the transcript that provided an understanding of how the participants experienced the phenomenon. The researcher developed clusters of meaning of these statements into categories of meaning units. After reviewing all the possible schemas for organizing and clustering the meaning units, the researcher selected the grouping arrangement that best reflected the ideas embedded in the transcribed interviews. The researcher ended data analysis with the ideas that were embedded in the transcript. The researcher looked for axial relationships between the meaning clusters (groupings) and their accompanying themes, and used those relationships to describe the essence of the phenomenon as experienced by multiple participants. At this point, the researcher was able to describe the participants’ textural and structural experience (Creswell, 2013).

The researcher also hired an auditor. The auditor looked over each transcript and provide information about the themes they saw throughout their analysis. This ensured that the researcher’s biases were limited.

Trustworthiness in Analyzing Data

For credibility in data analysis, the researcher organized and prepared their transcripts for data analysis. She also used voice memoing to record her predispositions, assumptions, comments, thoughts, and reactions that conflicted with the study, while reading through the transcripts and during the interview process. Further, the researcher described her own personal experiences through epoche (Creswell, 2013). She kept the interpretations of the data open.
throughout the analysis process to avoid bringing their “own” interpretations into the data.
Member checking was also used to ensure the trustworthiness of the data analysis. Participants
gave the researcher permission to use the transcripts they approved for data analysis. After the
data analysis was complete, the researcher elicited peer debriefers to review the transcripts used
for the data analysis.

Trustworthiness

For credibility, the researcher conducted interviews that were long enough to identify
salient points. The researcher accomplished this through probing and inviting the participants to
elaborate and expand on their responses. The researcher also engaged in memoing to monitor her
own developing constructs and/or biases. Memoing also helped to establish authenticity during
data collection and data analysis. The researcher used memoing to express my predispositions,
assumptions, comments, thoughts, and reactions that may conflict with the study. The researcher
kept the interpretations of the data open throughout the analysis process. (Mertens, 1998).
Finally, to ensure trustworthiness, there must be extensive amount of details given about the
study to promote transferability. The details are given in this study via participant profiles to
make a transferability judgment.
CHAPTER IV

FINDINGS

The first section of this chapter presents an overview of the purpose of the study and phenomenological approach. A depiction of the study participants follows, which includes information collected from the demographic questionnaire and details collected about their clinical and counselor education training background. The next section includes an in-depth analysis of the data and a discussion of the research findings that emerged from eight interviews with African American counselors discussing their clinical experiences working in and/or with clients who live in the most violent neighborhoods in Chicago, as well as their counselor education training experience. Lastly, a collective narrative is provided to describe the meaning of their experiences.

Overview of the Study

This study seeks to explore the lived experiences of African American counselors and their reactions to trauma survivors. Results from this study may provide opportunities for inclusivity and diversity of experiences within the counseling professional, as well as promote curriculum development in traumatology. Several research questions guided this study and were used to gather information on: (1) the participants’ clinical experiences in general, (2) the participants’ clinical experiences working with trauma survivors, and (3) the participants’ training experiences in counselor education.

A phenomenological hermeneutic approach was utilized to uncover the meaning of the participants’ clinical experiences and training experiences related to working with trauma survivors. A phenomenological approach is appropriate because it focuses on a phenomenon (Creswell, 2013), which is the experiences of African American counselors who work in the
most violent neighborhoods in Chicago. And, a phenomenological approach seeks to understand the meaning of their experiences. This methodology takes into consideration the lived and subjective experiences of the participants in this study, which includes their work with trauma survivors and their training experiences in their graduate counselor education programs. The researcher wanted to explore the individual experiences of each participant and tell a story about their experiences. She also wanted to understand what it meant to the participants to work as an African American counselor within and/or with clients from the most violent neighborhoods in Chicago.

Hermeneutic phenomenology offers descriptive, reflective, and interpretive modes of inquiry of an individual’s description of his or her experience in the world and assumes human existence is meaningful and of interest in the sense that we are always conscious of something (van Manen, 1990). The researcher focused less on interpretation and more on the description of the participants’ experiences working with trauma survivors, their training experiences, and the meaning that the participants make of such experiences.

Semi-structured interviews were conducted based on the interview protocol (see Appendix B) and credibility was accomplished through member checking and peer review (Lincoln & Guba, 1985; Marshall & Rossman, 2016). Themes that emerged from the participant interviews were the result of a recurrent process of reading and gathering quotes into piles that ultimately answered the overarching research question. The quotes provide the reader with a greater understanding of the lived experiences of African American counselors and their reactions to trauma survivors, and reflect the voice of each participant (Creswell, 2013).

During recruitment, the researcher found it difficult to engaged potential participants. While the researcher was canvasing community agencies, hospitals, and other social service
agencies in Chicago, she had little to no contact with professional counselors. Most of her interactions were with receptionist and office managers. Flyers for recruitment were left at the front desk at every location. The researcher believes if she had a relationship in the community and with fellow colleagues, she would have gained more participants and possibly more information.

Furthermore, during data collection, it was sometimes difficult to engaged participants over the phone. Most of the time, interviews were conducted after the participant finished their workday, which presented to be the best time for them. It was also difficult to engage the participants because the researcher herself was coming off a long day of work as well. There was a time where the researcher had to contact one of the participants to ask additional questions because she failed to probe at some point in the interview, which was potentially due to her lack of rest. Also, conducting interviews over the phone possibly limited the researcher from gathering additional information from participants because she was unable to observe their nonverbal behavior. Overall, the recruitment and data collection went fairly well; however, there were some limitations to the study, which will be discussed further in chapter five of this research study.

**Description of Participants**

This section presents a summary of all participants included in this study. To maintain anonymity, participants’ personal address, places of work, and names of schools were not included. Pseudonyms were selected by the participants. A total of two men and six women completed the informed consent process and interview about their experiences.

The length of the interviews ranged from 34 to 85 minutes, with an average interview lasting 48 minutes. One of the interviews were conducted in-person, five were conducted over
the phone, and two were conducted on Zoom video conference system. All eight of the
participants identified as African American. The average age of the participants was 39, with a
range from 24 to 60 years old. See Table 2 for demographic information for each participant.

The following summary in Table 2 provides a breakdown of participants’ demographic
information that collected from the demographic questionnaire. Information from the
demographic questionnaire included items such as years of experience, counselor education
programs, school type, trauma history, and work setting. All participants work with clients from
one or more of the 11 most violent neighborhoods in Chicago and/or work within one of the
most violent neighborhoods in Chicago.

Neal

Neal is a 51-year-old African American male. He is a Licensed Clinical Professional
Counselor. He has 25 years of clinical experience, including private practice and social services.
Neal attended a Predominantly White Institution. His counselor education program was
accredited by CACREP. Neal shared that he does not have a history of trauma. Neal worked with
individuals from North Lawndale, Garfield Park, and Humboldt Park neighborhoods.

Purple Flower

Purple Flower is a 38-year-old African American female. She is a Licensed Professional
Counselor. She has 3 years of clinical experience, including a federally qualified health center.
Purple Flower attended a Predominantly White Institution. Her counselor education program was
non-CACREP accredited. Purple Flower shared that she does have a history of trauma. Purple
Flower works mostly with individuals from the Englewood neighborhood.
Table 2

**Demographic Information**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age</th>
<th>Years of experience</th>
<th>Ethnic Background</th>
<th>Counselor Education Program</th>
<th>School Type</th>
<th>Work setting</th>
<th>Credentials</th>
<th>Pseudonym</th>
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<td>Private practice</td>
<td>LCPC</td>
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</tr>
<tr>
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<td>FQHC and private practice</td>
<td>LCPC, LMHC</td>
<td>Kane</td>
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<td>Predominantly White College</td>
<td>Private practice</td>
<td>LCPC</td>
<td>Missy</td>
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**Nicole**

Nicole is a 42-year-old African American female. She is a Licensed Clinical Professional Counselor. She has 13 years of clinical experience, including private practice. Nicole attended a Predominantly White Institution. Her counselor education program was accredited by CACREP. Nicole shared that she does have a history of trauma. Nicole works mostly with individuals from the Austin neighborhood.
Charlisa Green

Charlisa is 33-year-old African American female. She is a Licensed Clinical Professional Counselor. She has 8 years of clinical experience, including a group practice. Charlisa attended a Predominantly White Institution. Her counselor education program was non-CACREP accredited. Charlisa shared that she does not have a history of trauma. Charlisa works with individuals from the Englewood and Auburn Gresham neighborhoods.

Francis Reed

Francis is a 24-years-old African American female. She is a Licensed Professional Counselor. She has one year of clinical experience, including clinical mental health agency. Francis attended a Predominantly White Institution. Her counselor education program was accredited by CACREP. Francis shared that she does not have a history of trauma. Francis works with individuals from the Oak Park neighborhood.

Kane

Kane is a 31-year-old African American female. She is a Licensed Clinical Professional Counselor. She has 5 years of clinical experience, including a federally qualified health center. Kane attended a university “not classified as a Historically Black college, but the student population was predominantly Black.” Her counselor education program was accredited by CACREP. Kane shared that she does have a history of trauma. Kane works with individuals from the Englewood neighborhood.

MH

MH is an Africa American male (he did not disclose his age). He is a Licensed Professional Counselor. He has 5 years of clinical experience, including crisis intervention. MH attended a Historically Black College. His counselor education program was accredited
by CACREP. MH shared that he does have a history of trauma. MH works mostly with individuals from the Englewood neighborhood.

**Missy**

Missy is a 60-year-old African American female. She is a Licensed Professional Counselor. She has 18 years of clinical experience, including private practice. Missy attended a Predominantly White Institution. Her counselor education program was accredited by CACREP. Missy shared that she does not have a history of trauma. Missy works with individuals from the Oak Park neighborhood.

**Data Analysis**

The researcher used the thematic analysis approach to analyze the data she collected from each participant. Thematic analysis (TA) is a method for “identifying, analyzing, and interpreting patterns of meaning within qualitative data” (Clarke & Braun, 2017, p. 297). Thematic analysis is not bounded by a theoretical approach; however, it can be applied to several theoretical frameworks (Clarke & Braun, 2017). The researcher chose TA because of its flexibility and accessibility. TA is flexible in terms of “research question, sample size and constitution, data collection method, and approaches to meaning generation” (Clarke & Braun, 2017, p. 297). The researcher was interested in reporting the experiences and meanings of the participants lived experiences. Also, as a novice qualitative researcher, it was easier for the researcher to manage the data analysis using thematic analysis.

The thematic analysis process in this study was conducted in six primary phases and generated 10 meta-themes. To answer the research questions, the researcher utilized a theoretical analysis process (Braun & Clarke, 2006) that allowed her to use trauma theory in order to provide a rich analysis of the participants’ trauma reactions and experiences. Trauma
theory focuses on the exposure to actual or threatened death, serious injury or sexual violence, often referred to as post-traumatic stress disorder (APA, 2013). People who have suffered trauma(s) may present with symptoms of recurrent, involuntary, and intrusive memories of the traumatic event. Dissociation, avoidant behavior, and impairment in social, occupational, and other important areas are also symptoms related to trauma (APA, 2013).

Regarding this research study, witnessing (indirectly) a traumatic event(s) can result in secondary traumatic stress, which can also yield the same symptomology listed above. Secondary traumatic stress, often used interchangeably with compassion fatigue, describes how mental health professionals experience stress as a result of caring for someone who is suffering from a traumatic event(s) and/or wanting to help someone who is experiencing a traumatic event(s) (Figley, 1993). Secondary traumatic stress has a physical, psychological, and social impact on mental health professional (Robinson-Keilig, 2010). STS can result in PTSD, which can have a personal and professional impact on African American counselors. This is important for the researcher to explore because of the lack of information related to the lived experiences of African American counselors working with trauma survivors. It was also important to explore how these counselors are impacted, and the way in which they deal with secondary traumatic stress. Furthermore, the researcher wanted to explore the lived experiences of African American to give voice to the unique experiences of African Americans who work with trauma survivors to promote inclusivity and diversity in the counseling profession, as well as curriculum development in traumatology, specifically for counselors who work in inner-urban cities.

Braun and Clarke (2006) designed the six-phase method as a guide for analysis of the data gathered from participant interviews. First the researcher sent out transcripts to a
transcriptionist after each interview. The researcher read through each transcript after it was completed. Next, the researcher sent a summary of the participant interviews to each participant for member checking (Mertens, 1998). Then, the researcher read the transcripts a second time and made notes in the margins. She also made notes on the back of each transcript for initial ideas on coding. The researcher was reflective when she read each transcript, and she listened to voice memos several times. The transcripts and voice memos were created after the interviews. The voice memos included details of the researcher’s own reactions, assumptions, and reflections on potential blind spots (Richards, 2015).

Secondly, the researcher read over transcripts a third time and continued to search for latent themes in the data to describe the phenomenon of the lived experiences of African American counselors and their reactions to trauma survivors specific to each research question (Braun & Clarke, 2006). The researcher searched for words and phrases that were comparable in meaning or connection to the research questions, along with new findings for the researcher (Creswell, 2013). Since the researcher was manually coding the data, potential patterns were highlighted (Braun & Clarke, 2006; van Manen, 1997) and lines were drawn to indicate segments of data. To keep the context of the segments intact, relevant surrounding data was included, and the researcher coded the data for as many potential patterns as possible (Braun & Clarke, 2006).

Third, the researcher cut out each piece of code and began organizing the pieces of paper into approximately 21 categories (Braun & Clarke, 2006). Reflexivity was continued through journaling and voice memos (Lincoln & Guba, 1985) so that the researcher could make sure the preliminary groupings reflected the participants’ lived experiences and reactions to trauma survivors. In this phase, the researcher created a visual thematic map (see
Appendix D) of how she was visualizing and organizing the themes (Braun & Clarke, 2006). The researcher read each grouping category several times and placed pieces of code together that shared similar features into sections of participant themes and subthemes. A miscellaneous section was also created at this phase to temporarily set aside any pieces of code that did not fit within the participant themes.

In the fourth phase, emerging themes were identified. The researcher paired all participant themes by the research question. The researcher read each section several times and decided whether the themes should be divided into subthemes or made into a separate theme. This process was repeated until the research exhausted all possibilities and determined that all themes made a coherent pattern in relation to the research question (Braun & Clarke, 2006). At this phase, the researcher had strong themes. The researcher sent a summary of the data and research questions to peer reviewers for feedback.

In the fifth phase, the researcher continued to read through the data to refine it and to determine the essence of each theme. The researcher utilized the feedback of the participants’ and peer reviewers to help define the story of each theme, as well as to determine which themes matched the research questions (Braun & Clarke, 2006). The themes were considered on their own and in terms of how they related to each other. The researcher continued to practice reflective journaling (Lincoln & Guba, 1985) to ensure that the resulting meta- and subthemes were truly the result of the analysis process and the participants’ lived experiences. Themes were determined by prevalence and salience amongst the research participants as they related to the research questions and theory of trauma (Brandel & Ringel, 2012; Frankel, 1998), which focuses on the exposure to actual or threatened death, serious injury, or sexual violence, often referred to as post-traumatic stress disorder. In the last phase, the researcher
identified quotes that captured the essence of each meta-theme. The final report was written and told the story of the participants’ lived experiences related to their clinical and training experiences.

Findings

Thematic patterns began to emerge as the data was gathered, coded, and refined. Many of the themes were interconnected and shared overlapping qualities since the general experiences of the counselors included their clinical experience with trauma survivors. The themes were presented with their corresponding research question, beginning with the five sub-questions (Table 3). The overarching research question was answered as a narrative based on the findings from the sub-questions and is presented in the last part of this section.

The overarching research question was, *How do practicing African American counselors who serve clients from Chicago’s 11 most violent neighborhoods experience and make personal and professional meaning of their work with trauma clients?*

The five sub-questions are:

1. What are the clinical experiences of African American counselors in Chicago?
2. What experiences do African American counselors have working with clients who have experienced trauma?
3. What experiences do African American counselors have with secondary traumatic stress, vicarious traumatization, and shared trauma?
4. How do these experiences shape their interactions and responses to their trauma clients?
5. How do African American counselors draw upon their counselor education training to work with trauma clients? Where do they draw upon services outside their training?
Table 3

Themes

<table>
<thead>
<tr>
<th>Research Questions</th>
<th>Themes</th>
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<tr>
<td>RQ1: What are the clinical experiences of African American counselors in Chicago?</td>
<td></td>
</tr>
<tr>
<td>1. Diverse Experiences</td>
<td></td>
</tr>
<tr>
<td>2. Awareness and Understanding</td>
<td></td>
</tr>
<tr>
<td>RQ2: What experiences do African American counselors have working with clients who have experienced trauma?</td>
<td>1. Challenging and Complex</td>
</tr>
<tr>
<td>2. Rewarding</td>
<td></td>
</tr>
<tr>
<td>RQ3: What experiences do African American counselors have with secondary traumatic stress, vicarious traumatization, and shared trauma?</td>
<td>1. Personal Impacts and Client Well-being</td>
</tr>
<tr>
<td>RQ4: How do these experiences shape their interactions and responses to their trauma clients?</td>
<td>1. Increased Awareness</td>
</tr>
<tr>
<td>2. Self-Care</td>
<td></td>
</tr>
<tr>
<td>RQ5: How do African American counselors draw upon their counselor education training to work with trauma clients? Where do they draw upon services outside their training?</td>
<td>1. Limited Preparedness</td>
</tr>
<tr>
<td>2. More Trauma Training Needed</td>
<td></td>
</tr>
<tr>
<td>3. Need Training in Urban Trauma</td>
<td></td>
</tr>
</tbody>
</table>

Findings for Research Question 1

What are the clinical experiences of African American counselors in Chicago?

Theme 1: Diverse Experiences

The participants all discussed their individual clinical experiences. Many of the counselors described how their careers started, including where they work, how many hours worked, clinical issues, and their therapeutic approach. The overall sense was that their clinical experiences included how long they provided therapeutic services. For example as Neal stated, “I have been a counselor for 24 years. Um, I started out as an individual and group therapist in a residential treatment program on the Southwest side of the city and a residential treatment home that is no longer in existence.”

The average years of clinical experience among the participants was 9.75 years. An overwhelming majority of the counselors commented on their experience with individual
therapy. One of the eight counselors was new to the profession, with one year of experience, and commented on not having experience with “long term therapy.” Francis described her clinical experience as a short-term interaction with her clients. Francis said, “I'm an intake specialist at [EMPLOYER REDACTED] and which I don't do too much of long-term of, of that ongoing long-term counseling. I would, what I do is just, I conduct mental health assessment to folks living in nursing homes in INB (incremental net benefit) to see if there's a fit to transition.” In sum, the clinical experiences of each participant told a story of how they came to be a counselor and how their experiences determine their career trajectory.

All the participants commented on the population they served. For some, their clinical experiences helped determined what population each counselor preferred to work with. MH commented on his past clinical experience. MH said:

My experience began with the elderly population. I work with individuals who acquire brain injuries, performing rehabilitation services, uh, from that it excelled to trauma individuals specifically in the crisis setting, uh, inpatient psychiatric hospitalization. I did that for 5 years after working with the elderly for about 3 years. Inpatient psychiatric hospitalization, of course, is just as intense as it sounds. You deal with some of the most severe individuals, uh, dealing with psychotic as well as trauma um, experiences that make them, you know, uh, behave in situations that are not appropriate.

He went on to comment on how he wanted something different, stating:

I wanted to get out of that crisis. So, it meant a lot to me work with individuals who, um, were, I don't know about the correct terminology, but individuals who were not necessarily needing intensive services. Um, so it was very vital to me that I chose the
population that I was going to have some form of flexibility with as far as dealing with trauma and well as in living with, um, you know, depression and all of those other sorts.

Five out of the eight participants were very specific about the population they wanted to serve based on their clinical experience. Missy described it this way:

I made the decision that my preference is to work with adults and to work around issues…I did switch my, well I don’t want to say switch my focus, but actually, um, started to market myself as a grief counselor because I saw a lot of grief and loss issues presenting in my office and I felt ill prepared to kind of deal with them. So, I've set out to learn as much as I can about grief and started to market myself as a grief counselor. And you know what? I have found that also to be very gratifying.

For others it was their clinical and personal experiences that led them to serve a specific population. Nicole commented on her experience growing up in a certain neighborhood and her clinical experience coming right out of college that led her to work with individuals who are connected to the justice system. Nicole said:

I first got into the field in 2006, um, I immediately went into working with the forensic population. So, I went with an agency in Lawndale, um, and they worked with various, um, specialties. So domestic violence for perpetrators, anger management. We did outpatient substance abuse treatment level one and two. Um, and then the mental health component, which was, uh, you know, general counseling, um, couples counseling, family counseling. And so just working a lot with mandated, the mandated population. Did that for 8 years and then, which is current um, and now I actually have my own practice and I'm doing literally the same thing, uh, that I was, that I was doing.

She went on to say:
I grew up in [NEIGHBORHOOD REDACTED] I saw things and, and I've always stood out. Um, and I was just the observer. And so, it baffled me to see how we stayed the same. So, people I grew up with, we're going to jail for life, right. Because things were just, just going, you know, haywire. They were two parent homes. They were decent. Um, but I also saw other things happening as well, and not just all families, but just being lost and caught up, but high school where I was going, you know, into this thing. And I was determined not to go to places where it's convenient to do counseling, right? Because it's convenient to go where people have money, you know, and that, that, that the counseling is a part of their lifestyle. Right. But what about those who were never exposed don't understand it. Don't even recognize that this is, that this should be a part of their lifestyle too. So, I always knew I wasn't born in that direction.

There was a strong sense of passion from the participants concerning the importance of being present for their clients. Furthermore, the clinical experience of African American counselors included how many hours they worked per week. The average hours worked was 36.25 hours per week, with a range from 2 to 70 hours per week. The hours per week included direct and indirect care. They served an average of 24.5 clients per week, with a range from three to 84 clients. Most of them served mostly African American clients. Neal serves as a supervisor as well, so he also sees an addition six people for supervision. All the participants commented on what kind of clinical issues they see. Kane asserted:

Um, I see all types of patients, um ranging from small kids as young as four all the way up to geriatrics older adults. Um, and I just do one on one therapy, crisis support for the doctor's and then once I get off there, um, I go to my private practice where I, again, I see a range of, um, clients from four all the way up to geriatrics. Um, a lot of them at my,
private practice as well as full time job suffer from trauma. Um, a lot of sexual assault victims, rape victims, child molestation, a lot of, um, family of course, a lot, a lot of families, um, relationships that are struggling, um, and that are in crisis. I deal with that often. That's majority, it's like 80% of my clients that I see at my practice and at my full-time job.

There was a consensus among the participants that they see a wide range of clinical issues.

Theme 2: Awareness and Understanding

Eight counselors discussed the relevancy of working with the population they serve. Throughout the interviews, it became apparent that major aspects of what was relevant when working with their specific population was awareness, understanding, and mindfulness of what their clients needed from them. Nicole said:

I think what's relevant would definitely be, um, you know, being aware of what's going on in, um, what do you call it? I mean like, am I even up on it sometimes? Not always, but, um, you know, pop culture, music, what's happening in, you know, social media, you know, or just the, the, the social world in general. Um, you know, but then also being aware of our issues and like what's happening in the culture with us. Um, you know, when a lot of us, you know, we were, I mean, we're always being killed, but when there was an influx of us being shot and it was videotaped and things like that, that's what a lot of the conversations were about.

Three of the eight counselors talked about what they thought their clients needed from them as counselors. Neal commented:

One of the things that I have noticed in both settings as a service provider, as a supervisor, as an administrator, manager, trainer, is the lack of continuity. I think what
drives people crazy and it's also a part of the, uh, the symptomology of the trauma that we see in this setting at [EMPLOYER REDACTED], is that, uh, they're frustrated because they might be working with [NAME REDACTED] today and be working with [NAME REDACTED] the next day. And um, you get comfortable with [NAME REDACTED]. [NAME REDACTED] has given you a line and it sounds really good. She's gained your trust and confidence and then you ready to go in and work with her and work with her plan and her vision because you've adopted that vision and she's gone. You didn't know she was going to be gone. You didn't know it was gonna happen. And now it starts all over again. And that person may not process think, plan, be as um, empathic and supportive as [NAME REDACTED] was. And so, you got to plan and prepare and then that person might go. And so, uh, who is it that you can trust but yourself and I mean, unfortunately you do need to trust yourself and part of clinical work is helping people to develop some self-efficacy. However, traumatized clients need continuity in their early relationships so, that they can build up the capacity and coping skills to learn how to be independent and think on their own. But if the relationships are not constant, then that's a problem.

A couple of the counselors believe understanding their client as an individual and where the client came from was relevant. Missy explained, “it's helpful to understand in general the dynamic and structure of the family.” All the comments focused on what the counselors thought were relevant in their work with the populations they served. They were focused on what the clients needed collectively and individually.
Findings for Research Question 2

*What experiences do African American counselors have working with clients who have experienced trauma?*

**Theme 1: Challenging and Complex**

All the participants discussed their experiences with trauma survivors. Their experience with trauma survivors is not separate from their general clinical experience. It was embedded in their work as clinicians. The participants in this study discussed their experiences with trauma survivors in different ways. Some of them talked about the challenges of trauma work. Francis said, “It's a lot. It kind of takes, um, I've realized it, it really, like at the beginning kind of took a toll on me especially because the trauma isn't...It's like I don't know, like I said before, like they were dealt with the bad hand.”

A few discussed how their clients normalize trauma and how difficult it was to tell them that their experience was not “normal.” Purple Flower stated:

So, when, the biggest thing that I have experienced with individuals that are experiencing trauma is that a lot of them have normalized it, right? So, they're telling you horrible events that happened in their life, but they normalize it and then you're listening to it and you're holding it for them. Right? And then I always struggle with do I, how do I let this person know that this was a traumatic event and not a normal occurrence. Right? Without them feeling as if I don't understand them anyway.

Working with trauma survivors is complex. Some of the participants commented on the overwhelming trauma their clients experienced, which contributed to how “challenging” (as Missy stated) work can be with trauma survivors. All the participants shared the type of trauma that their clients often experience. Charlisa said:
Most of my experience there is Millennials. Um, and even the Xennials age pop, age ranges to anywhere from 21 to 20 to about 35, 37, 40 is where my range is and its life transition, work life balance or work life alignment as I like to call it. Um, and uh, depression, a lot of anxiety, a lot of social anxiety, um, boundaries, relationship issues. And then there's some traumas, um, you know, things that you find out, you know, that happened in their childhood and you know, not really recognizing how that's affecting their relationships.

The majority of the participants were very specific about the trauma their clients experience. Kane commented:

I deal with a lot of trauma cases… So, a lot of times they will come at my full-time job and they will tell me about their childhood. That's how I get the trauma out. Um, they would say like, Oh, it was a lot of abuse in the home. And then when I asked them have they ever been sexually assaulted or have they ever experienced, you know, crime or anything like that?

Purple Flower went further saying:

So, I think of trauma as definitely violence. Um, there can also be trauma, uh, a lack of basic needs, right?... Um, so yeah, so definitely food insecurity, housing insecurity, financial insecurity in general, um, violence. There's also, um, the, the traumatic thing of forced abandonment and I call it forced abandonment where, um, where you, where your parent was forced away from your life. So, whether that's through incarceration, whether that's through, um, maybe a drug addiction and then you're living with like grandparent or another relative and then they tell you your parents can't come around anymore. There's a whole host of, of traumas.
Some of the participants shared that they learned their clients are experiencing some form of trauma during assessment, which is done during their first session.

The overall sense was that working with trauma survivors was challenging and complex. Trauma survivors come into treatment with complex issues, often referred to as complex trauma. A few participants believe that working with trauma survivors who are Black was different than working with trauma survivors from other races, in that, normalization of trauma is unique to the Black population they serve. Charlisa said:

Um, and so I think for me, um, acknowledging traumas in our community, you're going to be working with people of color, you're going to be working with the African American population. You can guarantee there's some type of trauma somewhere… And so I think exploring and explaining how it can manifest for us, how it looks, you know, and even when, you know, obviously our coping is not, um, we're not coping from a more healthier angle with it as well… its important because again, in my clinical program, we did not have one class specifically dedicated to working with individuals with trauma. Um, and so I think that every program needs either a subset of core courses or a course, at least, um, focused on trauma. Um, and acknowledging the cultural differences of trauma, that it looks differently and it's not, you know, what we say textbook experiences where it's, you know, violence and, and, you know, sexual abuse and physical abuse and, you know, obviously all those things are traumatic, but to talk about some of the other things that are not as obvious as to how they can be traumatic.

There were instances in which the participants talked about their professional rewards and challenges when working with trauma survivors. While most of the participants acknowledged that working with trauma survivors can be rewarding and challenging, focusing
on themselves was not an option. Ultimately, the participants wanted to provide the best service to their clients. Charlisa emphasized this point by acknowledging when she could no longer provide services to trauma survivors. She said:

I think for me, just the thought that I knew that I wanted, I want kids or at the time I want kids myself. And I was like, I don't think this is something that I would want to continue to listen to… Um, I just know that this is something that is happening and I'm well aware of it. It happens. Um, but I just didn't think I had the mental and emotional fortitude to work with kids on a consistent basis who are constantly experiencing some type of trauma.

She went on to say how working with trauma survivors has been challenging. MH emphasized that providing short-term care was the most challenging for him. MH said:

I pretty much had to provide the services that I was employed to provide, uh, you know, having, uh, a passion for the field, uh having a passion for the field and an actual passion for helping individuals, it's quite disturbing knowing that you're all knowing that what you're doing is only gonna start, it's only going to initiate something um, that is not necessarily going to be fulfilled. Uh, treatment is going to be initiated and you're going to, you're going to break the surface but you, you are not going to go in depth. Uh, and again, due to your, in not due to your incompetency in being a [INAUDIBLE] but sold and just based on the setting in itself, you are just, it's just impossible for you to provide what you feel is needed in this situation.

Theme 2: Rewarding

Some of the comments related to professional rewards emphasized establishing therapeutic relationships. Neal said, “The reward is that, um, you know, when people are able to
establish a relationship and you have some continuity with that and you can actually work on some things, um, that, that's really good.” Some of the counselors generally asserted that the professional reward for working with trauma survivors is building a therapeutic relationship that is relatable and trustworthy. Other counselors asserted that receiving positive affirmations was the most rewarding part of their job. As Kane stated, “getting accolades” confirmed that they were doing right by their clients.

**Findings for Research Question 3**

*What experiences do African American counselors have with secondary traumatic stress, vicarious traumatization, and shared trauma?*

**Theme 1: Personal Impacts and Client Well-being**

The participants all discussed their reactions to work with trauma survivors. These reactions were related to the stories the clients told in relation to their traumatic experience. Some of the counselors reported being empathic, paranoid, disturbed, angry, or feeling nothing. However, some of them did not have lingering reactions after their initial response. One of the eight participants had strong reactions to working with trauma survivors. Charlisa shared that she cried to her supervisors about her experience with a case. Charlisa said:

> Uh, this is my first experience with something like that. I was probably, I was, I had a hard time processing what was happening, but I also felt upset about the situation probably the rest of that week, um, so I can probably say about two or three or four days maybe. Um, but certainly every time I met with them, either a different part of the story would come up or something else would happen with the mom or something like that. And so, it would kind of trigger some of those emotions all over again. And it just, it
really broke my heart, you know, for them, I, my heart was hurting for them because the situation was just so hard.

There were other participants who heard client’s stories who cried and/or wanted to cry and talked about in supervision; however, Charlisa not only talked about it, she decided not to work trauma survivors as often. Charlisa said:

Ooh, I think for me, just the thought that I knew that I wanted, I want kids or at the time I want kids myself. And I was like, I don't think this is something that I would want to continue to listen to.

Two of the eight participants reported having lingering effects. Francis said:

Uh, in, uh, kind of like um, with like people like I'm like romantically involved with, they live in like a high crime neighborhood and so I'm always thinking like, all the times, like, uh, just like overreacting. Like, oh, are you saying this because are you going through something? I, I, um, I, I know that has to be hard for you because he liked your friends and I, I'm pretty sure living like that and you got so much [INAUDIBLE] before. Like yeah, you really need to see someone, but that's about it. Like I feel like I'm being like overbearing or like really pushing the issue with people that probably don't really register things as traumatic event. Like sometimes I noticed that we, some counselors especially like we'll register stuff like, Oh that's, that's trauma, that's trauma. But that person that's kind of like that's all they know, so is it really trauma to them, you know so...

The reactions of the counselors did not indicate distress. Most of the counselors did not appear to experience secondary traumatic stress, vicarious trauma, and/or shared trauma. As traumatic as the stories could have been and could have affected their personal and professional
lives, the counselors were focused more on the well-being of their clients and not themselves.

Purple Flower emphasized:

So, I've literally sat in sessions and had to fight back tears because what I heard was so terrible, right? Or so like anger inducing, but then I always bring it back to the fact that the individuals sitting across from me, this is their life. This is something they experienced and I'm here for them. I'm not here for my own self.

Five participants commented on their reactions to the violence in Chicago and how it affected them professionally and personally. Some of them discussed how they are more cautious of their surroundings. Missy commented:

Because nothing has personally happened. Um, you know, I mean, well, I mean, I guess what I was saying earlier about paying, being more cautious and paying attention. I do that, but I also try and keep myself, I also try my best to give myself a reality check to say that, you know, it's a small, extremely small population of the people that might be dealing with that might be perpetrating the violence and that the likelihood of it happening could be low. You know? That's how I kind of deal with it.

Others also commented on being more vigilant of their surroundings.

Most of the comments focused on being present for their clients and not being concerned about their own feelings while working with their clients. Purple Flower emphasized how she is not concerned about her feelings while working with her clients. She said:

Um, the first thing is not putting my feelings and emotions on them, right. Not putting my narrative on how I feel and assuming that it's just a universal feeling. Right? So, that's the one thing. And treating them as an individual and to be totally honest, everyone that walks through the door, I know everyone has a story and that story run deeper depending
on who you are. And people have different levels of trauma. So, just treating everyone's trauma as what it is, their trauma, hearing their story, how it affected them, and trying to help them heal from it. And then the best thing that I've ever done was to get a therapist of my own. So that way when I leave work, I have someone that I can process it with, you know?

The overall sense was that the counselors were focused on the well-being of their clients, and their feelings and reactions to the traumatic stories fueled their desire to work harder and be more present with their clients. All the counselors shared how they took care themselves after hearing traumatic stories, which included self-care and seeking supervision.

**Findings for Research Question 4**

*How do these experiences shape their interactions and responses to their trauma clients?*

**Theme 1: Increased Awareness**

Working with trauma survivors provided an increase of awareness related to the prevalence of trauma and what causes mental illness. A couple of the counselors understood that they would not work solely with trauma survivors. Charlisa said:

Mhmm. I think what I just mentioned helped me to acknowledge that this is not something that I could take on, you know, as a main focus. Um, and so I do a lot of screening when it comes to taking on a new client. Um, obviously, you know, in your 15 to 20-minute phone consultation, you might not find out everything that's happening and what's going on. Um, but you know, in those first couple of sessions, it more than likely will come out, whatever the issue is or whatever else might be underneath what they're coming into therapy for. And so, um, just really, um, assessing and acknowledging and
processing whether or not this is something that I feel well versed or, or like I can jump into with this client.

For Charlisa, working with trauma survivors was too much to bear. She mentioned that being privy to certain information about trauma survivors left her to change what she did in her personal life. Charlisa said:

Mmm. Um, a lot. I mean, I think doing this work in general, it has very much, um, shaped me on a personal level. Um, good or bad and different, judge me if you want to, it don't matter, but I don't like watching the news. I don't watch the news. Um, you know, when we were getting shot and killed left and right and every other month or every other day it seemed like somebody else was, you know, dying and getting shot by police, you know, I wouldn't watch those videos. Um, um, and I wouldn't get in those conversations. Um, you know, especially on social media and things like that. Um, I wouldn't comment a lot on a lot of stuff like that. I think that's how it's shaped me personally, you know, and I haven't probably watched the news in years. It's just, it's a lot. It's, we already got so much going on, you know, and Chicago news, obviously it's not filled with positive things all the time. So, it's like you get tired of listening to that. And so, I just kind of stay in my own little bubble so to speak, you know?... I mean I have to protect my peace somehow.

Missy also shared the same sentiments. She said:

I think it has shaped me in the sense of, um, recognizing how prevalent it is for one. It has also helped me to understand that it's not something I would, uh, solely do as a counselor. You know, like I don't consider myself to be a trauma therapist. I have clients who come to me that have some trauma issues. Um, but it’s kind of, it shows me, you know, it’s the
seriousness of taken on people dealing with some severe trauma. So that's why I kind of, um, was screen for that to make sure that I don't get someone who is severely past the, nearly been traumatized.

Six of the eight counselors discussed how working with trauma survivors made them better counselors. It appears that working with trauma survivors is a challenge, Kane mentioned:

Um, you have therapists who do marriage and family. You have therapists who do you know, strictly family. That therapist I say I only deal with, um, was it, I only deal with patients, uh, who are adults. I know a lot who say they don't deal with children, but it helps me a lot because I tend to say that I'm very rounded as a therapist and I'm great at dealing with trauma and relationships and that's the bulk of a lot of issues with people in general. So, it helped me professionally be a very good therapist.

Similarly, MH shared, “It made me stronger, um, as a counselor it made me more understanding, to different, um, to different, um, why can I get these words out, different pathology. It helped me understand what causes a lot of mental illness in individuals.”

**Theme 2: Self-care**

The participants discussed the difficulty of working with trauma survivors. Self-care was a huge part of the counselors’ daily routine to maintain peace and wellness. All the participants discussed how important it was for them to take care of themselves. They also mentioned ways in which they engaged in self-care. Francis said:

I feel like I'm pretty good about like when I'm done, I'm done… I feel like I take time for myself too much. Cause I can’t get nothing else done. I've like, I'm really good about like taking time for myself. Like I don't, it's like with work, if it's not, if it's not done, then It's not done, but I don't come home and do any work unless there's a specific deadline. And I
knew like at work I was just like talking that day you know, it’s not being as diligent in my work and that's only been one time. So other than that, I really like to take time for myself a lot.

Some of the counselors talked about taking care themselves “everyday.” MH emphasized, “But daily I find ways to self-care as far as gym um, as well as stretching and, uh, journaling. Different things of that sort, journaling and devotion. I read our daily devotion every day.” For MH, self-care was daily ritual. He went on to say how he has always been about taking care of himself.

Purple Flower described her self-care practices as part of her work-life balance:

I take, well I get one, two days out the month, we get flex days, right? When we can just take it to do whatever. Um, I also get five days for professional development. So, I use all of my flex days. Um, I do take a week off for professional development and then I make sure every other month to use, you know, a vacation day to have a long weekend. So, every other month at least I need that break. I need that four days away from the clinic to just focus. And part of my self-care- Oh, I said part of my self-care is to travel. So, so every other month I go to like a different city and just spend four days there, recharge, come back, feeling better.

The participants also commented on self-care as a discussion in the counselor education programs. Most of the counselors discussed how they did not learn self-care from their respective counselor education programs. Nicole mentioned self-care was not overtly discussed in her counselor education program and it lacked practicality:

Girl, no. Oh yeah. That one, and I always, uh, it's funny because even when I do it in my classroom now, I literally give them assignment to do something on their weekend, right? Because it's like what's the point in saying, Hey, you better make sure you do self-care
and because this can happen, you could burn out. Okay, we gonna practice or are we gonna wait til I get there, and you are like see, I told you. Right. So, they told me about it, but it wasn't no practice you know, what come up.

For Charlisa, supervision and professional experience was where she received the most help in taking care of herself and providing clinical services:

Nope, no. Um, I can probably say in, in the class where we actually practice providing therapy, we probably had more conversations about, um, self-care, you know, what did it look like to take this stuff home? Making sure you don't take it home, but I could probably count on my hand. That was only what, one or two classes. Um, outside of that, it was all from personal experience or conversation with supervisors or super, you know, in supervision. Yeah. So, I guess if you want to count that, but I continued to see it, so after I had my LPC. Right. I still had pay for supervision, so I paid an outside, um, supervisor. And so, I can probably say that that was the most rich, um, of my supervision experiences um, for me where I felt like I really grew as a clinician and where I learned more about myself and about providing therapy.

The overall sense was that each counselor acknowledged the necessity of self-care in the counseling profession. They focused on making time for themselves often by implementing daily self-care practices, or maximizing their time during vacation time to recharge.

Findings for Research Question 5

*How do African American counselors draw upon their counselor education training to work with trauma clients? Where do they draw upon services outside their training?*
Theme 1: Limited Preparedness

Four of the eight participants discussed how they did not receive trauma training in their respective programs, while the other four participants discussed receiving “little” training. Those who described little training commented on the conversations related to trauma were brought up, but there was no depth to the conversations. Kane said, “it was more content based as opposed to like, hey, this class is specifically discussing how to deal with trauma. Each class kind of discussed it a little bit, but I don't think any class went in depth uh, besides crisis.”

The lack of training left most of the participants feeling unprepared to work with trauma survivors. Nicole commented:

Yeah. They just throw me in the lion’s den. So yeah, so a lot of it was a lot of self-learning. A lot of reading things for myself, finding webinars for myself because the one thing I didn't want to do was be a contributor to hurt harming people. Right? Um, I was like, I am not going to harm anybody else more than they've already been harmed. Right? I am not going to participate in that. So, a lot of it was for one, yeah. I didn't really know what I was doing. I was trying to use the counseling techniques that I learned. You know what I did know, and I was just like, this isn't working with this person. It's just not. So, I had to find webinars and other things so that I can, you know, actually treat them, but it took a lot of self-learning.

The other four participants discussed how they received “no” trauma training. Having no training in trauma left them feeling incompetent. Nicole asserted:

We had the core classes and electives, but it wasn't, it, the core, it wasn't what I call real trauma, right. We can talk about trauma is an experience that solicit, you know, emotions. We got that generic definition, but not for me. It wasn't in real life. It wasn't dealing with
even I went to school in Chicago, definitely didn't tell me about trauma in Chicago. So, it was very generic. Very generic, it wasn't a class though, right? It was incorporating into a textbook and they said, by the way, this is what happened, you know when this may happen, like with kids grow separation anxiety, we didn’t really get into all of that. Just told us how it happened. So, there's a bunch of movies from old white guys back in the day and that was it.

Others commented on their competency. They questioned if they were competent enough to help their clients. Missy shared:

Well, you know, I, I just think, um, it's, it's challenging, is how I see it. And, um, and I think there are just a lot of layers to it and I think it has been challenging. It was challenging when I think back at it because of the lack of training that I had at the time around trauma. And so I had to literally seek out, um, you know, go to trainings that people have, but, you know, sometimes these one day trainings, just not enough to understand how to work with someone around trauma, but I worked at an agency, um, during the time I was there, we just didn't get a lot of training around it either at that time. So I literally hired, um, a, a trauma specialist, you know, to kind of supervise me around some of those issues and did some online and course trainings with her to give me a better understanding, um, of the people who are dealing with trauma.

The overall sense was that trauma training was not a priority in participants’ counselor education programs. Seven of the eight participants emphasized receiving training outside of their counselor education programs. These trainings consisted of webinars, workshops, and other continuing education options, as well as on-the-job training. Missy commented on what help her. She said:
I guess what comes to mind is when I do my internship at, uh, I did it at [BUSINESS REDACTED], the outpatient mental health clinic, uh, at [BUSINESS REDACTED] and um, you know, there was a lot of trauma that would come through the door. And uh, my supervisor was the one who I had leaned on at that time to kind of help me deal with what was that, you know, that, what was happening with the clients that were coming in. So that's like on the job kind of training that I used to deal with that.

On the job training and continuing education became an integral part of the participants training to gain additional experience and knowledge to work with trauma survivors.

**Theme 2: More Trauma Training Needed**

After the discussion of clinical and training experiences of each counselor, participants gave recommendations to improve training within counselor education programs. There was a consensus among the participants in that counselor education should implement trauma training in their respective programs. A few of the participants discussed how counselor education should make trauma an integral part of their core curriculum. Purple Flower suggested, “First thing I would suggest is to have a whole course on trauma informed care. A whole course on it.” She went on to suggest implementing trauma informed care into every course that is offered:

And not only do a course, dedicated to it, just like we do, like I said, for different theories and stuff and incorporate trauma informed care into each of the other courses as well. Right? So, either we're talking about personality disorders and mental health disorders. It's like a lot of people I've seen have been diagnosed as bipolar. Well, where did you get this bipolar diagnosis from? Well, I was in prison and I'm like how every male coming in here is diagnosed as bipolar? You know what I mean? So incorporate trauma informed care treatment assessment and diagnosis into every single course.
Other participants agreed with the idea of implementing trauma into every course. For Kane, she recommended that the discussion about trauma be more in depth. She alluded to trauma being subjective. She said:

Um, I think it should be at least every single subject that we speak on, speak on it should address trauma. Um, and it should address like how that piece or that area could, trauma could present itself in it and how we can work in that area. Whether it's career, because that could, you could have trauma in that where a parent may say, well don't do that because the this ain’t good. And then they ended up doing what they parents say, and resent their parents and not in a relationship, you know that [INAUDIBLE]. So, it's just like every single discipline and area should discuss like how this person can be impacted. You know how even the smallest thing can be traumatic for somebody else. And just because it doesn't look like physical abuse or sexual abuse, you know what? That could be trauma for somebody.

**Theme 3: Needed Training in Urban Trauma**

Four participants discussed the importance of providing training from a multicultural perspective. One participant referred to it as “urban trauma.” Nicole asserted:

Keep it real. I think I've been to too many trainings that sugarcoat what trauma really is and how it impacts people. And that ticked me off. That's why I did my own training. Um, I became a CEU provider myself because I got tired of sitting in a training where they spoke more about their agencies than what's really going on. Tell me about what the people said, right. Tell, tell me about the statistics of what repeated behaviors do. Um, so, so I think we need to do a much better job of how we deliver training as it relates to trauma and make sure we focused on the people, right? Not on your bona fide you know,
counseling techniques that don't apply to everybody. Right. Uh, cause that's culturally insensitive and that, that's what I'm really tired of. You're giving me something I can’t use. So, I don't want to take this cause it doesn't apply to me, but you breeze by, right. The concepts you breezed by. Right. The statistics and all that stuff just to get to tell me what you do in your practice.

The counselors did not see the Eurocentric view of trauma feasible for the population they served. Missy said:

You know, I think, I think, I'm wondering, and I'm just saying this, I'm wondering if there is, I think, to understand how your environment can also be traumatic and how your upbringing and, and how as Black people we have been impacted by, you know, slavery and all that stuff that has come before us and to recognize the uniqueness of how Black people function and what we, what our needs are. Uh, what we lack, what we didn't get, and how all of that impacts how we, uh, are how we are today. I think just something like a carve out to focus on that.

Overall, the participants’ recommendations were centered around the need for trauma training in counselor education programs. More specifically, trauma training from a multicultural perspective is needed.

**Findings for the Overarching Research Question**

*How do practicing African American counselors who serve clients from Chicago’s 11 most violent neighborhoods experience and make personal and professional meaning of their work with trauma clients?*

A narrative is provided below to answer this overarching research question. This narrative provides further comments on the clinical and training experience of African American
counselors. It also includes a description of the clinical experiences of African American counselors, their experience with trauma survivors, and their training experience in their counselor education programs. The African American counselors in this study were able to identify their clinical experiences starting with specific details of their clinical work, which oftentimes included the population they serve, work location (e.g., private practice), years of experience, and clinical issues. Some of the participants described their clinical experience as working with clients who experience grief or working with the forensic population as inspiring the trajectory of their professional career. A few of the participants market themselves to the public to work with specific populations. All the counselors made it clear that most of the clients they serve have experienced some form of trauma. They did not separate their clinical experience, in general, from their clinical experience working with trauma survivors.

All the counselors commented on the difficulty of working with trauma survivors. A couple of the counselors mentioned working with clients who have experienced complex trauma. Complex trauma is referred to as both repetitive and cumulative (Herman, 1992). The African American counselors reported they see clients who experience an array of trauma, such as violence, sexual abuse, and food insecurity. They described their clients as normalizing these experiences, which made it difficult for them to help their clients acknowledge the trauma they are experiencing. No matter how difficult the work was to the counselors, they enjoyed their work. They took pride in being present for those who have experienced a difficult life. Most of the counselors were able to find meaning in the work they provided. Most responses were centered around helping clients, educating clients, being an advocate, and giving voice to the clients. The emotions of the counselors that may have arisen during their interactions with clients
were left to deal with at another time. Some of the counselors would make comments such as “it’s not about me” or make comments related to “focusing on the well-being of their clients.”

The counselors in this study were able to identify the challenges and rewards of working with trauma survivors. The challenges they faced were related to complex trauma. Their clients deal with a significant amount of trauma and/or other life issues, which can be overwhelming to manage. The rewards of the work resided in the therapeutic relationships they develop over time. The counselors enjoyed building relationships with their clients and being a source of relief for the people they serve.

The professional and personal meaning these practicing African American counselors found in their work with their clients reflected how they approached their work and how they sustained in their work. Working with individuals from one of the 11 most violent neighborhoods in Chicago meant that the counselors approached their work by being selfless and developing solid therapeutic relationships. For the counselors to sustain in their work, the counselors experienced post-traumatic growth and practiced self-care. Post-traumatic growth is a term often use to describe how mental health professionals may experience some sort of personal and professional growth when working with trauma survivors, while self-care is the practice of taking care of one’s self to improve one’s own health (Wilkinson & Whitehead, 2009). Overall, working with trauma survivors made these African American counselors engage in selfless acts, build healthy therapeutic relationships, experience professional growth, and engage in habitual self-care practices. The following chapter will discuss each meaningful take-away in-depth.

**Summary**

Chapter IV outlined the findings from this phenomenological study. Eight counselors provided in-depth interviews of their clinical and training experience. Ten meta-themes were
discussed. The first theme described years of experience, clinical issues, work hours, and population served. The second theme described what the counselors found relevant when working with the populations they serve. The third and fourth themes described the challenges and rewards the participants experienced while working with trauma survivors. The fifth theme described how the participants were impacted by their clients’ traumatic stories. The sixth theme described how the participants became more aware of their clients and their clients’ experiences. The seventh theme described how self-care is a ritual practice for the participants. The eighth and ninth themes described how the participants were not as prepared to work with trauma survivors, which led to their statements about the need for more trauma training in counselor education programs. Lastly, the tenth theme described how counselor education programs need to include training in urban trauma. The findings reveal a rich description of the clinical and training experiences of African American counselors who work with clients from 11 of the most violent neighborhoods in Chicago. The participants described how dedicated they were to serve their clients and providing them space to heal.
CHAPTER V
DISCUSSION

This chapter presents the overall conclusions taken from the results of this qualitative study. First, a summary of the study is presented, followed by a discussion of relevant literature, implications for counselor education graduate programs, and recommendations for future research.

Summary of the Study

Many studies (Culver et al., 2011; Ivicic & Motta, 2016; Hope & Edward, 2013) have discussed the risks of secondary traumatic stress, vicarious trauma, and shared trauma for counseling professionals. Literature on secondary traumatic stress, vicarious trauma, and shared trauma have discussed the negative and positive reactions experienced by counseling professionals, first responders, and those alike (Rasmussen, 2005; Robinson-Keilig, 2010; Tosone et al., 2012); however, there have been few studies that focused on the unique experiences of African American counselors working and/or living in violent neighborhoods that are relatively exposed to trauma.

The literature provides an abundance of knowledge about the clinical and training experiences of Caucasian counselors (Thompson et al., 2014; Thompson et al., 2015); yet information regarding the clinical and training experiences of African American counselors is largely unknown. Several studies conducted in the past few decades reveal that mental health professionals who work with trauma survivors overtime are subjected to experiencing secondary traumatic stress, vicarious traumatization, and/or shared trauma (Bride, 2004; Cohen & Collens, 2013; Rasmussen, 2005; Tosone et al., 2012). Mental health professionals included in these studies include social workers, psychologists, and nonprofessional trauma counselors.
There are three significant aspects of research within the mental health literature that have not been explored with Black counselors. These areas are: (1) Black counselors’ repeated exposure to servicing individuals who are exposed to traumatic events, (2) Black counselors’ clinical and training experiences, and (3) Black counselors’ lived experiences as counseling professionals. Black counselors’ experiences within the profession are important aspects of research since there is little information about this subject. Most research about the experiences of Black mental health professionals can be found in the social work and the counseling psychology literature (Merriman & Joseph, 2018; Wagaman et al., 2015). African Americans may have unique experiences within the counseling profession that have not been included in the literature. Therefore, this study explored the lived experiences of African American counselors in Chicago who work and/or live in violent neighborhoods, and their reactions to working with trauma survivors. The results of this study can increase organizational support, promote inclusivity and the diversity of experiences within the profession, and promote curriculum development in traumatology.

**Overview of the Problem**

Literature related to Black counselors’ clinical experiences is often related to their clinical experiences as counselors-in-training (Haskins, et al., 2013; Lu et al., 2017). The literature about Black counselors’ training experiences in their graduate programs often focuses on the lack of racial representation in their respective graduate programs (Walker et al., 2001), isolation as a Black student (Haskins et al., 2013; Rasheem & Brunson, 2018), the challenges they face navigating White spaces (Rasheem & Brunson, 2018), and multicultural training competence (Bowie et al., 2011). This focus is problematic because training programs focus primarily on Black student issues within their counselor education program rather than focusing
on improving Black student experiences and enhancing their clinical skills, specifically enhancing clinical skills to work with trauma survivors and to work with Black clients.

The literature discusses the effects of working with trauma survivors (Lee et al., 2018; McCann & Pearlman, 1990; Perez et al., 2012; Stuthridge, 2012); however, some researchers have grouped trauma professions (e.g., social workers, psychologists, interpreters, etc.) as one, and have not given voice to the unique experiences of African American counselors. Researchers also do not consider the differences in the training and professional identity of the sample population used. Therefore, little is known about African American counselors’ perceptions of the preparedness they received in their counselor education graduate training programs to work with trauma survivors. There is even less research focused on the clinical and training experiences of African American counselors working and/or living in some the most violent neighborhoods in inner urban cities, in this case, Chicago.

Finally, there is a lack of training in traumatology in counselor education graduate training programs (Adams & Riggs, 2008; Butler et al., 2017; Cook et al., 2017; Courtois & Gold, 2009; Pearlman & Saakvitne, 1995). Researchers have called upon graduate programs to include trauma training in their core curriculum (Butler et al., 2017; Finklestein et al., 2017; Makadia et al., 2017). According to the Centers for Disease Control and Prevention (CDC), 1 in 7 children experienced abuse or neglect in the last year, 20 people are victims of physical violence by an intimate partner every minute, 1 in 2 women experience sexual violence in their lifetime, and 1 in 5 men experience sexual violence in their lifetime (Centers for Disease Control and Prevention, 2017), not to mention the ongoing racial violence, police brutality, terrorism, and natural disasters that permeates the mere existence of human nature. Counselors are more than
likely to work with someone who has experience trauma (Trippany, et al., 2004), thus training in evidence-based traumatology is important in the counseling profession.

**Purpose Statement and Research Questions**

Given the problems related to the lack of literature about African American counselors clinical and training experience, specifically in inner urban cities succumbed with violence, the purpose of this study was to explore the lived experiences of African American counselors in Chicago, and their reactions to working with trauma survivors.

The overarching question guiding this study is: *How do practicing counselors who serve clients from Chicago’s 11 most violent neighborhoods experience and make personal and professional meaning of their work with trauma clients?* The sub-questions for this study are: (1) *What are the clinical experiences of African American counselors in Chicago;* (2) *What experiences do African American counselors have working with clients who have experienced trauma;* (3) *What experiences do African American counselors have with secondary traumatic stress, vicarious traumatization, and shared trauma;* (4) *How do these experiences shape their interactions and responses to their trauma clients;* (5) *How do African American counselors draw upon their counselor education training to work with trauma clients? Where do they draw upon services outside their training?*

**Review of Methodology**

This was a qualitative research study and utilized hermeneutic phenomenology (van Manen, 1997), which required the researcher to examine the text in order to reflect on the content to discover something meaningful (Sloan & Bowe, 2014). This study consisted of eight African American counselors who work in and/or work with individuals from one or more of the most violent neighborhoods in Chicago. Each counselor sat for an in-depth interview in which they
discussed their clinical and training experiences, more specifically their experiences working
with trauma survivors. All interviews were audio recorded by the researcher and transcribed by a
professional transcriptionist. Data collection began August 2019 and concluded April 2020.
After each interview was transcribed, the researcher sent each participant a summary of their
transcript for member checking, in which the participant could elaborate or make corrections.

Thematic analysis was used to analyze the data and included six primary phases (Braun
& Clarke, 2006). Nine meta-themes were identified. A process of theoretical analysis (Braun &
Clarke, 2006) was utilized in order for trauma theory to provide a rich analysis of the counselor’s
lived experiences. Trauma theory includes the definition of trauma and its symptomology profile.
Trauma theory includes the description of PTSD, which is defined as the exposure of actual
death or threat. People who have been diagnosed with PTSD can potentially experience
symptoms such as intrusive memories, recurring thoughts, physiological reactions, and negative
alterations to their mood.

**Findings Related to the Literature**

There are a few findings in this study that were inconsistent with the results of other
research studies. All the participants began their interview with sharing their clinical and
education experience. The participants described their reactions to working with trauma
survivors. Some shared that they experienced immediate reactions to traumatic stories such as
crying; however, they did not experience any lingering effects as described in previous studies
(Godfrey et al., 2013; Price & Stevens, 2012; Makadia et al., 2017), which discuss the physical,
social, and psychological effects of secondary traumatic stress, vicarious trauma (McCann &
Pearlman, 1990), and shared trauma (Baum, 2010; Tonsone, 2010). One participant described
feeling unable to worked solely with trauma survivors to protect their peace and future family,
which was similar to findings found by Steed and Downing (1998) as it relates to secondary traumatic stress and its social impact on mental health professionals.

**Selflessness**

In this study, all the African American counselors discussed how they approached their work as counselors. They all expressed a sense of selflessness. They talked about focusing on their client’s well-being, and less on how the traumatic stories of their clients affected them. The African American counselors expressed honoring the work they were doing with their clients. Some of the counselors voiced passion in their work, and a sense of pride of being present for their clients. Selflessness is often described as compassion, which is essential in the mental health profession (Bowen & Moore, 2014). Compassion is defined “as a feeling of deep sympathy and sorrow for another person who is stricken by misfortune, accompanied by a strong desire to alleviate the suffering of the individual or community” (Bowen & Moore, 2014, p. 18; Merriam-Webster 2002, 2010). Compassion in a therapeutic relationship promotes a supportive work environment for the client(s) being served (Bruhn, 2001). The participants in this study also expressed how they valued their positions as counselors and their work with their clients. During the interviews, the counselors were asked if there were times, they wanted to leave the counseling profession. None of the participants wanted to leave the profession. In fact, many of them expressed that they were right where they needed to be. This sense of purpose radiated throughout their interviews.

**Therapeutic Relationship**

Counselors in this study discussed the necessity and the importance of a solid therapeutic relationship. This was an area that was consistent with previous research (Bell et al., 2016; Elliot et al., 2011; Horvath et al., 2011; Later et al., 2001; Rogers, 1957; Wiseman, 2017). The
counselors in this study expressed an understanding of the importance of a therapeutic relationship. Particularly, the African American counselors in this study expressed that their understanding for the population they served was imperative. Most of the participants in this study serve Black clients. Black clients are unlikely to share and/or attend psychotherapy if the counselor is unable to build rapport with the client (Sanders-Thompson et al., 2004). Previous studies discussed inadequate mental health services (Richardson, 2003), lack of cultural awareness (Awoson et al., 2011), and mistrust (Wilkins et al., 2013) among the many reasons Black clients do not seek out counseling and/or remain in counseling. Such concerns that Black clients have about counseling might be byproducts of the lack understanding and a lack of a solid therapeutic relationship among Black clients and their counselors, specifically White counselors. According the Multicultural and Social Justice Counseling Competencies, being aware of self and others is imperative in a therapeutic relationship with Black clients (Ratts et al., 2015). The African American counselors in this study understood the importance of understanding and knowing their clients and the things that affect them within their respective communities.

**Post-traumatic Growth**

In this study, participants experienced vicarious traumatic growth (VTG) or post-traumatic growth (PTG) (Barrington & Shakespeare-Finch, 2013; Sansbury et al., 2015). Post-traumatic growth is a term often used to describe how mental health professionals may experience some sort of personal and professional growth when working with trauma survivors. Tedeschi et al. (1998) described post-traumatic growth as the development of positive meaning gained from a traumatic experience. There are five areas that result in growth after a trauma: (a) new possibilities, (b) relating to others, (c) personal strength, (d) appreciation for life, and (e) spiritual change (Tedeschi & Calhoun, 1996). New possibilities referred to new interests or a
new career. Second, relating to others referred to a greater sense of compassion for others. Third, personal strength referred to the strength that one sees when actively working with someone who has experienced trauma that would otherwise remain unseen. Fourth, appreciation for life, is the increased of gratitude for life and the focus on more meaningful aspects of life. Finally, spiritual change is characterized by a deepening of spirituality (Calhoun & Tedeschi, 2006). The participants in this study discussed their greater sense of compassion for others when they were focused on the well-being of their clients. They often discussed their concern for their clients, so much so that their own well-being was set aside until they were alone. The participants also acknowledge how working with trauma survivors sharpened their counseling skills. The challenges they experienced working with trauma survivors enhanced their ability to be effective counselors. Also, for the counselors in this study, the growth they experienced working with trauma survivors kept them engaged in learning.

“Posttraumatic growth is characterized as positive changes to the self, interpersonal relationships, and one’s life philosophy that are experienced as a result of one’s internal struggle with adversity” (Manning-Jones et al., 2017, p. 257; Tedeschi & Calhoun, 1996). Cohen and Cohen (2012) conducted a meta-synthesis of 20 published articles to examine the impact that trauma work has on those who work with traumatized clients within the framework of VT and VPTG. They found that the impact of trauma work can potentially increase short- and long-term levels of distress, that such psychological impact can be managed through personal and organizational coping strategies, and that trauma workers can also experience growth as a consequence of their engagement in trauma work (Cohen & Cohen, 2012). The participants in this study expressed how working with trauma survivors made them better counselors. For these participants, being a better counselor included being more understanding and empathic. Post-
traumatic growth is a result of empathetic engagement with trauma survivors (Cohen & Collens 2012).

**Self-care**

The utilization of coping strategies such as self-care is associated with higher levels of vicarious post-traumatic growth (VPTG) among health professions (Manning-Jones et al., 2017). One of the meta themes in this study was self-care. The African American counselors in this study detailed how they engaged in self-care and how often they took the time to take care of themselves. Lawson and Myers (2011) concluded in their study that counselors who engage in healthy self-care habits are more likely to experience compassion satisfaction in their professional careers. Compassion satisfaction refers to a sense pleasure derived from effectively helping others through psychotherapy (Stamm, 2005), as well as a sense of efficacy in one’s ability to make a positive impact on the world (Stamm, 2002). The self-care practices among the African American counselors in this study were specific to what each counselor believed to be helpful for them, especially working with trauma survivors. Practicing self-care may have minimized STS, VT, ST, and burnout in this study, as indicated in previous studies (Baird & Kracen, 2006; Lawson & Myers, 2011; Salloum et al., 2015). The participants self-care practices served as protective factors for STS, VT, and ST. All the participants engaged in self-care practices daily, which they described as a necessary practice while working as a mental health professional, specifically working with trauma survivors. According to the participants, self-care kept them mentally healthy. Additionally, the African American counselors in this study were adamant about taking care of themselves in addition to their clients.
Limited Trauma Training

The lack of trauma training in graduate training programs was another area that was consistent with previous findings. The participants in this study expressed the lack of training in their graduate training programs (Adams & Riggs, 2008; Butler et al., 2017; Cook et al., 2017; Courtois & Gold, 2009; Pearlman & Saakvitne, 1995). Other researchers have called for graduate training programs to offer trauma in their curriculum (Butler, Carello, Maguin, 2017; Finklestein et al., 2017; Makadia et al., 2017), as did the participants in this study. Such training might decrease the chances of secondary trauma. There was an overall contention from the African American counselors in this study that training in traumatology was imperative for all counselor education graduate programs. More specifically, trauma training from a multicultural perspective is crucial. Some of the participants mentioned that counselor education graduate programs should include training in urban trauma. It was implied that the definition of trauma is too narrow of a description. Urban trauma is a set of conditions that sustain modern day oppression (Akbar, 2017). These conditions include racism, housing insecurity, drugs and health problems associated with poverty, which lead to trauma, specifically PTSD. Training in urban trauma is important because people of Color experience stress in systems in which they occupy, rather than institutional or cultural encounters with racism (Landrine & Klonoff, 1996; Utsey, 1999; Utsey & Ellison, 2000). These race-based stressors can have an impact on their physical and psychological health.

Conclusion

The purpose of this study was to explore the lived experiences of African American counselors, in Chicago, and their reactions to working with trauma survivors. The results are explored through the lens of trauma theory. Despite many studies exploring secondary trauma in
different forms, very few have used these concepts to include the unique experiences of African American counselors. The results of this study add to the literature on the clinical and training experiences of clinicians who work in violent neighborhoods and who are trained in counselor education graduate programs. The experiences of African American counselors are unique and relative. All the African American counselors in this study committed their life, time, and energy to working in some of the most violent neighborhoods in Chicago. They work with clients who some may deem unhealable, lazy, or complacent, which produced empathy and a sense purpose.

Challenges

While conducting this research, the researcher experienced several challenges with data collection. The researcher recruited participants from the inner urban city of Chicago, while living in another state. It was not geographically possible to conduct all interviews face to face. Five of the interviews were done over the phone, one was done face to face, and two were done on Zoom videoconference. The interviews done over the phone limited the researcher’s ability to observe non-verbal behavior. For example, during a face to face interview, Neal’s eyes would light up when he spoke about how clients were affected by the “lack of continuity” they experienced in mental health settings. Given this example and the challenges with conducting interview via the phone, it was possible that these types of interviews took away from anecdotal information the researcher could have gathered. The researcher wanted to make sure the participants were as comfortable as possible; therefore, the researcher gave participants the decision upon which platform they wanted to use for interviewing.

Limitations

While it is common to transfer the findings of qualitative studies onto specific situations or the population studied, the researcher is unable to do so in this study. One of the limitations
for this study is that it does not capture the experiences of all African American counselors. This study was specific to African American counselors who work in the inner-urban city of Chicago. Because this study was so specific, it lacks transferability. African American counselors who work in rural or suburban areas are not represented in this study.

Another limitation of this study concerns the intersectionality of race and trauma. Although some of the participants in this study mentioned the lack of training related to multiculturalism and trauma, the study does not capture the intersectionality of race and trauma. According to Carter (2007), race-based traumatic stress injury refers to the emotional or physical pain or the threat of physical and emotional pain that results from racism in the forms of racial harassment (hostility), racial discrimination (avoidance), or discriminatory harassment (aversive hostility). His research led to the creation of race-based traumatic theory. Racism and discrimination impact the mental, physical, and social aspects of Black people lives both negatively (e.g., PTSD) and positively (e.g., activism).

Lastly, this study did not discuss race and racism. This topic was not broached in the study since it focused on African American counselors who were positioned as the majority. Additionally, the majority of the clients the participants worked with in this study were also primarily African American. Therefore, the discussion about race and racism was not asked and it was often left out.

**Implications for Counselor Education Graduate Programs**

The findings from this study yield several implications for the practices of counselor education. The study of African American counselors remains relatively an under-researched area of focus within counselor education. Implications from this study center around the need for more discussion about the unique experiences of African American counselors and African
American clients. Discussions should include how unmet basic needs (Sanders et al., 2004) (e.g., finances) and racism and racial discrimination (Carter, 2007; Hoggard et al., 2012) have a trauma effect on African American clients and African American counselors.

Implications from this study also center around training in traumatology in graduate counselor education programs. Previous studies (Courtois & Gold, 2009; Lu et al., 2017; Turkus, 2013) have revealed that trauma training is an integral part of counselor education graduate programs. Given this and the literature which asserts that trauma training can lower levels of trauma symptoms (Cook et al., 2011) and clinicians will be less likely to experience STS, VT, and ST (Adams & Riggs, 2008; Courtois & Gold, 2009), more intentional implementation of trauma training and/or trauma related coursework should be offered to counselors in their respective counselor education graduate programs.

As previously stated, clinicians are more likely to work with trauma survivors no matter what population they choose to work with (Trippany et al., 2004). Counselor education programs should become more intentional about including trauma focused literature and experiential learning in core coursework, as well as be intentional about assisting students in selecting field experiences that include experiences working with trauma survivors with a focus on African American counselors. Continuing education should also be encouraged and supported in counselor education programs, focused on the unique experiences of African American counselors and the clients that they serve.

Most of the counselors in this study suggested that counselor education programs should create “whole” courses, or a subset of courses related to trauma. Four of the participants in this study stated that trauma courses should specifically speak about trauma from a multicultural perspective. Some of them used terms like “urban trauma” or acknowledging the unique
experiences of Black people. Maysa Akbar defined urban trauma as a set of conditions that sustain modern day oppression (Akbar, 2017). These conditions include racism, housing insecurity, drugs, and health problems associated with poverty, which lead to trauma and PTSD. Dr. Akbar asserted that “urban trauma can manifest as strong emotions, irritability or flashbacks. There are moments of depression and lack of motivation, giving up, due to hopelessness.” (Art International, 2020, p.n.p) Urban trauma is more likely to affect primarily young, male African Americans who are poor, less educated, engage in criminal behavior, and abuse alcohol or drugs (National Research Council, 1993). Although this research is dated, current data from the Cook County Medical Examiners (2018) showed that out of 597 homicides in Chicago in 2018, 492 of the victims were Black, and 547 were males between the ages of 15 and 24 years. Education about urban trauma and its effects on urban individuals is a necessary component of the counselor education curriculum for all counselors-in-training. Disadvantaged, urban individuals are at higher risk for trauma exposure and trauma-related mental health diagnoses such as PTSD (Gillespie, et al., 2009). Such training in urban trauma is not only necessary for Black counselors but all counselors working in urban environments and studying at urban institutions.

The information provided from this dissertation could improve how counselor education programs and counselors-in-training are prepared to work with trauma survivors. For instance, two of the meta themes in this research addressed the counselors’ limited preparedness to work with trauma survivors, and how to better meet the needs of counselors-in-training, which in turn will meets the needs of trauma survivors. Trauma training is a standard in counselor education graduate programs (CACREP, 2016), which shows the importance of trauma training to be effective in the counseling field.
Recommendations for Future Research

This study has highlighted the current state of knowledge related to African American counselors who work with trauma survivors from one or more of the 11 most violent neighborhoods in Chicago. A few questions have emerged as being worthy of future research. First, it is important to expand on the clinical and training experiences of African American counselors in inner-urban cities like Chicago. Researchers in this area may consider conducting research on African American counselors who work in rural and suburban areas. A quantitative study that examines if African American counselors’ experience VT, STS, and ST would be helpful. Alternative research methodologies need to be considered particularly to further investigate the lived experiences of African American counselors in counselor education, reported by qualitative and quantitative research. Longitudinal studies may be useful as well.

Further, future research should include the prevalence of African American counselors who work with Black clients. African American counselors working with Black clients is necessary because of Black representation. African American counselors and Black clients share similar experiences such as systemic racism. Black clients are unlikely to share and/or attend psychotherapy if the counselor is unable to build rapport with the client (Sanders-Thompson et al., 2004). Previous studies discussed inadequate mental health services (Richardson, 2003), lack of cultural awareness (Awoson et al., 2011), and mistrust (Wilkins et al., 2013) among the many reasons Black clients do not seek out counseling and/or remain in counseling. Such concerns that Black clients have about counseling might be byproducts of the lack understanding and a lack of a solid therapeutic relationship among Black clients and their counselors, specifically White counselors.
Summary

This qualitative phenomenological study explored the lived experiences of African American counselors and their reactions to working trauma survivors. The results of this study provide new information and a new perspective on the clinical and training experiences of African American counselors who work in some of the most violent neighborhoods and/or with clients who live in these neighborhoods. This information may be relevant to counselors, counselor educators, counselor education programs, and organizations affiliated with the counseling profession. This information can help improve training in traumatology, specifically training in urban trauma for all counselors-in-training. The findings from this study can promote self-care practices within the counselor education curriculum and within organizations that employ professional counselors. Furthermore, information gathered from the African American counselors in this study can improve overall counselor education training by helping professionals to be intentional about including the unique experiences of African American counselors and adapting current counseling skills for working with Black clients. Further research should expand to various inner-city urban neighborhoods across the United States.
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Appendix A

HSIRB Approvals
Date: June 14, 2019

To: Glinda Rawls, Principal Investigator
    Zanovia Tucker, Student Investigator for dissertation

From: Amy Naugle, Ph.D.

Re: IRB Project Number 19-06-06

This letter will serve as confirmation that your research project titled "The Lived Experiences of Black Counselors: An exploration of their Reactions to Trauma Survivors" has been approved under the expedited category of review by the Western Michigan University Institutional Review Board (IRB). 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: This research may only be conducted exactly in the form it was approved. You must seek specific board approval for any changes to this project (e.g., add an investigator, increase number of subjects beyond the number stated in your application, etc.). Failure to obtain approval for changes will result in a protocol deviation.

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 IRB for consultation.

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

A status report is required on or prior to (no more than 30 days) June 13, 2020 and each year thereafter until closing of the study.

When this study closes, submit the required Final Report found at https://wmich.edu/research/forms.

Note: All research data must be kept in a secure location on the WMU campus for at least three (3) years after the study closes.
Date: July 15, 2019

To: Glinda Rawls, Principal Investigator  
Zanovia Tucker, Student Investigator for dissertation

From: Amy Naugle, Ph.D., Ch N

Re: IRB Project Number 19-06-06

This letter will serve as confirmation that the change to your research project titled "The Lived Experiences of Black Counselors: An exploration of their Reactions to Trauma Survivors" requested in your memo received July 11, 2019 (to revise data collection protocol to add questions) has been approved by the WMU Institutional Review Board.

The conditions and the duration of this approval are specified in the Policies of Western Michigan University.

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 IRB for consultation.

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

Approval Termination: Jun 10, 2020
Date: January 29, 2020

To: Glinda Rawls, Principal Investigator
    Zanovia Tucker, Student Investigator for dissertation

From: Amy Naugle, Ph.D., Ch

Re: IRB Project Number 19-06-06

This letter will serve as confirmation that the change to your research project titled "The Lived Experiences of Black Counselors: An exploration of their Reactions to Trauma Survivors" requested in your memo received January 28, 2020 (to clarify eligibility criteria and add questions to data collection protocol) has been approved by the WMU Institutional Review Board.

The conditions and the duration of this approval are specified in the Policies of Western Michigan University.

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 IRB for consultation.

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

Approval Termination: June 13, 2020
Informed Consent

Western Michigan University
Counselor Education and Counseling Psychology

Principal Investigator: Dr. Glinda Rawls
Student Investigator: Zanovia Tucker
Title of Study: The lived experiences of Black counselors: An exploration of their reactions to trauma survivors

STUDY SUMMARY: This consent form is part of an informed consent process for a research study and it will provide information that will help you decide whether you want to take part in this study. Participation in this study is voluntary. The purpose of the research is to: explore the lived experiences of Black counselors in Chicago and their reactions to trauma survivors and will serve as Zanovia Tucker's dissertation for the requirements of the Doctor of Philosophy degree. If you take part in the research, you will be asked to in participate in an individual interview.

Your time in the study will take approximately 60 minutes plus 15-30 minutes for member checking. Possible risks and costs for to you for taking part in the study may be discomfort from answering sensitive questions and time to complete the interview. There are no costs for your participation and there is no direct benefits for your time. Your alternative to taking part in the research study is not to take part in it.

You are invited to participate in this research project titled "The lived experiences of Black counselors: An exploration of their reactions to trauma survivors" and the following information in this consent form will provide more detail about the research study. Please ask any questions if you need more clarification and to assist you in deciding if you wish to participate in the research study. You are not giving up any of your legal rights by agreeing to take part in this research or by signing this consent form. After all your questions have been answered and the consent document reviewed, if you decide to participate in this study, you will be asked to sign this consent form.

What are we trying to find out in this study?
This study would hope to understand the unique experiences of Black counselors, namely their experiences working and living in some of the most violent neighborhoods in Chicago. Black counselors' experiences in the literature is relatively unknown. The counseling profession should be better informed about the experiences of Black counselors to promote inclusivity and the diversity in experiences of the profession.
The findings from this study have relevance to the counseling profession, since the Council for Accreditation of Counseling and other Related Education Programs (CACREP) requires master and doctoral level students to be trained in trauma (CACREP, 2016). Also, this information gleaned from this research could provoke curriculum development in the areas of traumatology. Exploring these concepts is significant in the counselor education field because counselors work in environments that experience traumatic events constantly.
Who can participate in this study?
You must work in one of the 11 most violent neighborhoods identified by the Chicago Police Department. The participants should be a Black counselor who is actively engaged in counseling and who is a Licensed Professional Counselor or a Licensed Clinical Professional Counselor.

Where will this study take place?
The data collection will take place via video conference or a place selected by you or the researcher (e.g. conference room at your office, in your office where you hold counseling session, etc.) You will be advised to participate or choose a location where you are comfortable and where your confidentiality will be protected. All recordings and transcripts will be secured on a password protected laptop and an encrypted flash drive. Also, you will be asked to review a summary of your transcripts before data analysis.

What is the time commitment for participating in this study?
You will be asked a series of questions as it relates to your clinical and training experience. The interview will take approximately 60 minutes plus 15-30 minutes to review a summary of your transcript at a later date (dependent on how long you will take member checking).

What will you be asked to do if you choose to participate in this study?
You will be asked to respond to a series of questions as it relates to your clinical and training experience. You will be asked to participate in a 60-minute interview. You will also be asked to review a summary of your transcript once the transcript is completed.

What information is being measured during the study?
I will be using the responses from the research question that are asked of you as measurements.

What are the risks of participating in this study and how will these risks be minimized?
The possible risks of this study will be the time I am asking you to participate. Also, some parts of the conversation may make you uncomfortable. I will reassure you that you can stop the interview at any time. Also, you will be given information about free community counseling in your respective communities. You will also be encouraged to seek counseling services through your Employee Assistance Program (EAP), if available. Furthermore, I will inform you on how I will secure the information that I receive from them (e.g. encrypted flash drive).

What are the benefits of participating in the study?
There is no direct benefit for participating in this study. The potential benefits of this research for the counseling profession could provoke curriculum development in the areas of traumatology.

The counselor education profession could benefit from the information of this research because counselors work in environments that experience traumatic events constantly. There are three significant aspects of research within the mental health literature that have not been explored with Black counselors. These areas are Black counselors repeated exposure to
servicing individuals who are exposed to traumatic events, Black counselors' clinical experiences, and their training experiences.

Black counselors' experiences within the profession are important aspects of research. This study can better inform the counseling profession about the experiences of Black counselors to promote inclusivity and the diversity in experiences of the profession.

Are there any costs associated with participating in this study?
There are no costs associated with participating in this study.

Is there any compensation for participating in this study?
There is no compensation for participating in this study.

Who will have access to the information collected during this study?
The results of this study will be disseminated in the student investigator's dissertation and submission to research conference and journal. The student and principal investigator will be the only ones with access to the data that is collected. Data will be secured on a password protected laptop and an encrypted flash drive.

What will happen to my information collected for this research after the study is over?
The information collected about you for this research will not be used by or distributed to investigators for other research.

What if you want to stop participating in this study?
You can choose to stop participating in the study at any time 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. The investigator can also decide to stop your participation in the study without your consent.

Should you have any questions prior to or during the study, you can contact the student investigator, Zanovia Tucker at 773-459-5391 or Zanovia.p.tucker@wmich.edu. You may also contact the Chair, Human Subjects Institutional Review Board at 269-387-8293 or the Vice President for Research at 269-387-8298 if questions arise during the study.

This consent document has been approved for use for one year by the Western Michigan University Institutional Review Board (WMU IRB) as indicated by the stamped date and signature of the board chair in the upper right comer. Do not participate in this study if the stamped date is older than one year.

I have read this informed consent document. The risks and benefits have been explained to me. I agree to take part in this study.
Appendix B

Interview Protocol
This is an interview protocol for the Research Question: How does a sample of Black counselors working in one of the most violent neighborhoods in Chicago describe their clinical and training experiences?

Setting up the conversation:

Thank you for agreeing to participate in this study about the lived experiences of Black counselors in Chicago and their reactions to trauma survivors. Through interviews people who currently work in one of the most violent neighborhoods in Chicago, the researcher is seeking to explore clinical and training experiences of Black counselors.

For this study, I am exploring your clinical experiences in general, your clinical experiences working with trauma survivors, your training experience in your counselor education program and you perceived preparedness to work with trauma survivors.

In our interview today, I am interested in any experiences you had during your clinical practice, in this neighborhood and within your counselor education program. I am interested in how you obtained your clinical experience and how your program prepared you for your role as a counselor.

Again, thank you for letting me interview you about your experiences.

Getting the conversation started:

Please start by telling me about your experience as a counselor?
What kinds of clients do you serve?
How many hours per week do you work?
How many clients do you see per week? Per caseload?
What are the primary clinical issues you work with?
What is your theoretical approach do you use for this population?
What does it mean to you to work in this community? With this population? What is your reason(s) for choosing to work in this neighborhood?
Do you live in the neighborhood in which you work in? How long have you lived here? If you do not live in the neighborhood, what was your reason for living outside of the area in which you work?
What do you find relevant with working with this population?
Have you ever worked with a client who experienced trauma?
Describe your experience working with clients who experienced trauma?
What kind trauma did the client experience? How did you react to hearing the client’s traumatic experience?
What was most challenging personally and professional while working with this particular client or your clients experiencing trauma in general? What was the most rewarding?
Tell me about your reactions to your most difficult cases? Were there any lingering affects after hearing their story? How long were you experiencing these affects? How long was the client on your caseload?
How did you know your client was experiencing or had experienced trauma?
Have you ever had a client whose traumatic experience affected you? If so, describe that experience and the impact it had on you. How has working with trauma clients affected your personal life? How has it affected your professional life? How has it been rewarding? Looking back on any case that you have had working with trauma clients what would you have done differently?

How has your experience working with trauma clients shaped your work as a counselor? Shaped you personally?

What theoretical approach do you use for clients who is experience trauma? Was it effective? Did you ever feel like quitting your position or leaving the counseling profession? What caused this feeling?

According to many reports, Chicago has been saturated with violence, namely gun violence, how have you been affected by this? Do you find this experience traumatic? How does the violence you experience and/or witness as a resident of Chicago affect you as a counselor? How do you handle working with individuals who are affected by the violence in Chicago, while also experiencing and/or witnessing such violence?

Now, please think about a time when you were provided guidance in your counselor education program to work in this kind of environment? With trauma survivors?

What was experience like?
What training did you receive in trauma? What classes were you in?
Was the information useful with working with trauma survivors? Who were the people involved?
What was their approach to educating you about trauma work? Was it active engagement? Lecture? Group work?
How did you feel about what was happening?
How did you feel about serving trauma survivors? During training? After training?
Have you received additional training in trauma outside of your counselor education program?

Our training teaches us to try not to take our work with our client’s “home” with us and to engage in self-care, have there been a case where you have not engaged in self-care?
How often do you take the time for self-care? What does self-care look like for you?

How did you draw upon your training to help you with self-care? Was the training helpful?
Were you trained in your agency or from your graduate program to address trauma when working with clients? Discuss your experience with training or discuss your limited training experience.
Did you feel adequate in your ability to work with clients experiencing trauma? How so? If not, why not?

**Reflection questions:**

Looking back on your experience in your program, how would you describe your preparation for trauma counseling?
Are there situations that stood out the most in your preparation in your discipline?

For you, what was the most important take-away from your experience as a counselor so far? As a student?
Now that you have worked with trauma survivors, what would you recommend to training programs about training in trauma?

Thank you for sharing your experience with me. Your story will be of great value in helping me explore the lived experiences of Black counselors in Chicago and their reactions to trauma survivors. Is there anything that I did not ask that you would like to share about your experience you just described to me?
Appendix C

Flyer
Do you identify as a member of the African Diaspora?

Are you actively engaged in clinical work?

Do you work in the urban inner-city of Chicago?

Are you a Licensed Professional Counselor (LPC) or a Licensed Clinical Professional Counselor (LCPC)?

If so, please consider participating in my research study to better understand the clinical and training experiences of Black counselors in Chicago.

JUNE 2019

IF YOU WOULD LIKE TO LEARN MORE ABOUT THIS STUDY

PLEASE CONTACT: ZANOVIA TUCKER @ZANOVIA.P.TUCKER@WMICH.EDU
Appendix D

Thematic Map
Thematic Map

RQ: 1
Diverse Experiences
Awareness & Understanding

RQ: 2
Challenging & Complex
Rewarding

RQ: 3
Personal Impacts and Client Well-being

RQ: 4
Increased Awareness
Self-care

RQ: 5
Limited Preparedness
More Trauma Training Needed
Need Training in Urban Trauma