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THE IMPACT OF WORKING WITH TRAUMA SURVIVORS ON THE TRAUMA THERAPIST

By

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ABSTRACT

THE IMPACT OF WORKING WITH TRAUMA

SURVIVORS ON THE TRAUMA THERAPIST

By

Brooke VanBuren-Hay

This study explored the impact of working with trauma survivors on the trauma therapist. Self-care skills of the therapist were also addressed. Six trauma therapists were interviewed for ninety minutes. A follow up contact one week later was used to further illicit information. The data was analyzed using a modified analytic induction process. The data were reviewed for common and divergent information. Main themes were created for each case, and then compared with all of the cases in order to create consistency. The final results were presented to illustrate the impact of work with trauma survivors, as well as the self-care skills used by the therapists. A model of the results was created to display a pictorial representation of the findings. Recommendations for training, supervision, and support for the new trauma therapist are provided.

This is dedicated to Bill, Victoria, and Quinton, without your love and support, this would not have been possible.

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Chapter One

Introduction

This study explores the impact of work with trauma survivors on the therapist. Self-care skills of the trauma therapist are also addressed. A qualitative design was used to illustrate a model of the impact of trauma work and the self-care skills of the therapists who continue to do this work.

Background

The incidences of trauma in this country continue to rise (FBI Statistics, 1998). According to the Diagnostic and Statistical Manual 4th edition (DSM-IV), 58% of the population has or will experience some form of trauma that may warrant a diagnosis of Posttraumatic Stress Disorder (PTSD) (APA, 1994). Given the number of people experiencing trauma, the number of these people seeking mental health services is substantial. As a result, more knowledge and attention needs to be given to the therapists working with trauma survivors. To date, the majority of literature addressing trauma focuses on the primary trauma survivor.

Wilson and Lindy (1994) define traumas as being divided into human-made and naturally occurring traumas. According to the DSM- IV, natural or human-made traumas that could lead to a diagnosis of PTSD could include sexual assault, natural disaster, domestic violence, or an act of terrorism. It is important to note that although these events are distressing in and of themselves, it is the individual's response to the event that determines whether the event is traumatic. An event is considered traumatic to the individual when he or she is unable to use

everyday coping skills to attend to the event. A trauma taxes a person's coping ability.

It has been documented that doing psychotherapy is difficult, and that it affects the therapist (Figley, 1995). Trauma therapists face a unique set of difficulties given that they are facing material that is often horrific, and that can illustrate the cruelty of humans towards each other. Given the difficult nature of this work it is important to understand how this work affects the therapist, not only in an effort to support and protect the therapist, but also in an effort to assist in providing quality services to clients. As Pearlman and Saakvitne (1995) note, "too often, therapists, counselors, trauma workers, and researchers lack conceptual frameworks, practical approaches, and supportive environments for either examining their role in relationships with trauma survivors or for understanding the impact their work has on them. Lack of information and training increases the likelihood that therapists will impose their needs and conflicts on their clients and psychotherapies" (p. 1). Therefore, it is important for therapists to understand the impact on them that work with trauma survivors can have. It is not often that therapists find a forum in which to share their work; not having such a forum keeps the impact of working with trauma a solitary act. The literature will show that feelings of being alone are often quite disturbing to trauma therapists.

Several concepts address the potential impact trauma may have on support people such as therapists. These concepts most commonly referred to include secondary traumatic stress/compassion fatigue, vicarious traumatization, countertransference, and burnout. Although the concepts may have overlapping

components, each one provides a distinct and important description of the effects of trauma work.

Secondary traumatic stress or compassion fatigue is a concept that was created by Charles Figley (1991) that uses Posttraumatic Stress Disorder as a foundation. This concept identifies the trauma symptoms that professionals may develop as a result of working with the primary traumatized individual. According to Figley (1995), unwanted memories of a traumatic event, a sudden re-experiencing of a traumatic event, feelings of detachment, difficulty concentrating, and sleep disturbances are all symptoms that can appear in therapists as a result of work with trauma survivors. Whereas this construct is symptom based, another similar construct, vicarious traumatization, focuses less on symptoms and more on "...meanings and adaptations..." (Pearlman & Saakvitne, 1995, p. 281).

Vicarious traumatization is the damaging effects on therapists who work with trauma survivors over a long period of time (Pearlman & Saakvitne, 1995). The duration of the work is critical in vicarious traumatization. Saakvitne and Pearlman (1996) define vicarious traumatization as "...the cumulative transformative effect upon the trauma therapist of working with survivors of traumatic life events" (p. 31). Vicarious traumatization encompasses not only behavioral or symptom responses but addresses cognitive schemas of the therapist that can be affected by working with the survivor population. McCann and Pearlman (1990) noted several specific schemas that can be affected when a therapist begins to engage with his or her client. These schemas are identity, worldview, psychological needs, beliefs, and memory system of the therapist

(McCann & Pearlman, 1990). Each of these schemas can be affected either in a positive or negative manner. It is believed that "vicarious traumatization is the transformation in the inner experience of the therapist that comes about as a result of empathic engagement with clients' trauma material" (Saakvitne & Pearlman, 1996, p. 31). Being able to engage with clients is the basis for good clinical work, yet as noted above, it is also what may be the catalyst for vicarious traumatization. The concept of vicarious traumatization speaks to the idea that trauma work changes a person forever, and is not situationally or momentarily based.

Countertransference is a psychological concept that originated with Sigmund Freud in the early 1900s (Wilson & Lindy, 1994). Countertransference is the reaction of the therapist to the client's responses to the material discussed in therapy and to the therapist. Wilson and Lindy (1994) describe countertransference responses as being expected aspects of work with trauma survivors. Two very important reasons for beginning to understand the countertransference reactions of therapists are the potential harm to self and to the clients that unresolved countertransference issues could cause. These authors identify how countertransference can have both positive and negative effects on the therapist and the survivors (Wilson & Lindy, 1994). "Countertransference positions (role enactments) range from positive (the therapist becomes a fellow survivor or a helpful supporter, rescuer, or comforter near the trauma) to negative (the therapist becomes a 'turncoat' collaborator or hostile judge)" (Wilson & Lindy, 1994, p. 9). A therapist's reaction to the trauma

story of his or her client may be the result of the therapist's own personal history or it may be only related to the horrific nature of trauma. Either way it is important for each therapist to attend to countertransference issues with each client. Wilson and Lindy (1994) note that "...countertransference can lead to empathic strain which, if unmanaged, will cause a rupture of empathy and a loss of therapeutic role" (p. 13).

According to Wilson and Lindy (1994) empathic strain can manifest in several different reaction styles of the therapist. There are four types of reactive styles: empathic withdrawal, empathic disequilibrium, empathic enmeshment, and empathic repression. These reactive styles can be divided into two categories: objective and subjective. Empathic disequilibrium and empathic withdrawal are considered objective reactions. These reactions are characterized by "...expectable affective and cognitive reactions experienced by the therapist in response to the personality, behavior, and trauma story of the client..." (p. 16). Alternatively empathic enmeshment and empathic repression are thought of as subjective reactions. These reactions "...originate from the therapist's personal conflicts, idiosyncrasies, or unresolved issues from life course development" (Wilson & Lindy, 1994, p.16). Wilson and Lindy have created a model that helps a therapist to begin to understand his or her reaction style as it relates to countertransference issues. Wilson and Lindy (1994) found that,

> elaborating a two-dimensional model for a topology of countertransference has its limitations as well as its value, and we do not mean to say that all relevant complex countertransference reactions to PTSD fit neatly into one

> of the four quadrants....Nevertheless, this model provides an important starting point, one that includes rather than excludes other descriptive dimensions and, for purposes of clinical use, establishes an important point of orientation. (p. 18)

Although the countertransference reactions of therapists are often difficult to identify, the research supports active awareness of these reactions in order to decrease the harm that can occur to therapists and to their clients.

Burnout is another concept used to identify the effects of working with a difficult population. Burnout is defined as "emotional exhaustion resulting from the stress of interpersonal contact" (Maslach, 1978, p. 56). One major distinguishing factor between burnout and the previously mentioned concepts is that burnout can occur with any client population whereas the other concepts are trauma population specific. Iliffe and Steed (2000) note that some relevant symptoms of burnout a therapist might experience are "...diminished self-concept, irritability, loss of compassion, and feelings of discouragement" (p. 395). In addition to these emotional symptoms, burnout can include physical components as well. Ailments such as headaches, recurrent colds and other stress related illnesses have been noted (Iliffe & Steed, 2000).

Each of these concepts provides a good basis for beginning to understand the impact of trauma work. However another component needs to be added that describes how a therapist copes with these effects. After exploring how trauma work affects therapists, a natural second inquiry concerns self-care skills, and the

ways in which therapists take care of themselves given the difficult nature of trauma work.

Self-care is a topic that has received very little attention in the literature. Many of the studies or writings that address self-care do so by focusing on the client as opposed to the therapist. "So much has been written about treating survivors of sexual abuse, but not until recently have sexual abuse therapists acknowledged the need to develop a certain set of practices to assist them in dealing emotionally and mentally with the traumatic stories imparted to them on an ongoing basis" (Bell-Gadsby & Siegenberg, 1996, p. 213). Of considerable interest is the minimal attention directed towards the self-care literature for both general psychotherapists and trauma therapists.

Purpose of the Study

The main purpose of this study is to provide a model of how trauma work impacts therapists based on interviews with six trauma therapists. This model will also address the self-care skills used by trauma therapists. I will identify how trauma impacts not only the professional life of the therapist but the personal life as well. I would hope that this small-scale model would be used to provide support for future research in the area of trauma therapists, which in turn could aid teaching, training, and supervision. I also hope this model and the process of participating in the study will be beneficial to the trauma therapists. Hopefully, by being able to discuss his or her work, each therapist will gain a better understanding of how this work has impacted him or her. Also by giving each

therapist an opportunity to discuss his or her self-care skills, perhaps this will assist in identifying strengths or weakness in the area of self-care.

Approach to Inquiry

The interest in interviewing, and using the data to begin to create a model of the impact of trauma work on therapists, is based in narrative theory. Narrative theory is based in constructivism, which has many different models. In general, constructivists believe that the individual creates meaning and reality. "It is our own personal truth, with its inner coherence and internal logic, that we construct" (Rosen & Kuehlwein, 1996, p. 5). The form of constructivism that was used in this project was more closely related to social constructivism, in that I the researcher was not merely a silent observer, but influenced either directly or indirectly, the responses of the therapist. The therapist's responses in turn influenced my behavior as well. Thus, what was constructed was not solely from the individual but from the interaction of the environment as well. Use of narrative theory in psychotherapy allows the client to tell and retell his or her story, and begin to construct new meanings and possibly new outcomes to his or her life. I believe that narrative theory provides a good foundation for listening to therapists' discussion of their work with trauma survivors. Perhaps through the telling of their story as a trauma therapist, he or she can make sense, draw conclusions, and affect change in his or her life as needed. Also because many therapists have limited opportunity to discuss with anyone the impact of providing therapy, allowing each therapist to talk about him or herself may be healing. And

by sharing their stories through this project, other therapists may also be able to gain new meaning and perspective about their work with trauma survivors.

A qualitative design is the most appropriate design given this theoretical approach. Narrative theory relies on the individual being able to talk about his or her experiences in an open format, which a qualitative design more clearly allows than a quantitative design. Qualitative designs can have many different forms but all are created from a similar foundation. This foundation is comprised of several assumptions that form the basis for qualitative study. First, the qualitative researcher is interested primarily in process, and secondarily with outcomes or products. Another assumption is that the researcher is concerned with meaning or how the individual makes sense of his or her experience or situation. A third assumption is that the researcher is the primary instrument in data collection and analysis. Fourth, qualitative research involves fieldwork; the researcher has to go out into the field to discover the events and the people. The fifth assumption is that qualitative research is descriptive; the researcher will describe processes, events, and experiences. Lastly qualitative research is inductive rather than deductive. The researcher is attempting to build hypotheses or theories from small pieces of information (Bogdan & Biklen, 1982).

The rationale for conducting a qualitative study on the impact of work with trauma on therapists can be found in Morse's (1991) descriptions of the appropriate use of qualitative designs. "Characteristics of a qualitative research problem are: (a) the concept is 'immature' due to a conspicuous lack of theory and previous research; (b) a notion that the available theory may be inaccurate,

inappropriate, incorrect, or biased; (c) a need exists to explore and describe the phenomena and to develop theory; or (d) the nature of the phenomenon may not be suited to quantitative measures."(p. 120). The rationale for this study is encompassed by all of the criteria. This study will attempt to create a model of the impact of working with trauma survivors on trauma therapists, as well as how the therapists respond to these effects.

Chapter Two

Literature Review

Secondary traumatic stress/compassion fatigue

The empirical literature on secondary traumatic stress/compassion fatigue is scant. The majority of the literature is theoretical. Originally, secondary traumatic stress (STS; Figley, 1991) was created to describe the effects of trauma work on first responders such as police, fire, or emergency medical personnel. As the field of traumatology grew, the need to understand the effects of trauma work on other professionals became apparent. Dutton and Rubinstein (1995) have used Figley's concept of STS to identify the possible effects of trauma work on mental health professionals. According to their model, there are three primary areas that can be affected by work with trauma survivors. These areas are psychological distress or dysfunction, changes in cognitive schema, and relational disturbances (Dutton & Rubinstein, 1995). From these anticipated areas of disturbance, Dutton and Rubinstein (1995) have created a theoretical model that explains STS reactions. The authors note four main domains of their model as being the traumatic event, the trauma worker's reaction to the event, the coping strategy of the trauma worker, and the personal and environmental aspects of the trauma workers life. According to these authors, a mental health person who works with trauma survivors will note disturbances in either one or more of these domains.

The first domain identified by Dutton and Rubinstein (1995) is the traumatic event itself. The authors believe that the number of traumatic incidences a person encounters does not matter but that it is the simple fact of facing a trauma that can lead to STS. This point becomes very important when considering that trauma therapists at times solely encounter trauma day in and day out. The very focus of the trauma therapists' work is trauma.

The second domain is the reactions of the mental health worker to the traumatic event. Given that mental health workers often work with survivors of trauma over an extended period of time, the response of the mental health worker can be quite varied. The work over an extended period of time often focuses not only on the traumatic event itself but also on the psychological response of the survivors. It can be these responses that affect the functioning of the mental health worker. Dutton and Rubinstein (1995) note that being faced with the fear, guilt, shame, rage, and hopelessness of a survivor can be overwhelming. "The complex assignment to integrate knowledge of the client's life history, premorbid (i.e., prior to the onset of current or prior traumatic event) level of functioning, tangible and social support resources, other stressors in the client's life, and personal strengths with information about the traumatic event and the client's response to it places considerable demands on the trauma worker" (Dutton & Rubinstein, 1995, p. 93). The trauma therapist not only has to be skilled in how to help clients manage strong emotions, but must also be skilled in managing his or her own emotional responses.

The third domain identified by Dutton and Rubinstein (1995) is the coping strategies of the mental health professional. The coping strategies of the mental health professional will help to determine the level of distress he or she experiences as a result of working with trauma survivors. Dutton and Rubinstein (1995) believe that the mental health worker will have coping strategies to use in private life and also ones to use in the professional arena. It is hypothesized that the more a mental health therapist uses both personal and professional types of coping the less traumatized he or she may become.

The final domain is the personal and environmental characteristics that may influence the level of traumatization of the mental health worker. Dutton and Rubinstein (1995) identify four personal factors that may impact how working with trauma survivors affects the mental health worker. Inner strength, personal or professional vulnerability, countertransference issues, and general satisfaction with personal and professional life are identified as important factors that should be addressed when conceptualizing the impact of trauma work on mental health professionals. Some environmental factors that may impact a mental health worker are personal and professional support, other personal stressors, institutional responses to trauma, and the social and political context of the mental health worker (Dutton & Rubinstein, 1995). Each of these areas can potentially inform the STS reactions of the mental health worker in either a positive or a negative direction.

Although this concept of secondary traumatic stress reaction for mental health professionals is discussed in the field of trauma, few studies have been

conducted to verify or document its prevalence or intensity. To date, there are no empirical studies that have specifically researched secondary traumatic stress. The studies that mention STS are generally measuring vicarious traumatization as the primary line of inquiry. These two concepts appear to be considered interchangeable in the current literature even though their definitions encompass different aspects of the impact of trauma work on therapists. Given the overlapping nature of these concepts, the few empirical studies available will be discussed under the concept of vicarious traumatization in keeping with the primary line of inquiry of the study, and in many cases keeping with the terminology used by the authors. A study that addresses the criteria for STS and the coping skills of the individual would be beneficial given that the model of STS encompasses not only aspects of the trauma but aspects of the therapist as well.

Vicarious traumatization

Because vicarious traumatization is a relatively new concept, the few studies that address the concept were conducted to operationalize and measure vicarious traumatization. The majority of the writing on this subject has been conceptual or theoretical in nature, and headed by the team of researchers that coined the term.

Researchers from the Traumatic Stress Institute coined the term vicarious traumatization in the early 1990s. Several studies have emerged from these researchers verifying and further defining the term, as well as providing guidance for the future on this topic. Pearlman and Saakvitne (1995) authored a book that addresses specifically the theoretical and conceptual aspects of vicarious

traumatization. The empirical studies that have been conducted support the existence of vicarious traumatization, and reveal that its effects can have a great impact on the therapist.

Working with sexual violence survivors

In a study by Schauben and Frazier (1995), 148 counselors were surveyed regarding their work with sexual violence survivors. The researchers surveyed a group of female psychologists from an organization of women psychologists, as well as sexual violence counselors from the Midwest. The participants in this study were primarily from the organization of women psychologists, White, heterosexual, in a relationship, and held Master's degrees. The two groups of participants differed in that the sexual violence counselors were younger, had lower incomes, and less education. The two groups were given several different instruments to identify how the work affected them. First, the counselors were asked about their work with sexual violence survivors. Counselors were also asked about their personal experiences with trauma. Five subscales of The Traumatic Stress Institute(TSI) Belief Scale (Pearlman & Maclan, 1993) were administered in order to measure beliefs and schemas about self and others. This scale measures the psychological needs described earlier of safety, self-trust, other-trust, other-esteem and other-intimacy.

Posttraumatic Stress Disorder was assessed using a symptom checklist from the DSM III-R. As noted earlier, Figley's Secondary Traumatic Stress disorder(STS) uses the criteria for PTSD. Therefore, this study not only addresses vicarious traumatization it also was used as a measure of STS.

Vicarious trauma was assessed by using several different scenarios and having the therapist rate the event or feeling on a five point Likert scale. Negative affect was also measured in this study by using four subscales of the Brief Symptom Inventory (BSI). The subscales measured anxiety, depression, hostility, and obsessive-compulsive symptoms, which can be common among survivors of sexual violence. Lastly, the Maslach Burnout Inventory (MBI, 1986) was given to assess levels of burnout.

Schauben and Frazier (1995) also asked two open-ended questions in their study. The first question asked about the five most difficult aspects of this work and the second question asked about the five most rewarding aspects of working with survivors. The researchers also assessed coping strategies by having the therapists endorse the coping strategies they utilized most frequently.

Schauben and Frazier found that counselors that had a high percentage of survivors on their caseload reported more disruptions in their view of themselves and others, as well as more PTSD symptoms, and more vicarious traumatization. Vicarious traumatization was not correlated with negative affect or burnout. Another finding was that there were no differences in symptoms between clinicians with or without a prior trauma history.

The final area of the study addressed coping strategies. The most commonly identified strategies were active coping (defined as doing something about the problem), seeking emotional support, planning, seeking instrumental support (defined as getting advice from someone about what to do), and humor. Schauben and Frazier (1995) found that these five most common coping

strategies were related to lower PTSD symptoms, disrupted beliefs, and vicarious traumatization. The subjects were asked to write other coping strategies that were important to them. A common theme in the strategies was performing some physical activity like exercise. The second most commonly written in response was engaging in spiritual activities such as meditating and enjoying nature. Schauben and Frazier (1995) found that the third most frequently endorsed coping strategy was to participate in leisure activities.

The importance of this study in the literature on vicarious traumatization is that clinicians' prior trauma history does not make performing trauma therapy more difficult; it is equally difficult for clinicians without a prior trauma history. Schauben and Frazier (1995) conclude based on their findings that hearing the abuse stories are what makes this work most difficult for clinicians.

This study also found that the clinician's coping strategies are very important. Clinicians with active coping styles had lower levels of PTSD symptoms, disrupted beliefs, vicarious traumatization, and negative affect (Schauben & Frazier, 1995). Although this study does provide information regarding what helps alleviate some of the difficulties in working with this population, this study could be strengthened. A more in depth qualitative inquiry would provide the reader with more information as to how the clinicians developed these active coping styles. It seems that although active coping is correlated with more positive functioning for the clinician, no information was gleaned regarding how or when the clinicians adopted these coping styles. Also it would be important to find out if the clinicians always had used active coping styles or if they developed

as a result of doing trauma work. It would also be beneficial to address how the clinician's coping styles at work were similar to or dissimilar from coping styles used outside of work in order to identify if working with trauma necessitates a certain type of coping style for longevity in this field. Another issue that could strengthen the utility of this study to the field of traumatology is further delineating the differences and/or similarities between STS and vicarious traumatization. Criteria for STS were gathered, but the syndrome itself was not discussed. Similar to other studies and articles, these two concepts were used interchangeably.

There are a few additional limitations to this study. One is that the clinicians assessed were all White and female. This study also only had clinicians that worked with survivors of sexual abuse. Other types of trauma would be important to include in future studies to help identify if there is a difference in how the clinician is impacted. Each of these limits generalizability to other trauma clinicians.

Therapist trauma history Contrary results to the Schauben and Frazier (1995) study was found in another study that attempted to operationalize and measure vicarious traumatization. Pearlman and Maclan (1995) surveyed 188 self-identified trauma therapists on several measures. The independent measure was a demographic sheet that tapped prior trauma history of the therapist, hours spent doing trauma work, and general background questions. The dependent measures used were the Traumatic Stress Institute(TSI) Belief scale, Impact of Event Scale, Symptom Checklist-90-R, and the Marlowe-Crowne Social

Desirability Scale. The TSI Belief scale was used to measure disrupted cognitive schemas. The Impact of Event Scale measures PTSD symptoms, whereas the Symptom Checklist-90-R measures general distress (Pearlman & Maclan, 1995). The Marlowe-Crowne Scale was used to assess the participants' need for approval.

Pearlman and Maclan (1995) found that on the TSI Belief scales this sample showed the least disruption of all samples studied by these researchers over several years. Therapists with a trauma history showed greater disruption than did therapists without a trauma history. They found that therapists with a personal trauma history showed more disruption in cognitive schemas such as beliefs about self and others, worldview, and esteem than those without personal trauma histories. Each of these findings was different from the findings of the Schauben and Frazier (1995) study that showed no significant differences of functioning between therapists with and without a prior trauma history.

These researchers note that more studies are needed to clarify the relationship between prior trauma history of the therapist and doing trauma work (Pearlman & Maclan, 1995); as well as questions about what specifically the therapists find traumatic about doing this work. Pearlman and Maclan (1995) also make recommendations for new therapists entering this specific field such as more training on trauma, more supervision by experienced trauma therapists, and more support.

The Pearlman and Maclan (1995) study could also be strengthened by adding a section where the clinician is allowed to further describe his or her experiences

in working with trauma survivors. This study also did not account for therapist self care. The ability to utilize self-care techniques may contribute to how a therapist is or is not affected by working with trauma survivors. This study also measured PTSD symptoms of the clinicians but did not discuss how endorsement of these items is related to STS, and how this is similar or dissimilar to vicarious traumatization.

Another limitation of this study is the low return rate for the surveys. Only 32% overall returned the packets, and only 24% were completed (Pearlman & Maclan, 1995). This low response rate reduces the generalizability of the study. The Schauben and Frazier (1995) study had a 28% response rate, which also limits its generalizability to therapists.

Another study that addressed the effects of working with trauma survivors on the therapist was conducted by Elliott and Guy (1993). Two thousand nine hundred and sixty-three professional women were asked to complete a packet of surveys. A general demographic sheet along with the Family Environment Scale, the Trauma Symptom Checklist-40, and the Object Relations Scale of the Ego Functioning Assessment Questionnaire were used. Similar to the Pearlman and Maclan (1995) study, the majority of women sampled reported some form of a trauma history. However, this study supported the Schauben and Frazier (1995) study in that the therapists with a trauma history showed no more disruption than therapists without a trauma history. Although these results sound promising for the mental health field, the discrepancy of findings between studies is disturbing. Again, this study does not allow the clinician to explore or explain why a prior

trauma history had no effect on his or her performance as a clinician. One key to beginning to understand and put in place training programs or support systems for trauma therapists would seem to rest with understanding the impact of a trauma history or some other characteristic on the therapist. As mentioned previously, an analysis of self care techniques may also provide much needed information regarding how personal characteristics have an effect on vicarious traumatization.

Additional limitations of this study include low generalizability given that many women chose not to participate for various reasons. Generalizability was not only limited to professional women but to mental health workers as well. The majority of mental health workers in the study held master's degrees in social work. Therefore, it may be unreasonable to generalize these findings to all disciplines.

Emotional exhaustion and coping Follette, Polusny, and Milbeck (1994) also have contributed to the literature on vicarious traumatization. They surveyed 225 mental health professionals and 46 law enforcement professionals on three measures: Therapist Response Questionnaire(TRQ), Law Enforcement Response Questionnaire(LERQ), and the Trauma Symptom Checklist-40. This study found that about 20 percent of both mental health and law professionals reported some type of physical or sexual abuse as children. Mental health professionals displayed a lower level of traumatic symptoms than law enforcement professionals. Both groups were found to use more positive coping strategies than the groups without a trauma history. This study is consistent with the Elliot and Guy (1993) and Schauben and Frazier (1995) that therapists with a

trauma history showed no more disturbances than those without a trauma history. It is noteworthy that law enforcement professionals with a trauma history did show more symptoms of distress than mental health professionals.

This study asked its respondents to identify the coping strategies used to do their work. The most commonly endorsed positive coping techniques were consulting with colleagues, educating self and others about abuse, getting assistance and support from others, and the using humor.

The group of workers that reported less disruption also reported using more active coping styles. The researchers did not provide information regarding whether these workers developed active coping styles as a result of this work, or if these individuals would be considered to have more of a hardy or resilient personality type. In addition, it would be beneficial to identify if the therapists used similar coping styles both a work and at home to help alleviate stress to determine if trauma therapists who remain in this field for many years use a coping style that is specific to their work environment or to the individual therapist.

Follette et al. (1994) addressed several limitations to their study. First, the study relies on all self-report measures, and there are no measures that would triangulate or provide support for the therapist's responses. There also may be some gender discrepancies in that the majority of therapists were women, whereas the majority of law enforcement professionals were men. The study does not analyze the gender differences beyond suggesting that the helping field in general attracts more women than men. This can limit the extent that the

findings can be generalized to a more diverse group in the future because not all therapists are women nor are all law enforcement professionals men. Another issue of concern for this study is the cross-sectional design, which does not enable a causal inference to be made. Despite these limitations, this study provides interesting and helpful information to this line of inquiry.

In a study by Johnson and Hunter (1997), 41 sexual assault and 32 general counselors were surveyed. They completed the Maslach Burnout Inventory, The Ways of Coping Scale, and the Beliefs and Values Questionnaire. The research found no significant differences between the sexual assault counselors and the comparison group of counselors on demographic variables, such as age, years of education, years at this job, or gender. One significant difference between the two groups was that the sexual assault counselors had a more diverse background of education than the comparison group. These sexual assault counselors could have a degree in disciplines other than psychology or social work.

The findings on the Maslach Burnout Inventory showed that sexual assault counselors endorsed more emotional exhaustion than the general counselors. On the Ways of Coping Scale, the sexual assault counselors as a group more frequently endorsed escape-avoidance as a primary coping mechanism. After completing an exploratory factor analysis on the Beliefs and Values questionnaire, the authors were able to determine that the each of the items were measuring different constructs. A multiple regression was used to look for relationships between the Beliefs and Values questionnaire and the burnout

inventory. The results for the sexual assault counselors showed that intimacy, power and safety/trust issues had a significant relationship with burnout. Since emotional exhaustion was the most commonly endorsed item experienced by the sexual assault counselors, this was used to conduct another multiple regression. Intimacy and power were found to be related to the emotional burnout scores. According to these authors, intimacy reflected difficulties in interpersonal relationships, while power reflected the difficulty counselors may experience in the advocacy role with outside agencies.

According to these authors, the results support their hypothesis that doing trauma work affects therapists greater than doing general therapy. Although this study provides a good picture of many ways that trauma therapists and general therapists differ, a next step would seem to be to begin to identify factors that play a significant role in these differences, such as past trauma history and level of support. Another area that could help to improve and provide rigor to this study would be to either use a psychometrically validated measure similar to the Beliefs and Values Inventory, or to enhance this inventory to a level that is psychometrically acceptable. In addition, because this study used surveys as the sole method, response bias is a possibility. These researchers did not provide evidence to the contrary which makes it difficult to ascertain how the results on each of the measures is deviant from or in keeping with responses from other similar studies.

Working with domestic violence survivors The one solely qualitative study that addresses the impact of trauma work on therapists was conducted by Iliffe

and Steed (2000). These researchers interviewed 18 domestic violence counselors on the ways in which each was impacted by working with trauma survivors. The study identified several areas that were affected by working with trauma survivors. According to Iliffe and Steed (2000), most of the participants identified feeling a loss of confidence in the beginning stages of work with trauma survivors. Most participants also endorsed feeling as if they were taking too much responsibility in the counseling relationship, and that each needed to learn to pull back. Iliffe and Steed (2000) also found that most of the participants felt horrified at one time or another by what they heard, and that oftentimes what they heard came back to them not only in words but also as visual representations of the trauma. These participants also endorsed common responses to hearing trauma material such as anger and physical illness (Illife & Steed, 2000). Participants in this study noted several disruptions of certain cognitive schemas consistent with vicarious traumatization. For instance, Illife and Steed (2000) found that the majority of participants felt less secure and more aware of issues of power and control. Some of the participants found they were less trusting of others as a result of working with this population. Although this study provides a good example of the rich data that qualitative studies can bring to the discussion, its main limit would be in only interviewing domestic violence counselors. Although many aspects of trauma are similar, each specific type of trauma provides a different perspective that may be important to illuminate by interviewing therapists who work with a wide range of trauma survivors. The empirical literature on vicarious traumatization is limited yet provides a good

beginning to understanding some of the results of working with trauma survivors. Countertransference is another area that may shed additional light on the impact of working with trauma survivors.

Countertransference

Countertransference has a long history in psychoanalytic and dynamic literature, and to a lesser extent in the trauma literature. One well-known researcher in the area of Holocaust survivors and their families is Danieli. In 1988, Danieli wrote about the effects of working with Holocaust survivors on therapists. This work leads the field in addressing how countertransference to the trauma material, as opposed to countertransference to the survivor, impacts the therapist. Danieli (1988) was able to identify several themes that he determined to be countertransference. These themes were defense, guilt, rage, shame, dread and horror, grief and mourning, references to death and dying, and an inability to contain intense emotions. Danieli (1988) also identified the theme of therapists struggling with being both victim and liberator. This may be a common theme for many therapists working with trauma survivors in that the therapist may feel victimized on one hand but, on the other hand, may perceive her/himself as a savior. These feelings are often confusing and overwhelming for trauma therapists. Fox and Carey (1999) provide another way to view countertransference issues in working with survivors of trauma. According to Fox and Carey (1999), collusion can occur as a result of countertransference. Collusion is when the therapist begins to work with a traumatized client, and the therapist's sense of being vulnerable is triggered and he/she defends against this

by working to lower anxiety rather than by helping the client alleviate his or her current distress. These authors believe that countertransference issues such as collusion will always occur but that it is the knowledge of it that helps the therapists to not negatively impact the client. As Fox and Carey (1999) note, "when therapists are unaware of their own internal responses, they may either over-identify with the client, seeing the world too much from his or her perspective or may under-identify, responding un-empathically or constructively to the client"(p. 189). Although these authors attend to the possible outcomes of countertransference with trauma survivors, they do not recommend ways a trauma therapist might detect when countertransference issues are occurring and how to remedy these issues.

Neumann and Gamble (1995) discussed the unique countertransference issues of therapists working with trauma survivors. Unlike the previous article, these authors illuminated the special countertransference issues that can occur in response to working with trauma survivors and how to work with these issues. Neumann and Gamble (1995) identified four common countertransference themes therapists may encounter when working with trauma survivors. The first theme is best characterized as the rescuer/hostage role. The therapist may have fantasies of being the one person who can save or rescue the client from his or her pain. In addition to rescue fantasies, the therapist can also feel like a hostage to the client's pain. In this role, the therapist feels unable to challenge or disagree with the client due to the intensity of feelings. The second theme occurs when the therapist's worldview is altered by hearing the traumatic material of the client.

Neumann and Gamble (1995) noted that, as a result of this altering of his or her worldview, therapists may attempt to minimize or discount the experiences of their clients. A third countertransference theme is the voyeuristic response. This occurs when the therapist is fascinated by the horrific stories that he or she may hear from clients. Neumann and Gamble (1995) stated that much of this voyeurism may be unconscious to the therapist, but when the therapist is aware of these feelings, guilt and/ or shame can arise. In response to this guilt, therapists can then become mean or angry towards their clients. The final countertransference theme identified by Neumann and Gamble (1995) is the "container countertransference" (p. 342). This theme occurs when the therapist becomes overwhelmed with the emotional lability of his or her client. Many times therapists are witnesses to the client's constriction and flooding of emotions as he or she begins to address the trauma (Neumann & Gamble, 1995). In response to these countertransference issues, Neumann and Gamble (1995) suggested that each therapist have supervisory support as well as organizational and collegial support. Similar to the other literature on STS and vicarious traumatization, the literature on countertransference and trauma therapy is limited. Qualitative methods may provide more of an opportunity to discuss countertransference issues, and thus aid in our understanding of the impact of countertransference issues in trauma therapy.

Burnout

In keeping with the trend of limited research, the concept of burnout has been well developed in general therapy issues, but is limited when specifically

addressing trauma therapy. Despite the limited research conducted on burnout and trauma work, the concept of burnout is discussed frequently when addressing the impact of trauma work on trauma therapists.

According to Fox and Carey (1999), trauma therapists may experience burnout as characterized by: emotional exhaustion, a sense of not being able to help the clients, developing cynicism, feeling emotionally numb, and feeling isolated. Therapists who become overwhelmed by their work may feel unable to share with colleagues their feelings, or there may be limited avenues to gain support. There appears to be a small unspoken rule that therapists, just as physicians, should be able to heal themselves, so reaching out to someone and admitting that the work is overwhelming may not be viewed as an option. Maslach (1976) writes that isolation and withdrawal often exacerbate the burnout syndrome.

As noted in the previous sections, several studies have included data on burnout. However, burnout alone has not yet been addressed in the trauma literature. One study by Brown and O'Brien (1998) explored burnout in shelter workers. Ninety-one shelter workers completed the Maslach Burnout Inventory, the Perceived Social Support Scale, the Job Stress Index, the Shelter Stress Inventory, and the COPE (measures emotion-focused and problem-focused coping styles and strategies). Brown and O'Brien (1998) found that, although the workers did not meet the criteria for burnout, they did experience moderate stress as a result of working with trauma survivors. This study also found that there was a positive relationship between coping mechanisms and burnout. For example

emotional exhaustion and depersonalization were positively correlated with the coping style of mental disengagement. These authors also discovered that perceived social support from both supervisors and family and friends was negatively correlated with emotional exhaustion and depersonalization. The results of this study supported the importance of providing supportive supervision and having a good outside of work support network. Another important result of this study is the type of coping skills used by the shelter workers. According to these findings, it is less helpful to use disengaging types of coping styles, and would appear to be healthier to stay engaged and involved to help reduce burnout. This point could possibly strengthen the idea that isolation and being withdrawn lead to higher levels of burnout, as Pines and Maslach (1976) hypothesized. However, given the correlational nature of the results, the data may also support that isolation and being withdrawn do not lead to higher levels of burnout.

In the study by Iliffe and Steed (2000), twelve of the eighteen participants identified experiencing symptoms that are consistent with burnout. Iliffe and Steed (2000) reported that the participants noted long hours with high numbers of trauma clients on their caseloads as being the primary cause of burnout. Lack of training and isolation were also cited as reasons for burnout.

This study provides a good example of a qualitative study that explores the impact of trauma work on the therapist. One limitation of the study is that the interview questions were based on criteria for vicarious trauma, and this may have been too specific to allow for information that may illuminate other types of

responses. Despite this critique, the study did produce a great deal of information that is important to the literature of traumatology, such as how specific circumstances may impact a therapist's level of burnout.

Two studies that were mentioned earlier in the review of vicarious traumatization also addressed burnout. Schauben and Frazier (1995) found that burnout was not correlated with percentage of survivors on the caseload. However, there was a strong positive correlation between percentage of survivors on caseload and PTSD, vicarious traumatization, and disruptions in schemas.

The researchers also calculated correlations using the Maslach Burnout Inventory and most commonly endorsed coping strategies. Emotional support and burnout had the most significant negative correlation. The findings also showed that active coping and planning were also negatively correlated to burnout. These findings support the hypothesis that a counselor may be less likely to feel the effects of burnout if he/she utilizes active, planned, and purposeful coping strategies.

Now that the literature shows that therapists can and often do become affected by working with trauma survivors, the next question seems to be how do therapists mediate these effects? The literature suggests that there is a strong association between trauma work and the various ways a trauma therapist may be impacted. One area that has not been accounted for in this relationship is what may intervene or help to protect the trauma therapist from effects of working with trauma survivors. One area to explore as possibly moderating or buffering

for the trauma therapist is self-care skills. It is hypothesized that a therapist's self care skills may serve as a buffer to the impacts of working with trauma survivors.

Self Care

The literature on self care of the therapist is scarce. When attempting to find self care in the databases, the majority of the literature focuses on self-care and the client. The literature on self-care and the therapist is anecdotal, theoretical, and rarely empirical. Faunce (1990) defined self-care as "...attending to all the domains of our existence: the emotional, physical, play, and cognitive areas in particular" (p. 124). Although the existing literature on self-care does address each of these domains, more in depth research is warranted to further illuminate the critical need for healthy self-care skills for a trauma therapist.

In their book, Trauma and the therapist, Pearlman and Saakvitne (1995) devote an entire section on self-care techniques for the therapists. Pearlman and Saakvitne (1995) identify supervision and consultation as being two of the most important ways a therapist takes care of self while working with trauma survivors. "We believe all therapists have an ethical as well as personal responsibility to engage in regular, frequent clinical consultation on their psychotherapeutic work..." (Pearlman & Saakvitne, 1995, p. 360). Pearce and Pezzot-Pearce (1997) also agree that sharing the work with colleagues is very beneficial. They note that "these relationships provide therapists with emotional support and the opportunity for case discussion and consultation" (Pearce & Pezzot-Pearce, 1997, p. 335).

Besides supervision and consultation, the authors suggest setting limits to the amount and extent of exposure to traumatic material (Pearlman & Saakvitne, 1995). By not allowing themselves to become over exposed to traumatic material, therapists may be less overwhelmed and better able to provide good services to their clients (Pearce & Pezzot-Pearce, 1997). Another suggestion is to attend to empathy. Pearlman and Saakvitne (1995) note that by attending to empathy with clients, therapists may be less likely to become overwhelmed with feelings, and thus do their clients a disservice. Naming reenactments is another suggestion for self-care and lowering vicarious traumatization (Pearlman & Saakvitne, 1995). Participating in reenactments with clients can feel confusing and overwhelming if the therapist is unaware of the need for this intervention with clients, and/or feels uncomfortable doing this type of work. Pearlman and Saakvitne (1995) state that naming the intervention as a reenactment and understanding its importance in trauma therapy will help the therapist to lower vicarious traumatization and to take care of self.

Setting limits within the therapeutic relationship is another self care technique that can assist in lowering or ameliorating vicarious traumatization (McCann & Pearlman, 1999; Pearlman & Saakvitne, 1995). The therapist is better able to maintain a sense of self and to not become over extended or involved by being consistent with clients regarding beginning and ending time of sessions, phone calls apart from sessions, and availability of the therapist apart from regularly scheduled sessions. Another issue to address within the therapeutic relationship is setting realistic treatment goals (Pearce & Pezzot-Pearce, 1997). Because

trauma survivors can be a difficult population to work with, it is important for the therapist to be realistic in his or her goals and desired outcomes. This work is often times slow and may be terminated before long term goals can be reached (Pearce & Pezzot-Pearce, 1997). A part of these goals is the realization by the therapist that this therapy time may not be all that the client needs. The client may need to come back later in life to revisit these issues (Pearce & Pezzot-Pearce, 1997). This does not mean the therapy was a failure or not useful but perhaps an intervention introduced at a wrong period in the clients recovery course.

Other self-care techniques that were suggested are maintaining professional connections such as, continuing education and support groups (Pearce & Pezzot-Pearce, 1997; Pearlman & Saakvitne, 1995). As noted by Pearce and Pezzot-Pearce (1997), "given the complexity and demands of this work, therapists with limited and narrow training or those who are just beginning to explore this area of work should seriously evaluate whether they have the requisite skills, experience, and knowledge to function independently" (p. 331). Not only will increased training of the therapist benefit the client but the therapist will be better able to manage some of the difficult aspects of the therapy if he or she is knowledgeable about the dynamics.

Creating balance in one's practice was another suggestion. Pearlman and Saakvitne (1995) believe that creating balance by doing other types of work besides therapy, or by working with families and couples not just individuals can help to reduce vicarious traumatization. Spirituality is another area that is

believed to be an important self-care technique (Pearlman & Saakvitne, 1995). Developing or cultivating an already existing spiritual life can help restore hope to therapists who may not feel hopeful after hearing the horrific trauma material they hear often. Saakvitne and Pearlman (1995) also support therapists participating in their own therapy as a way to care for self and lower vicarious traumatization. "The importance of personal therapy for the therapist cannot be overemphasized, and has been recommended by others as a way of remaining open to ourselves and our clients" (Pearlman & Saakvitne, 1995, p. 394). Pearce and Pezzot-Pearce (1997) concur that attending to personal issues is an important strategy to use in combating vicarious traumatization. By being aware of personal issues, therapists will better be able to assist their clients. Identifying within themselves when a client's disclosures are very close to their own, can help therapists to obtain their own therapy or to just share with someone before they harm self or their client. Maintaining a good sense of humor is suggested by Pearce and Pezzot-Pearce (1997) as a way of lowering vicarious traumatization. Allowing the therapist's personal world to be healthy and separate from their work world is another way to reduce vicarious traumatization (Charney & Pearlman, 1998; Pearce & Pezzot-Pearce, 1997). By not bringing home work, the therapist is setting boundaries and helping to maintain one area of his or her life that is relatively free from trauma material.

As mentioned earlier, vicarious traumatization disrupts five major areas of the individual: frame of reference, self-capacities, ego resources, psychological needs and cognitive schemas, and imagery (McCann & Pearlman, 1990).

Pearlman (1995) wrote an important chapter that highlighted various self care techniques that would address these five major areas. Self care techniques to help with a disruption in a therapist's frame of reference include: "...balancing work, play, and rest helps us to remain grounded in various aspects of our complex identities. Practices that renew a cherished sense of identity or that expand one's identity beyond that of trauma therapist are helpful in this realm" (Pearlman, 1995, p. 54). The next area that can become disrupted as a result of doing this work is the self capacities. These are capacities that help the therapist maintain a sense of well being and self esteem. Pearlman (1995) suggests that by meditating, praying, or journaling a therapist can reconnect or remain connected with the side of him or her self that is connected and loving towards others. This is the area where a therapist may find him or her self wanting to disconnect from clients due to the intense emotions found in trauma therapy. Ego resources are the third area that may be disrupted. These are "those inner abilities that allow us to meet our psychological needs and to manage interpersonal relationships..." (Pearlman, 1995, p. 59). Some suggestions by Pearlman (1995) for combating a disruption in this area are to give and receive supervision and to use humor to alleviate some stress. The psychological needs and cognitive schema domain address the issues of trust and intimacy. Self help strategies include professional and personal connection (Charney & Pearlman, 1998; Pearlman, 1995). Psychotherapy is often done in isolation from other therapists, especially when the therapist is in private practice. Attempting to connect with other therapists and discuss the effects of trauma work can help

lower the disruption in this area. Also, making connections with people in the therapists' private world will help to keep work and home more separate (Pearlman, 1995). Intrusive imagery is something that visits both the therapist and the client (Pearlman, 1995). The therapist must try to understand what is being triggered by the intrusive imagery as well as try to reach out and connect with others (Pearlman, 1995). Sharing that the therapist is having intrusive images allows the therapist to not suffer alone and/or to receive assistance if this becomes necessary. The intrusive images may occur either in the workplace or at home, and many times occur in both areas. The therapist will be using good self care techniques by reaching out to someone and not suffering alone (Charney & Pearlman, 1998; Pearlman, 1995). In general, although the above mentioned self care techniques are useful, a therapist could and should utilize self care techniques that are most helpful and easily accessible to them.

Bell-Gadsby and Siegenberg (1996) promote the idea that each therapist should create a "...personally relevant path of self-care" (p. 224). Each therapist will not benefit from all self care techniques, and the therapist should take time to create techniques that work for him or her. Bell-Gadsby and Siegenberg (1996) suggest several techniques that can be used. Guided meditation that is used in "...assessing, clearing, and rebalancing both the body and the mind" (Bell-Gadsby & Siegenberg, 1996, p. 224). A second technique is called metaphorical meditation (Bell-Gadsby & Siegenberg, 1996). This meditation is similar to guided meditation but focuses on helping the therapist to ward off integrating client trauma material into his or her own stories.

The empirical research on self care is rather limited in scope. Most of the literature found addresses coping strategies, not specifically self care. Although coping strategies are one form of self care, there are many other forms that are not addressed in the literature at this time. One study that was described above explored the coping strategies of therapists (Follette, et al, 1994). This study assessed coping strategies by using the Therapist Response Questionnaire(TRQ). A small portion of the questionnaire asked about various coping strategies used by the therapist. The mostly frequently endorsed coping strategies were: education related to sexual abuse, supervision, consultation, and humor (Follette, et al, 1994). Only a small group of respondents endorsed using self care techniques like meditation and yoga or prayer (Follette, et al, 1994) to lower vicarious traumatization. This study shows that most professionals use a more intellectual form of self care rather than an affective one. Sadly, this study does not provide any information regarding why a therapist may be more likely to seek intellectual avenues to address vicarious traumatization. It would be beneficial to the literature to know how therapists viewed their use of coping strategies, and whether or not these have changed as a result of working with trauma survivors for a period of time. It would also be helpful to understand why a therapist may use intellectual forms of self care like the coping strategies identified in this study versus more personal forms of self care.

The Schauben and Frazier (1995) study described previously also contained a section that addressed coping strategies and self care. In this study therapists

were first asked to respond to a 15 item questionnaire about coping. The results showed that the majority of respondents used active coping such as working to reduce the problem, seeking emotional support, and planning some form of action (Schauben & Frazier, 1995). These findings are consistent with the above mentioned study in that more intellectual forms of coping were used primarily as opposed to more affective forms of coping.

Schauben and Frazier (1995) also allowed the respondents to write in any other strategies or activities that were used to cope. Four strategies were most common: activities that promoted health, such as exercising and eating healthy; spiritually oriented activities such as meditating; participation in leisure activities; and seeking emotional support from friends and family (Schauben & Frazier, 1995). These activities are more specific than the general active or passive coping strategies that are often elicited on a questionnaire or a survey. It is noteworthy that therapists find more personal and specific self care techniques to be crucial to their coping and functioning. As with many of the studies, there was no attempt made to understand how or why these self care techniques developed. The question is still unanswered as to how these techniques may have developed over the course of a therapists' career.

There are several studies that address self care of the therapist but that are not specifically targeting work with trauma survivors. Nevertheless, the findings have direct implications for the research on self care and the trauma therapist.

Medeiros and Prochaska (1988) conducted a study on the coping strategies used by therapists working with stressful clients. The majority of clients were

diagnosed as borderline personality disorder, with the other clients ranging from depressed to psychotic. Six hundred therapists were mailed packets that included a demographic and general information questionnaire, a stress questionnaire and a coping scale. The response rate was 41%. The researchers found that therapists reported using self-reevaluation and wishful thinking, humor, optimistic perseverance, social support, seeking inner peace, and contingency control and avoidance as coping strategies when working with stressful clients. This study would be strengthened by providing the respondents a way to share how they viewed these coping strategies. Also by allowing the respondents to share about their experiences in another format other than paper and pencil measures, more information could be gleaned about the context for using these coping strategies, and whether there were other coping or self care techniques that are also used by the therapist.

Mahoney (1997) conducted a study of therapists and their self care patterns. Each therapist was given a questionnaire that asked about personal problems experienced during the past year as well as self care practices over the year. The most commonly reported personal problem was emotional exhaustion, and concern about the severity of their caseload was second (Mahoney, 1997). The self care patterns noted ranged from engaging in a hobby to religious activities. Personal therapy was a commonly reported self care strategy. Although these findings are not directly related to trauma work, the results can be used to identify techniques that help alleviate stress for the general practitioner, and may work with the trauma practitioner as well. This study was very simplistic in that it did

not go into greater detail regarding how the therapist came to use these techniques or if these techniques were used on a continuous basis or only during times of crisis. Also, as the author noted, there are some limitations to the self - selection of the respondents as well as the self-report instrument (Mahoney, 1997). Since the respondents all self-selected to participate in this study, there could be a characteristic they all share that may have direct influence on the results obtained. A random sample of respondents would help to alleviate this possible bias. In addition, a range of instruments that were not all self-report may also help to lower any response bias. Despite these limitations, this study did support therapist use of self care techniques in alleviating job related stress. Future research could begin to focus on how therapists develop these techniques.

Norcross (2000) wrote an article compiling the various self care strategies that he reports learning about directly from other clinicians, research, and his own self care techniques. He identified ten self care strategies. The first strategy is to recognize that psychotherapy can be hazardous. Norcross (2000) noted in this section that many therapists do not discuss or identify the toll of doing this work. The second strategy was to identify various techniques or strategies to use when the therapist feels overwhelmed or taxed by the work. The third was increased self awareness as one basis for good self care. Norcross (2000) stated that knowing the self is crucial. A fourth strategy was to become less tied to strategies prescribed by a particular theoretical orientation. He reported that many therapists will become attached to a theoretical orientation but that

strategies outside of this orientation may be very helpful to the therapist. The fifth strategy was to use stimulus control and counterconditioning as self care techniques. Norcross (2000) felt that therapists should alter the environment to fit their individual needs as opposed to changing their needs to fit the environment. Counterconditioning techniques were identified as diversion, cognitive restructuring, assertion, relaxation, and exercise (Norcross, 2000). Norcross (2000) commented that action oriented techniques were very effective. Reaching out to others for support or as Norcross (2000) stated "emphasize the human element" was the sixth strategy. Therapists need not view themselves as alone but should utilize the relationships available to them. Personal therapy was the seventh strategy, and was noted as being one of the most beneficial and most utilized self care technique. The eight strategy was to avoid self blame and wishful thinking. As stated earlier, Norcross (2000) believes that more action oriented techniques were more effective than these two passive examples. A call to diversify the clientele or type of work the therapist undertakes was the ninth strategy. Norcross (2000) noted that he has heeded this advice, and found it to be useful. The final strategy, and one that appears to get lost for many therapists, is to appreciate the rewards of doing this work. Norcross (2000) reminded the reader to look around and notice that most therapists feel good about this work, and find it important both professionally and personally.

In sum, the current literature on the impact of working with trauma survivors is young and growing. The literature has begun to identify concepts such as vicarious traumatization, countertransference, secondary traumatic stress, and

burnout as important areas of study. However, more attention to this area is needed. Currently practicing therapists rarely discuss or are provided with information regarding the possible effects of working with trauma survivors, nor is there much information dispersed regarding ways to help reduce or alleviate these effects (Norcross, 2000). The field of psychology provides a great amount of information regarding ways to cope for clients, but information for therapists on ways to cope with being a therapist is still in its infancy. There are theoretical writings on trauma work that include chapters and articles on the need for self-care. Although the traumatology field is growing, psychologists are still more adept at focusing on client issues and not therapist issues, especially not on issues involving the impact of trauma work on the therapist. By understanding the difficult nature of trauma work, the questions about how a therapist is coping with this work seem necessary. I will use the current information on the impact of trauma work on therapists as well as the input from trauma therapists to add to this literature. I believe that a crucial next step in the literature is to solicit directly from trauma therapists descriptions about how this work affects them professionally and personally, and how they cope with the work.

Chapter Three

Methodology

Design

There are several types of qualitative designs. Many of these designs have specific characteristics that inform how the data will be collected and analyzed, as well as how to write the finished project. This study was conducted using a modified analytic induction design. "The procedure of analytic induction is employed when some specific problem, question, or issue becomes the focus of research. Data is collected and analyzed to develop a descriptive model that encompasses all cases of the phenomena" (Bogdan & Biklen, 1982 p. 66). This procedure is often used in open-ended interviewing, which is why I believe it was the most appropriate design for my study. Analytic induction allowed me the opportunity to form an initial hypothesis, and then to begin to develop a description of the impact of trauma work on trauma therapists. Schwandt(2001) adds that analytic induction allows for a hypothesis to be created and re-worked based on the data. My process deviated from the pure use of analytic induction in that I began with a hypothesis, and did not necessarily refine it based on the individual cases but on the information gained from all of the cases. I was able to look case by case at the data, and then to look across cases to find commonalities as well as differences. The subsequent interviews were then used to further form my model (figure 1). After all the interviews were conducted, a descriptive model of the impact of trauma work on trauma therapists was

completed. Based on my initial hypothesis, the model describes the impact on the therapist as well as the self care skills developed and used to help alleviate the stress of trauma work.

Data Collection

The data were collected using face-to-face interviews. I conducted an initial sixty to ninety minute interview with each participant. I was prepared with questions to help the therapist talk about his or her experiences as a trauma therapist. I took notes during the interview and audiotaped. The audiotapes were then transcribed and later destroyed.

A week after each interview I contacted the participant again to explore any other information the person wished to share about our initial interview. This allowed the participant the opportunity to think about the interview and to possibly add more information or describe further his or her thoughts and feelings regarding subjects talked about previously. This second contact also provided for debriefing. I was prepared to provide support and resources if needed to each therapist. I anticipated that some therapists would need this second opportunity to talk further, whereas others would feel our first meeting was sufficient.

I allowed the participant to request material not to be audiotaped, but was prepared to ask if I may continue to take notes. I would have reassured the person that no direct quote of this particular section would be used in the final document. As part of the follow up contact I tried to describe in more detail how I was going to use the information they shared with me.

Participants

Participants of this study were either Master's- or Doctoral-level therapists who were currently working with clients. These therapists had at least one client who identified as a survivor of trauma. The client was a survivor who had experienced some form of trauma firsthand. For this study trauma was defined as an event, either man-made or naturally occurring, that taxes the individual's ability to cope, and results in various psychological disturbances (APA, 1994). I used my professional contacts to invite therapists to become a part of this study. I used purposeful sampling to obtain my participants as well. Purposeful sampling is when "you choose particular subjects to include because they are believed to facilitate the expansion of the developing theory" (Bogdan & Biklen, 1982 p. 67). My sample was six participants. One held a Ph.D. in psychology, four held a Master's degree in Social Work, and the sixth held a Master's degree in Psychology. Three participants identified themselves as Caucasian, one as Jewish, one as African American, and one as Bi-racial. Their age range was from early 40's to early 50's. Each participant had over five years of clinical experience. One participant identified herself as having a disability. There were five women and one man in this pool.

I contacted participants after our mutual colleague had asked for initial permission for me to call. I hoped that by having a mutual colleague, the therapist would be more likely to participate in the study as well as be more comfortable

with me since we were connected by someone. I offered to meet at an office or an area that was comfortable and private for the participant.

Data Analysis

I began my study with a hypothesis about the impact of trauma work on trauma therapists as well as the role of self care skills for this population based on my professional experiences and the current literature. Throughout data collection I modified my hypothesis based on the information from each case. At the end of data collection I was able to identify a beginning description about the impact of trauma work and self care skills for trauma therapists. I analyzed the data as an on-going process.

After an interview I transcribed the audiotape. I then read the transcript and made preliminary notes in the margin while the material was fresh. The notes I took included my first impressions that fit with my initial hypothesis as well as information that were different. I also created general codes that helped to group my data so that I could begin to develop a description about the impact of trauma work and trauma therapists' self care skills. The general codes were created based on summarizing the data provided. I did this case by case, and then looked across cases to create general codes that encompassed similar ideas where possible. This enabled me to look across cases for similarities with ease. I then created various two dimensional models to help further illustrate the connections between cases, as well as to provide a visual model of the data to aid in writing of the results. These models provided me the ability to determine if writing the results would best be served by using a case by case style or a theme

by theme style. Given the many similarities across cases, I felt writing by themes would best illustrate the complexity of the data but would also still provide the opportunity to illuminate the differences between the cases.

Generalizability

The role of this multi-person case study was not to provide a description that would generalize to all trauma therapists. I conducted this study to provide a description for the therapists that participated in the study. Some aspects of what was found may be generalizable to other settings and to other therapists. As Erickson (1985) noted, "the search is not for abstract universals arrived at by statistical generalization from a sample to a population, but for concrete universals, arrived at by studying a specific case in great detail and then comparing it with other cases studied in equally great detail" (p. 130). Although my study used only six therapists, some of the information gleaned will be applicable to the majority of therapists, but most will be specific to this small group. Erickson (1985) clarified this point of generalizability by remarking that some aspects of trauma work in this case will generalize to other situations of trauma work just by nature of commonality across humans.

My task according to Erickson (1985) was to determine "...the different layers of universality and particularity that are confronted in the specific case at hand- what is broadly universal, what generalizes to other similar situations, what is unique to the given instance. This can only be done "... by attending to the details of the concrete case at hand. Thus, the primary concern ...is particularizability, rather than generalizability" (p. 130). I identified the themes I

believed were common to the larger group of trauma therapists as well as the themes that were specific to each case and this study in particular.

Role of the Researcher

The role of the researcher in qualitative studies is explicit and involved. My role as the researcher was a vital component of the data gathered and analyzed. As Creswell (1994) noted, "... the biases, values, and judgment of the researcher become stated explicitly in the research report" (p. 147). In this study I provided information about how my past experiences affect my familiarity with the topic and the material (Creswell, 1994). By making explicit my role in the research, my values and biases become a critical part, rather than a stumbling block in understanding the experiences of the therapists.

I have experience working with trauma survivors, and this is where the interest in the impact of trauma work on therapists originated. At the time, I had no words to describe the impact on me. I realized how the therapists at my place of employment supported each other as we tried to do this hard work with trauma survivors. I also began to hear from other therapists the ways in which doing this work had affected them. This knowledge of how the work affected me was just beginning. It was not until after the birth of my first child that I could truly appreciate how the work affected me. I believe that it was a combination of new mother stress and the work I was doing that affected me. I remember needing to seek extra support from my supervisors and colleagues. I also can recall wondering if I should keep doing this type of work. I believe I was fortunate to be in an environment where I was supported and nurtured as a new trauma

therapist, or else I might have found myself transferring to a different area of therapy.

These personal factors were important for me to attend to throughout the study so that I was careful of imposing or over emphasizing similar issues from the study participants. Throughout this research, I sought support and supervision from trusted people who understood and supported my efforts, even though they did not always agree with my interpretations.

Another area that was important for me to attend to while conducting these interviews was my role as an African American female who has worked with trauma therapists. These characteristics could influence the relationship I build with the therapists in many ways. For instance my gender and race could have negative and positive meanings for each therapist. This would be an element that would be difficult to identify as that was not the focus of this study. However it is important to keep this in mind when wondering how I as an interviewer may have impacted the interviewees. My role as a therapist may have also created an atmosphere that would not have been present if I were merely a researcher without trauma work experience. This, too could have positive and negative meanings for the therapists. It would seem that I was included in this small group of trauma therapists because the assumption was that I knew firsthand what each may have been experiencing. This seems to be a positive outcome but again since this information was not directly sought, I can only speculate and leave it as a possibility. However, the therapists viewed their interactions with me, positive or negative, my role as an African American female with trauma therapy

experience is bound to have an affect. Another researcher may not have elicited the same types of responses. This is the positive and sometimes the negative of qualitative research.

In sum, this qualitative study used a modified version of analytic induction design to explore the impact of trauma work and the subsequent self care skill developed and utilized by trauma therapists. I used the information from each interview to help create and define a description of the impact of trauma work and the self care skills used by trauma therapists. I had an initial hypothesis that was modified as needed, case by case, to help inform my thoughts. Throughout the research process I kept a journal documenting important information gleaned from the respondents as well as from myself. I have provided a description of the impact of trauma work and how self care skills play a role for trauma therapists. I hope my project helps to increase support and understanding of the difficult work that trauma therapists provide.

Chapter Four

Results

The therapists

In an effort to maintain confidentiality, only a brief description of each therapist will be provided. Therapist one and Therapist five worked primarily with sexual abuse survivors but also provided therapy to survivors of other types of abuse as well. These therapists worked in settings that also served other populations. Therapist one is in her fifties, and has been working with this population for over fifteen years. Therapist four is in her forties, and has been working with this population for approximately ten years. Therapist two and Therapist three worked in settings that were trauma specific. These two therapists worked with survivors of all types of trauma. Therapist two is in her forties, and has been providing therapy to survivors for over fifteen years. Therapist three has been working with survivors for twenty years and is in his fifties. Therapist four was in private practice, but prior to this worked for an agency. The client population in her practice ranged from abuse survivors to people with disabilities. She has been working with survivors for twelve years, and is in her forties. Therapist four's case load was heavily weighted with survivors of sexual abuse, but she also worked with survivors of other types of abuse as well. Therapist six worked in an agency that saw a full range of client issues. She worked with clients who

were survivors of many types of trauma, as well as clients without a trauma history. Therapist six is in her forties, and has been doing this work for ten years.

Initial hypothesis

My initial hypothesis about the impact of trauma work on therapists was much less complex than what has unfolded here. I believed that the impact of the trauma work would be greatest at the beginning of a person's career, and that over time with increased self care skills, this impact would lessen. I also believed that each therapist would say that he or she entered this field due to a sense of altruism as I would have hypothesized for most people entering a helping field. My hypothesis also included that the impact of trauma work would penetrate both the professional and personal worlds of the therapists.

Several main themes emerged from the data. The data also illustrated the individual characteristics of each trauma therapist. This chapter will first discuss the main themes that represented a majority of the therapists, and then will address other themes that emerged, but only for a few of the therapists. As a conclusion this chapter will provide an outline of a model (figure 1) of how trauma work impacts trauma therapists and the self care skills that may be elicited.

Main Themes

Thirteen main themes emerged from the data. The main themes as explained in the previous chapter arose directly from reading and re-reading the direct transcripts. Of the thirteen, six themes were evident in what all six of the therapists said. These themes are titled skills, emotional toll, circumstances, self

care skills, and support. The next level of themes was represented by five of the therapists. These themes were opportunity, altruism, benefits, and growth. The next four main themes provided more information about individual therapists than these therapists as a group. The final level of themes is application of emotions, core values, personal history, and hope.

In addition to the main themes, the data provided information about the different areas that can be affected. These areas that can be affected by trauma work were defined as domains. The three main domains were self, family/others, and work. After continuing to read the transcripts it became apparent that each therapist found the impact of this work entering home and work. I further divided home into "family/friends", and "with the self". This occurred because some of the information provided by the therapists showed how trauma work may affect them individually, then how this work affects the therapist's relationships, and then finally how this work impacts them on the job. Although not all of the therapists clearly discussed the influence trauma work has in these three domains, it provided enough beneficial information to be included.

Skills The set of skills that these therapists identified as being a direct or indirect result of working with trauma survivors ranges from very general to a specific set of skills. For instance several therapists discussed an increased ability with certain skills in assessment of trauma survivors from working directly in therapy with this population. For example, this therapist noted that these skills are not typically acquired in training:

> From a training standpoint I feel competent in assessing individuals for trauma, and I feel that that's an area that a lot

> clinicians aren't trained in and that they don't assess for it or when they hear it they don't deal with it...I feel there is a large portion of therapists out there who don't do that, and I feel frankly pretty cool that I can do that, and I feel good about that (Therapist Four, personal communication, August 2000).

One person noted that learning how to work with a group is a skill that has been enhanced. Learning how to be a facilitator of the client's stories, and knowing how to process this with the client has also emerged. The ability to work with suicidal clients better was also noted. One therapist identified that for her it was being able to assess the clients quickly and accurately in order to determine if a referral was most appropriate to someone who would be able to work with this client for an extended period of time.

> On the other hand doing just this work has really helped me to develop an understanding of resources to offer to this client population. So that that minimizes the impact sometimes...(Therapist Five, personal communication, 8/00).

More specific skills that one therapist acknowledged were increasing in understanding, patience, tolerance, and being more tenacious in his work with this population. These skills appear to have emerged in response to the often difficult presentation of people with trauma histories, such as people with acting out behavior, personality disorders, etc..

> It has I think shaped me in being perhaps more of an advocate for consumers than I see my peers in other settings. I think it has shaped me in terms of being more understanding, more tolerant. I talk to people in private practice and they say no way would they put up with what we do, or put up with the long drawn out treatment or the repetitive attack from clients. So I think if anything it's made me a little more tenacious; sticking with clientele...(Therapist Three, personal communication, August 2000).

Larger systemic skills also were noted as being developed since working with this population. Advocacy emerged as a common skill that was born out of

trauma survivors oftentimes needing someone to fight for them at court, at home, or even at work.

> I think this is just good social work, to take on an advocacy role. Still, with clients knowing that especially in this arena they are faced with a lot of technical struggle with the other systems..foster care, the courts that kind of stuff..where I can be fairly effective far more than they can be. So negotiating the system for them is something that I'm willing to do on that advocacy level (Therapist Three, personal communication, August 2000).

One participant recognized that her voice as a woman, worker, citizen, and person outraged with violence has become louder as a result of working closely with this population. An increased political stance was also discussed as a new skill that has accompanied working with this population.

> I think it's helped me professionally. One impact is that for me to have a louder voice... one example was just last week I went to the press conference in Lansing, and the only reason I went was because I wanted to ask him why he has not signed on to the violence against women act yet and this press conference was developing this task force, this state wide task force to address the issue of GHB, and well that's all well and good and you know if you are so concerned about sexual assault and those issues why isn't your name on this legislation? And that's just, in some ways, that's really unlike who I used to be. So it has given me a louder voice I guess that is part of the impact..(Therapist Two, personal communication, August 2000).

While most of the participants noted an increase in specific skills, one therapist remarked that her confidence in her skills was decreasing. She wondered if this was directly related to the population or if it was related to age. Part of her speculation as to why her confidence in her skills has decreased was about the often overwhelming needs of the clients to know if as the therapist you are doing the right intervention with them.

> Now, feel less confident in my own skills. Second guess myself, maybe due to age but may also come with this population, being on the edge with them. Clients really wanting to know if you have done the correct thing with them (Therapist One, personal communication, June 2000)

It appears that this questioning of the therapist over time may lead him or her, in this case her, to begin to doubt her skills and her ability to work well with this population.

Emotional Toll The next main theme to emerge from the data was the emotional toll that work with trauma survivors can cause. Each of the therapists was able to discuss how this work has affected them. This emotional toll appears to occur not only at work but at home with significant others as well as personally for the therapists. This is one of the examples of how the domains of self, family/friends, and work emerged from the data. When looking at the information gleaned, although the emotional toll is great regardless of domain, the domains do provide a way for the reader to fully appreciate how far-reaching the toll can be.

The emotional toll of working with trauma survivors can be seen in all three domains of the therapist; at work, at home, and alone. The effects of trauma work on the individual, the self, can be as simple as having difficulty with the details of the stories to impacting the behavior of the therapist. One area that several therapists discussed was how this work can trigger personal issues. As one therapist noted, it has become very important for her to be able to identify what are her issues, and what are her client's issues. As these issues become more similar it would be difficult to know in the moment how to separate them.

This interaction of client issues and therapist issues led this therapist to note that part of doing good work is working to understand his or her own personal issues.

Therapist six also acknowledged that she felt more affected by her own personal issues earlier in her career.

> Other times, when it triggers other stuff, and so I have to spend energy working on my stuff. Making sure that it whatever stories I'm listening to, whatever presenting issues I'm faced with in my work with clients, that when I get home I know what is my stuff and I know what is their stuff, and so I make sure I deal with that, take care of that personally (Therapist Six, personal communication, March 2001).

One speculation about this could be that as a therapist becomes more seasoned in the field, the information heard is not as disturbing or difficult to hear, and the therapist becomes less affected and can simply work with the client. Whereas, when a therapist is new to the field, all the information is novel, and perhaps the therapist gets lost in this information more easily, and the resulting confusion or melding of issues then more directly triggers his or her own personal histories.

Feelings of responsibility were another issue identified by one therapist as being a carry over from her professional work. She noted that when she first began this work she saw people more in a victim role than as a survivor and that this lead to her taking more responsibility in the therapeutic relationship. As she began looking more closely at her personal relationships she saw this same dynamic occurring, her need or desire to take more responsibility for others than was warranted. As this dynamic began to change in her professional life she saw it changing in her personal life as well.

> I think it has come over into my personal life some earlier I was more... I took more responsibility for other people and that goes along with seeing them as a victim, you're a victim and I'm a helper, I'm more responsible. Where I think the change in how you view people in even like in my family system, the change in how I view people really has freed me from the responsibility. If you want help I'm here, if you don't well that is okay too, you have a right to be in whatever space you are going to be in. And this is not the right time for you to change, and all I can do is this piece of it. So I think that I have become less entrenched in my own thinking about my own responsibility pieces. So I am probably a lot less pushy (Therapist Six, personal communication, March 2001).

Other ways that this work has impacted the therapists is by crossing over into their personal worlds when uninvited. Some examples of how trauma work crosses over into the personal worlds of the therapists are by coming into their dreams, fear for their own children, inability to connect fully with their families, and changing their behaviors. One therapist spoke at length about trying to separate his work role from his home role and how this has been very difficult and has had a tremendous impact on him. He noted that being with clients and providing them with patience, support, guidance, and tolerance all appear to come so easily for him. However, at home he recognized that, in order to fully separate himself from his work persona, these beneficial skills are often left at work as well.

> My work persona is kind and patient and understanding and waiting and persevering and all that good stuff, and in the effort to separate work from home, sometimes leave that good stuff at work and don't bring it home with me where I certainly should. Not a good thing when I go home. My wife is not crazy about that (Therapist Three, personal communication, August 2000).

This distancing lends itself to strained, distant, and difficult relationships. This therapist appeared to have a good understanding of this process and works to change how this dynamic unfolds in his life. As he noted, he has learned to be

more conscious of what he does at home so that he can more fully participate in a reciprocal emotionally intimate relationship with his family.

> And that is kind of a tough shift to have to be here and feel like I have to do everything, and then go home and be able to go home and share. And when I am being taken care of, and that is probably one of the biggest impacts on my personal life, I'm very difficult to take care of...(Therapist Three, personal communication, August 2000).

As this therapist discussed the difficulty becoming aware of this strain occurring in his life, it led me to wonder what can happen to a therapist and his or her family when there is no awareness of this inability to fully connect with people at home. A person without this awareness may simply feel pulled and perhaps isolated at home due to this inability to connect fully. While this issue appeared to impact the family, it also impacted the therapist as an individual because he must identify the ways this work has pulled him and affected his ability to relate to others and himself.

Most therapists noted that feeling overwhelmed and tired were common responses to providing therapy to trauma survivors. These therapists noted that feeling overwhelmed was in direct response to identifying the many needs of their clients, and recognizing that these were oftentimes too much for one therapist to handle. One therapist identified that much of her work with her clients paralleled what she was providing to her own children due to the same developmental levels and needs. She was able to identify that this often feels like too much, and attempts to pull away from re-parenting with her clients. As she attempts to separate some emotions from work and home, feelings of resentment occur as her clients fight these attempts. It is clear to her that family comes first, but

oftentimes needy clients or clients in crisis are unable to respect these boundaries. This apparently leaves her feeling overwhelmed and feeling unable to continue on in this fashion.

> Not interested in doing the longer term work-because what I have found is that given the age difference between me and my students/clients most of them could be my own children. The age difference is appropriate. And what I find is that I end up reparenting. And I've had students call me from Europe when they were doing study abroad because they don't have a family, don't have a mother, and I have my own family and I have just felt too pulled in terms of having to raise too many young adult children...(Therapist One, personal communication, August 2000).

There are many different ways this work has impacted the therapist's ability to continue to do this work. One of the common effects of working with this population is noted as being a feeling of tiredness and at times feeling overwhelmed. One therapist identified this feeling of being tired as a result of having many cases in one day that were all dealing with trauma.

> I had a bad day already before that appointment because I was really feeling, I had a lot of cases, just tired and overwhelmed...(Therapist Five, personal communication, August 2000).

Another therapist commented that emotionally she feels very tired after sessions, and that she also often feels she wants to cry with her clients or for her clients.

> Emotionally, I guess the impact is tremendous and sometimes I'm very tired after a session, I'm worn out and I want to cry with my clients and I do occasionally and its difficult hearing these stories...(Therapist Four, personal communication, August 2000).

This feeling of being tired while tied to specific events for these therapists carried more of a pervasive feeling when they each spoke of it. Feeling tired seemed to carry more than just a physical connotation but an emotional one as well. I truly

sensed this when one therapist remarked how having to teach a person to depend on herself and help to increase her self esteem was something that she experienced with not just one client but many of her abused clients. How she described feeling as if this were something she had to do over and over again really put in words this pervasive feeling of being tired.

> Then not only do I have to turn around and give that to the person, but also teach that person to do that for themselves because probably no one else is going to do it now they are a grown up. And they probably shouldn't be dependent on anyone else doing it for them this late in life, so they really need to do that for themselves, and its over and over that I see it and that gets to me...(Therapist Five, personal communication, August 2000).

I wondered if the therapists felt tired from seeing the same presentation, the same effects of trauma everyday. The converse feeling like he or she could take on more was also expressed by one therapist. One person called this the superman complex, feeling invincible, able to handle whatever arises. This led to that particular therapist needing to find balance between the personal and professional life.

> And that was probably, it was the superman complex. Like I'm the be all and end all for her anyway, for this client. I'm the only one that could help her, I was naive and I was young and I wasn't playing this the way I should. But it was I think more so than what I already talked about to the exclusion of my marriage, my friendships, and everything else it became very pivotal in terms of time I was going to devote to my personal life. I was already working 12 hours a day and then these hour two hour long phone calls at home were not sitting well with my spouse. And I would just dismiss her, I have to do this, without explaining it it was like you just have to understand this, so in some ways it was a badge of courage to show how important I, I'm keeping people alive, but I lost sight of all the other important things that I also have to balance in my life. So the impact was kind of negative at this point, and it was only afterwards trying to regain that sense of intimacy with my wife that I had to really do some evaluating of what my priorities were. And in some ways it spurred me on to say you better take another look at

> how you are living your life because it was all work and that wasn't working out for the people around me (Therapist Three, personal communication, August 2000).

The ways in which this toll affects the family and friends can also be varied and great at times. One therapist identified how this work has made her a more cautious person, and how her husband is fearful she will pass this on to their daughter. She stated that she disagrees with her husband on this point and sees herself as being more pragmatic and simply helping her daughter to be more aware and careful.

> It's made me very cautious. My husband says I'm too cautious. He says I'm going to make our daughter a fearful person. I don't agree with him. I think he is naive. There are dangers out there, and bad things do happen, and that we do have to be cautious and careful (Therapist Five, personal communication, August 2000).

Another therapist shared this concern for what she has learned as a trauma therapist and how this has made her worry about her own children and that she may have become more cautious and protective of them.

> (At a) psychiatric hospital for kids and 99% of the kids had some kind of traumatic event-it was just huge amount. My children were small when I worked there, so I guess it impacted me personally because I was always afraid something would happen to them...(Therapist Four, personal communication, August 2000).

Given that many of the therapists hear about what happened to children, it is not surprising that this would affect how they view their own children and the issues of safety and protection. Another therapist provided a slightly different perspective by identifying how the emotional toll of this work has affected his relationship with his wife. One area that he noticed was in communication. He

identified that there is a work and a home persona, and the home persona is not as patient or as tolerant as the work one. He understands how this is not something his wife particularly appreciates but that it happens. This therapist also shared that his views on emotional intimacy have been shaped by trauma work and how this probably contributes to the struggles he experiences allowing himself to be cared for at home as opposed to doing the caring work. While the ability to allow himself to be cared for does not come automatically, it does occur but with a sufficient amount of self talk.

> Work is automatic for me, the home stuff still isn't.. and I've been with my wife for 25 years.. and it's not automatic for me to connect with her on an emotional level as it is here. Not that it is forced, but I have to think about it..think about not being a therapist and think about letting her take care of me..(Therapist Three, personal communication, August 2000).

One therapist shared how in an attempt to separate the work from his personal world he often leaves many good qualities at work. This inability to share these qualities appeared to be closely related to how much the therapists give to their clients, and that perhaps at the end of the day the ability or the desire to do this with other people is low. This was consistent with how one therapist views separating work from home also. He noted that he feels it is either all or nothing in terms of what he is able to provide in the form of caring. And since the majority of the day is spent providing this level of caring to his clients, it is his home life, and perhaps himself that do not benefit from this level of caring.

> I have less patience when I know the history and I know that there is not trauma back there. I have expectations that are pretty high, and I think part of dividing personal and private life...there's probably some very good parts of myself in terms

> of tolerance that I leave at work and don't take home with me (Therapist Three, personal communication, August 2000).

One therapist related that the largest emotional toll this work has taken on her is feeling as if her clients need her to reparent them, and this feels too close to what she needs to do in her personal life for her children that she has become less interested in taking on these types of clients. Her work now is more focused towards crisis intervention where she can provide support and help in the recovery process but it does not create the same type of strain that providing services to long term or ongoing clients often entails. Another toll for this therapist was found when a client is in crisis and she is also needed at home. She noted how this creates anxiety for her and can turn into resentment as she is being asked to make these types of choices. Her decision is that family comes first but this obviously can create some dissonance in that she still has a responsibility to her clients. Her attempts at managing these situations appeared to be quite dependent on her clients being able to work through the dilemma but when they are not she may be left with anxiety and decisions she does not want to make.

> I have teenage children, they have busy schedules, things are planned for them by their school, by their work, by their activities, that I cannot change. And so if I have a client in crisis five minutes before I'm supposed to go to my kids choir concerts, that produces a very high level of stress, and anxiety for me. And those kinds of situations can create in me a real sense of resentment-my family comes first and yet I have these longer term clients who have the sense that I'm their family. They have decided I'm their mom-well I'm not -when I'm able to do that with them I don't mind, but when I have my own life going on and their needing something outside of regular work stuff, I do have some resentment about that and I don't

like it...(Therapist One, personal communication, August 2000).

Many of the therapists discussed the importance of separating work and home, but as we can see now this separation is blurry and ill defined and perhaps occurs at a cost to the therapist and/or his or her relationships. Similar to balancing the physical demands of working outside of the home and inside of the home, balancing the emotional demands in these two areas is difficult. Perhaps as more workers identify that there is an emotional toll to the work they provide, more support and or information for these difficulties will be created.

Anger is one emotion that was identified by three therapists as how this work has impacted them. This anger and its source were identified directly by one therapist. The other two therapists did not identify this anger and its source in a direct fashion. The anger can stem from just knowing that there is child abuse occurring, or this anger appears to come from having to cope with the difficult information the clients bring and how clients may impede on the therapist's personal time. One therapist noted feeling "... rage at the perpetrator, still angry at abuse..."(personal communication August 2000).

Resentment seemed to grow from this anger of being contacted by the client or asked to give more of him or herself to the client in addition to what occurs in sessions.

> I really have come to resent it spilling over into my personal life-through dreams about it, having calls at home from people in crisis, its ok but I resent it spilling over...(Therapist Two, personal communication, August 2000).

Several therapists identified how this work has shown them the ugly side or the evil side of people. Hearing how people can be so vicious to each other has impacted their ability to view the world as a wholly safe and secure environment.

> Probably it impacted me personally the same way having this job for a while impacted me personally, I get a real look at the ugly side of the world. And I get a real sense that these things can and do happen to people and that people who are minding their own business sometimes get horribly and viciously attacked. That it could happen to anybody and sometimes there is just noting you can do about it. You are just in the wrong place at the wrong time and that's kind of scary. But you don't want to think about that everyday on a daily basis because you couldn't function (Therapist Five, personal communication, August 2000).

One therapist concurred, that doing this work continues to erode her beliefs in a just world. She identified that when she views people hurting others so maliciously it further strengthens her beliefs that the world is not just, and this affects her greatly.

> I think it goes down to that just world phenomenon, that will, continually.. when we work with trauma people that we are reminded that it is just not a just world. It is not fair, and even if we face it everyday in our offices, to see that as happening to lots of people, in lots of ways, still cuts at the core, and those are the times I am reminded that I want it to be a just world (Therapist Six, personal communication, March 2001).

Several therapists noted that the impact of this work could be seen in their dreams during particularly difficult cases. One person noted that at the beginning of her career the dreams were less about cases but more about her anxiety over competence to handle the cases. Whereas another therapist had dreams that were in response to the trauma material of her clients.

> I have dreams about situations..it has definitely caused me to view my own safety in a different way.. I without a doubt

> recognize my own vulnerability and I get frustrated that my husband doesn't entirely get it, as far as locking doors and that kind of thing...(Therapist Two, personal communication, August 2000).

Hypervigilance to the environment, anxiety, and inability to control the memories of the stories told by the clients were other impacts that some of the therapists identified.

> I was in the shower and heard a door closing, probably a neighbor, it startled me. I went into all the stories that begin with doors closing behind them.. far more into it, go to when startled/afraid, harder to clear those things now. I have increased anxiety around some things, like doing new things, being in unfamiliar situations, being in large groups... might not be able to move freely (Therapist One, personal communication, June 2000).

These experiences were very similar to the types of things the victim may experience after the trauma. The parallel process between the therapists growth and coping with being trauma therapists is beginning to look very similar to the recovery and healing a victim may experience.

Another common theme was feeling sad and hurt not only for what the client has or is experiencing but for the persuasiveness of abuse. One therapist in particular noted how it was the sadness that took the most out of her.

> And I truly feel sorry, I'm deeply saddened by their experience. So I think that is when it affects me personally is I have, I experience deep sadness, and hurt for the client. I've cried about my patients after work, might have to get up and go to the bathroom and collect myself, or I've cried in the session with them-I don't lose it with them, but I have gotten tearful- ...(Therapist Four, personal communication, August 2000).

Circumstances During the interviews it became apparent that the emotional toll that this work can take can be very situation dependent. For example, when asked to describe a key event in his or her career, each therapist quite easily was

able to generate an event and discuss its impact at the time and currently. Most of the therapists discussed a specific case and how that particular case has stayed with them and why. One therapist discussed how her key event was her introduction into her job and her agency, and how this has impacted her feeling supported. In each of the cases discussed it was not necessarily the entire case that stood out for the therapist but it was one particular aspect. One common characteristic of the cases was that each had a component that felt out of the ordinary or extreme for each of the therapists.

One therapist described a young girl with a disability who had very little family support. As the case unfolded over time the therapist learned more about the family dynamics which were impacting this young girl and her ability to cope with her disability. This case involved physical abuse and alcoholism. This therapist identified that one major aspect of this case that had significance for her was that she too is blind and understands completely the need for people in her life to be aware of and to attend to basic needs of a person who is blind. For example she related how this young girl's family placed her in an environment where the physical structure was always changing due to remodeling. This therapist identified how taxing this can be when a person who is blind cannot rely on the fact that her environment will be constant in terms of furniture, the walls, floors, etc. This therapist was particularly struck by how the family was unable to understand the importance of this to the young girl's well being.

> Mother was not handling the disability issues too much,, and her responses to having a child with a disability were not received well by her family. The whole family system became estranged from one another, so she was essentially isolated

> from this mother who was not coping with the child's onset of disability. And so mom started drinking, step dad was drinking all along, abusively, at some point the, paternal grandmother thought enough is enough, convinced the father to petition for custody of the child... blind 15 year old girl who saw her father three times a year now was taken from her mother. Moved to her father's who is building in his house, so part of the significance of this case is I am a blind person ...(one) of the coping mechanisms is you don't move things around because it takes too much energy to figure out where you're traveling...(Therapist Six, personal communication, March 2001).

Another case that this therapist shared was also about a person with a disability who found his environment hostile as well. This man was beaten by the police because they saw his walking cane as a weapon. The therapist noted that in each case it was the environment that was creating a great deal of the stress that these individuals were experiencing. For this therapist these aspects felt overwhelming and additive to an already chaotic and stressful life, and helped to make these cases ones she has carried with her for years.

Another therapist recalled a case where a young girl had been raped, her brother was murdered by the rapist, and she and her mother were still grieving and in a great deal of pain two years later. This therapist identified this case as being significant for her for two reasons. The first was that the facts of the case felt to her were quite horrific and not a common presentation for her clients. The other reason was that the family's level of pain was such that it was beyond normal grieving. She noted that it appeared the family had received no counseling for the event, and were not really aware that they could feel differently. This therapist felt that what the family was experiencing was far outside of what would normally be expected.

> The people who were calling me on the phone from mental health, those therapists were distraught, ... they were emotionally affected by what they heard. I read the newspaper account and the family talked to me about what they had been through. I felt very much that this was the most horrible thing I had ever heard of and seen. This family was grieving as far as I can see onwards of two years and more because they for one, had not really sought any treatment when it happened, I guess they didn't know they could or if they should or what is the difference between abnormal grieving and normal grieving, so they were still grieving bitterly, so that case still stands out for me...(Therapist Five, personal communication, August 2000).

One of the therapists recalled a case of a young boy who entered the hospital due to severe sexual abuse. The part that stood out for her was that a gun was used during the abuse by family members. She can recall how she reacted as well as how her staff reacted. Everyone's reaction was one of horror and a sense of this was way too much for anyone to handle. Again it appears to be that what caused her to recall this event was that it felt too overwhelming and outside of what she and her staff normally hear or experience.

> A child at the hospital who was held at gun point and sexually molested a number of times throughout his childhood. When we talk about the gun point I think that was the thing that blew me out of the water because there was absolutely no way the person could get free. And the other reason that description remains with me is because of the staff reacting to this intake. And a couple of times and a couple of different staff walked into my office and cried. One of the staff said to me was I would like to take a gun to that guys head. And I think the fact that there was gun point is what set everybody off...(Therapist Four, personal communication, August 2000).

Two other cases were relayed that both dealt with a child not being believed when the abuse was disclosed. This therapist noted that it was not so much that

they were not believed but that they were then punished for speaking the truth. This punishment is what makes these two cases stand out for her.

Another of the therapists recounted the story of a suicidal woman and how he talked with her on the phone for hours trying to help her stay safe. The next day the woman came to his office and gave him the vial of cyanide. He recalls leaving work with the cyanide and thinking to himself "this is odd work to say the least" (Therapist Three, personal communication, August 2000). Outside of dealing with the extreme lethality of her suicidal plan, he reflected more on the feeling of not knowing what to do with a person who was this suicidal, not telling him where she was, and feeling as if what he said or did would make the difference if she lived or died. This overwhelming sense of responsibility appears to be what marks this case in his mind.

> Lots of years ago I was working with a woman who was an adult survivor of some pretty horrific abuse I didn't know all of her history at that point I just knew that she was suffering tremendously and very suicidal.. and there was several events with her but I think the one that stands out the most was earlier in my involvement with her because it was probably my first..she was having a hard time staying at home and she was a mother of six kids..older kids, she called me from a campground at like 3 am in the morning called me at home, then I was young and naive at that point in my career and gave her my home number..and she called me and she had worked at a chemical plant, and she had some cyanide and she was going to kill herself..it was a little packet she stole from the lab..or something like that..so I, that this 2 hour phone conversation where I was envisioning her sitting in her station wagon next to a payphone in a campground someplace..I didn't know where it was she wouldn't tell me.. and we probably talked for 2 hours from 3-5 in the morning I was sitting on my kitchen floor I remember that..and what was really going through my head was, I don't know what the hell I'm doing here how am I going to keep this woman alive? She is clearly in pain and wanted me to do something for her..and

> I'm not sure what I can do..(Therapist Three, personal communication, August 2000).

This final therapist's case also supports the hypothesis that what keeps these cases fresh in a therapists mind is the sense of being overwhelmed and that this is outside of the norm, even for what these therapists hear on a daily basis. As part of her job, this therapist will go directly to the hospital to meet with people who have been sexually assaulted. This case involved an 82 year old woman who was severely beaten and raped. This therapist can recall how she felt walking over to the hospital, and what it was like to see an elderly person in this situation. She noted that the woman had not been cleaned up yet and so all of the physical signs of abuse were still visible. This case touched this therapist in how there truly must be evil in the world for this to happen. As well as touched the idea of this happening to someone elderly who for all practical purposes should be enjoying the last years of her life.

> They hadn't cleaned her up yet..she had blood coming out of her ears, her eyes were blackened, her hands had been tied and her hands were purple, it was just horrible, just bruises everywhere and I think.. you know I have no other way to explain this besides evil and you know on some level I can sort of get date rape but this I have no way to understand except evil...(Therapist Two, personal communication, August 2000).

Other cases that represented the out of the ordinary for this therapist and stay with her are the ones involving reported cult abuse. She noted how these cases stay with her because of the infrequency with which they appear but also how they impact her feelings of safety. One of the clients of the reported cult abuse expressed several times how she was frightened for the safety of the workers because she believed the cult would know she told and would want to harm the

people helping her. This therapist noted how this is not something that she will hear from other clients and thinking about her own safety from her client's perpetrators is also outside of the norm for her.

Each of these key events held a specific meaning for the therapists, and these meanings are different for each one. It also was different how the therapists coped with these experiences. But what was similar was that the cases were not the normal abuse cases that these therapists would encounter. Therefore these cases stood out in terms of the unusual circumstances, and how the therapists made sense of them, and how this then impacted his or her recalling these cases as key events, even though they may have occurred several years ago.

For one of the therapists the key event was how she was hired into her current job and the circumstances around that, and how this has impacted her ability to do her job. This therapist noted that she was told she was hired under much controversy, and this led her to believe she must prove herself as worthy of having this position. So in her words she noted that she never said no to a referral, and over worked herself. It took several years and a lot of processing before she was able to let go of this sense of having to prove herself, and realize that she could not prove herself to these people because the issue was not about her ability to do the work. She later realized the issues had very little to do with her. These realizations led her to set limits and to only do what was appropriate for her to do in this setting. This therapist recognized that these limits helped her to take better care of herself personally and professionally.

> One of the things that happened earlier in this position that what I was lead to believe, and now I'm not so sure its

> accurate, but I was lead to believe that when I started here that there was a lot of conflict in the selection committee to hire me. And that for the most part I wasn't really the person they wanted. So I came here thinking that I needed to prove something. So what it was that I did to try to prove that was to never say no, to take on every client that came in w a crisis. And I wasn't clear about the set up of my program. Who it was that I had to report to, and so the person that I thought I had to report to, had me doing all kinds of other stuff. And so I thought that was what I was supposed to do. That all sort of came to some resolution about 2 years ago in terms of my realizing that there was nothing I could do to prove myself to these people who didn't want me here. They still didn't want me here and it had nothing to do w my work and that my work was just fine and I didn't need to see twice as many clients as those who worked here. So I stopped doing that and I set some appropriate limits in terms of who I could see and who I couldn't and what I would do and what I wouldn't do. And that has really helped me in terms of self care...(Therapist One, personal communication, June 2000).

While this key event was very different from the specific cases provided by the other therapists, one element was similar which was that this situation felt out of the norm of what this therapist expected by coming to work for this agency.

I believe these examples illustrated how each therapist comes to this work with an expectation that he or she will hear and experience things that are horrific and devastating, but that there are still areas that can reach even outside of these boundaries. There are experiences that will tax the coping of a person who is expecting to hear the worst possible examples of human experiences. For each therapist the key event stood out because of a particular aspect. Each case or situation identified stood out because there was a component that felt out of the ordinary or extreme. Upon reflection, I wondered if these therapists would recount these events as trauma experiences or just part of being a trauma

therapist? Regardless of how each therapist viewed these events, it is clear that they each see the events as having an impact on them.

Self Care Skills The self care skills that the therapists have in place to handle personal crises sometimes are similar to the ones used to handle work crises but oftentimes are distinct. The self care skills that the therapists use in their personal lives range from being set to being in a state of transition. Most identified that over time their self care skills have changed, some say in a positive direction whereas one therapist noted that her self care skills have deteriorated. The range of self care skills was large. What appeared to be similar for each therapist is that self care skills are ever evolving and changing to fit life circumstances and needs.

Taking private time at home after work is one way in which a participant takes care of self. Another therapist described one of her self care skills or ways of coping is by shutting down. She noted that she will often get quiet or go away as she is trying to handle a significant stressor in her life.

> I shut down- when I have a problem I withdraw too- I become very quiet-very thoughtful- I think I sometimes get overwhelmed. So I become quiet and thoughtful to regain some ground. Sometimes it takes me days, not a hermit, but I'm in a process of trying to work things out. At night in bed, before bed, when I'm exercising when I'm on the phone with my friend or my support person I typically don't share a lot. Oftentimes I'll do it myself, the shutting down thing, the thinking thing. When I become quiet I'm really processing because with my own stuff not as good with it, and so I probably have to have that shutdown period. With someone else I can work through that with them quickly, my stuff I'm just not as equipped to deal with it. I'm just not, but yeah there is a difference...(Therapist Four, personal communication, August 2000).

Several therapists stated that eating is one way that they deal with stressors, with each of them noting that this is not necessarily their preferred method of self care. One of the therapists also noted that physical exercise is another method of coping with stress.

> I joined a health club in December and I have been there twice. So there's a ways to go on that!! The ideas are there, it's just scheduling the time to be there (Therapist One, personal communication, June 2000).

Sharing with friends and family was another way that several therapists cope with personal life stresses. One person described this as just telling her husband about her bad day not the specifics necessarily but simply sharing her feelings is helpful.

> I will say to my husband I had a really tough case but you know I never really tell him the cases- he doesn't know the cases- its really first of all none of his business, and I need to protect the client's confidentiality- and I don't think he's in a position to deal with the trauma anyway, so I just say I had a sexual abuse case and it shook me up or something- it knocked the breathe out of me or something like that- so that's about it...(Therapist Four, personal communication, August 2000).

There also appeared to be self care skills that have emerged for at least two therapists that were noted by them as being less ideal than other strategies used. These therapists noted that drinking was one form of releasing stress at home. One therapist described using a form of avoidance in his personal life when it comes to dealing with heavy material. He noted that he looks for avenues to have fun not to deal more deeply with emotions or problems. He described recreational activities, zoning out, building things, or just escaping. It appears

that his primary self care skills are the exact opposite of the types of skills he needs to use with his clients.

> Personally I escape, I go boating, I zone out, I do wood work, I drink, just ways--I don't drink a lot, I hang with my friends, what has made my friendships tend to be fun-based we do things together we don't just sit and talk..my friendships aren't like that they really are escapes...(Therapist Three, personal communication, August 2000).

One therapist identified that her self care skills were at a crisis level several years ago. She stated that since that time she has worked to increase her self care skills and sees this as an important area of her life. She stated that she tries to eat well, exercise, and to play hard. She was able to identify that part of her inability to increase her self care skills is a reflection of her lack of time away from work, her need to care for her family, and just simply putting other things ahead of herself. This therapist can clearly identify how in the past she believes she had better self care skills that entailed eating well, exercise, and rest but that her changing work role affects the time she has to devote to these.

> I would say that my self care skills were sort of at crisis level 2 years ago. Since then I have been working at improving self care skills. One of the problems that I have with self care skills is that some areas in my life over which I have very little control-... but in terms of my own personal self care it could be a lot better, a lot lot better-it just seems like that when I look at the priority list a lot of it not my choice because of the positions by my family and other responsibilities, that my needs are at the bottom in terms of what I need to do-but some of the things I have changed over the past 6 or so months is planning better-in terms of eating better, making sure I have nutritious food available to me- (Therapist One, personal communication, June 2000).

At work the self care skills the therapists use were a little different. This seems appropriate given the different setting, and perhaps the different issues

that need to be addressed. The most common form of self care for these therapists appeared to be taking a break from their schedules. For one therapist this means taking a brief walk or getting some coffee in between sessions and trying to understand what about that particular session is causing her to feel overwhelmed.

> In the moment when I'm feeling its been really difficult, I take that 10-15 minutes between sessions and go get a cup of coffee or sit by the fountain if its summer. And I find time to be alone, and what I do in that time, I process whatever piece of it...(Therapist Six, personal communication, March 2001).

Another therapist noted that she tries to distract herself and this may mean getting really busy with other work or taking a break by leaving her office. Another common coping strategy appeared to be actually writing the progress note about the case. One therapist noted that this helps to get it out of her head by writing it down. It appears that by writing down the events of the session help to diffuse the impact that session may have caused. What seemed interesting to me was to note that each therapist was rather limited or restricted in the types of self care they engaged in during work. It was unclear if these limitations are self or other imposed. I would imagine that the setting drives the types of activities a person can choose. One therapist did note that since she is at work she can't run down the hall screaming when she has a bad day, so this may speak to the limits that are natural to the work setting.

One therapist did speak of setting limits around the types of work she will engage in outside of regular work hours. She noted that while she would enjoy

participating in other trauma related teams, she finds the stress far outweighs the benefits and finally had to limit these activities.

> But I also find that things I'm drawn to in terms of extracurricular activities is all related to trauma work-this is the stuff I like-those are the kinds of books I read-I did try to get more involved with the staff here but I don't find them to be emotionally supportive. I have withdrawn from some of the professional commitments in the community that I would have done, that are related to this work-enough is enough-that is stressful for me-doing the debriefing isn't stressful to me-responding to a crisis is not stressful for me, but dealing with the personalities on the team is highly stressful to me. So I don't do it-but there is a loss in that too-not being able to do that work...(Therapist One, personal communication, June 2000).

Support Another common form of self care reported by these therapist was sharing the stories or the experience with someone else. This appears to be in a formal or informal manner but telling another person about the situation or the feelings that are being evoked by that situation are common for these therapists. This theme of gaining support from others was so prevalent that I felt it stood alone outside of self care skills.

When discussing self care skills, each therapist identified how either gaining support or not having support impacts his or her ability to manage this type of work. One therapist identified how when a particular case became too stressful and she felt overwhelmed that what helped was calling in other professionals to help manage different aspects of the case. For example, having an attorney deal with all of the legal aspects felt freeing to her. She could then be certain the client was getting her needs met, but that this therapist did not feel as if meeting all of these needs rested on her alone.

> So what I did with that, was I pulled in an attorney and actually the director of the agency that I worked with and managed it that , that way I felt like I had more support and I didn't have to take on all of it...(Therapist Six, personal communication, March 2001).

The other ways that getting support were discussed were in terms of needing to just share that the person was having a bad day or had just met with a very upset client.

> It is usually a mutual kind of thing, and I'm typically looking for an opening to share. I don't necessarily, and this may be part of being the director piece, I don't necessarily go and lean on people but I start talking with them and look for opportunities to share in a mutual kind of way. But I think it probably is fairly rare for me after a hard therapeutic day to not be able to process it on some level with somebody before I am out of here, it is not something I do at home...(Therapist Three, personal communication, August 2000).

Sometimes it appears that the conversation or the support is directly related to the case. It may be that the therapist is in need of advice or just support in his or her intervention. In other instances the support appears to be just needing contact with another human being, and not talking about trauma. One therapist stated that on a particularly stressful day she sought out another person and they talked about nothing in particular but that this was very helpful.

> Sometimes it is not a particular case that you need to regurgitate with another human being. Just for another human being to be available to you so you can say 'boy this is tough, or I'm tired, or this one got to me'. If you say it out loud maybe its less scary, or if another human being knows about it it's not so mysterious or powerful- all those kinds of things...(Therapist Five, personal communication, August 2000).

All of the therapists identified that their first action is probably to informally talk about the case with colleagues but that if they discover a more formal process is

needed they will seek this out. Some discussed paying for supervision or using a consultant to the agency to process the case. Others mentioned that their agency had a built in case conference that occurred on a regular basis that can be utilized when needed. In general, support echoed throughout these interviews as a basis for being able to continue to do this work.

> There is a natural progression-after a while gets to be a heavy burden, you never get used to it, so important to have someone to consult with--have someone to lift you up...(Therapist Five, personal communication, August 2000).

One therapist did share how she felt unsupported and undermined by her administrators, and how this affects her work and her feelings of worth as a therapist in that agency. As a result she seeks outside supervision for support.

> I feel not only unsupported, but I feel undermined by the administration here. There is a lack of caring, we are just cogs on a wheel so to speak. I tend to become less emotionally involved in certain things if I can control that, and usually I can control that...(Therapist One, personal communication, June 2000).

Although the majority of self care skills appear to be related, each therapist was able to identify specific self care skills that did not necessarily mimic another therapist. The use of support provides a common thread for all of the therapists.

The next level of themes that I identified from the transcripts were not necessarily endorsed by all six of the therapists, but for each theme at least five of the six made statements that were encompassed under these themes. Opportunity, altruism, benefits, and growth are the second level of commonality among the six therapists. As found with the first level of themes, the therapists can be viewed using the three domains I found: self, family/friends, and work.

Opportunity Five of the therapists talked about how he or she entered the field of trauma work. It was interesting to note that it was typically less plan full, and more based on opportunity or being in the right place at the right time. One interviewee noted that her interest in trauma work stemmed from a very personal case of trauma that affected the students she taught. Her recollection of the event was that, based on what she saw her students experiencing, it felt very natural for her to work with them on the grief issues. It seems that from there she felt more drawn to the field of psychology, and returned to school to quench this interest. This interviewee related that while she did not pursue a direct course of study in traumatology, she did inadvertently steer herself to working with an overly traumatized and under noticed population, people with disabilities. This work was born out of her own disability as well as her being a woman of color, and being able to identify trauma in her own history as a result of being a member of two underrepresented populations. Her account of how this transition from one career to another follows:

> I didn't choose it, it happened naturally... it was a natural response to do some grief work with them, and as time went on I found myself more inclined to hang out with the counselors than with the other teachers. And noticed that I preferred the one on one pieces, not that I didn't like teaching, I did but I naturally did counseling. And because I had that early experience, and because of who I am, as an Indian woman who is blind, I chose to do a master's in rehabilitation counseling. And people with disabilities typically have some kind of trauma story...(Therapist Six, personal communication, March 2001).

Other interviewees found that they were working in various areas of psychology or social work and had a passing interest or view of work with trauma

survivors. Some noted how the work they did with this population was rewarding and interesting, and it felt right to pursue this avenue further when the opportunity arose. One interviewee found that she was working with juveniles and found a great deal of trauma in their histories, and that gaining the knowledge there led to opportunities further down the line in this specific area. What was interesting was that she noted the interest was not necessarily there at the beginning to work specifically with trauma but it did emerge later. She stated ".. so the why is, there is no why, it just kind of fell I think but then the interest came..."(Therapist Four, personal communication, August 2000).

Another participant reported that when applying for his current job, the description of the work was not made available except that the work involved children and families. Based on this description, the position sounded good, but when it became apparent that this work specifically targeted trauma survivors, this participant noted that it did not scare him off and that is how he has remained in that position to this day.

> I don't know if coming out of school I chose to. So it wasn't necessarily a choice, although when I found out about it, it didn't change anything. It's just kind of something that happened, and I think it scared me when I found out exactly what the position was. It didn't ever occur to me to self exclude, because it was familiar (Therapist Three, personal communication, August 2000).

Altruism Although the therapists appeared to be hesitant to view themselves as altruistic, but more as people with skills who can help, altruism did surface in five of the interviews. What I have viewed as altruism in five of the therapists is the desire to help for the sake of helping, with very little identified secondary gains. I was impressed by the sentiments of several therapists that simply

expressed the desire to want to help people who were suffering. As one person commented, it was important for her to reach out and teach women that they were valuable. This statement speaks to me of someone who sees a need and wants to help fill this need based on her beliefs and desires for other women to increase their sense of worth. Another therapist simply stated she just wanted to do something about child abuse because now that she knew its prevalence, she felt she wanted to contribute in some manner to its ending. One therapist talked about the importance of doing this work for her was that she was able to understand how this impacted the victim and wanted to be an advocate for him or her to others who did not understand the impact or significance of the trauma.

> Because I recognize the impact the trauma that sexual assault has on victims and their families, and I think it's an issue that the general public doesn't understand a family member might say this happened a month ago why isn't she over it? and I feel like its important to me because I understand why she is not over it, and so I think that's probably the main reason..just recognizing the impact that that kind of trauma has and the long lasting nature of it..even the victims themselves recognizing themselves its ok that I'm not over it and I don't have to pretend to be over it to make it ok for my family member...(Therapist Two, personal communication, August 2000).

Being an aide during the process of recovery was another way one therapist discussed why this work was important to her. She noted that she finds this work interesting and stimulating but that she could also be of help to someone. While all of the therapists appear to have many altruistic qualities, one therapist explicitly noted that he did not necessarily enter this field to help. He was interested in the research side of human development as opposed to the clinical/practice oriented side. As a result of working and learning more about the

field, his desire to help others increased and now fuels what he does. This sense of just wanting to help to make an impact in the recovery of others may not be specific to trauma work but it does apparently play a large role because this was expressed by five of the therapists interviewed.

Benefits Given the emotional toll and the difficulties found in working with trauma survivors, the question of what keeps these therapists in this field becomes eminent. It seems that the answer is in the benefits that the therapists have received. The benefits of doing this type of work are not always readily apparent to outsiders, ones not working with trauma survivors. However for five of the therapists, the benefits of doing this work were many, and were often what kept each of them doing this work with enthusiasm and energy. One benefit that was noted by two participants was being able to provide a specific skill or having a niche within his or her agency. As one participant stated, being able to service her community was important and a benefit of being able to do this work.

> It also has helped fill a niche where I am at in my agency because a lot of times people come in specifically with diagnoses PTSD or adjustment disorder related to some particular event, and so the agency is happy to have somebody that is competent to handle that kind of presenting issue (Therapist Five, personal communication, August 2000).

For other participants the benefits of this work came on a smaller scale and were slightly more personal. For example one person noted that being able to work with a very suicidal client, and provide that support and be the person that helped her make the choice of living, was pivotal in keeping him in this work. This participant also noted that it gave him a sense of success and perhaps a glimpse

at how impactful his work can be on others, not just the client but her family as well.

> The whole notion of I can save lives, I was like yeah, I'm going to stay with this. So it was pivotal, in the sense that I think, one it felt very much like a big success. It was affirming of whatever skill I had at that time, and there was a rush that was connected to it, in terms of we can keep working and I kept her alive. That I know I would never get in the school of social work..so that really helped make a decision at that point in my career. That I need to stay in here because as much as it is giving of myself, which has rewards connected to it which are few and far between, but when they come through they are whoppers. So,.. and I had a few other experiences with her that were similar to that, but that I think was probably the most pivotal...(Therapist Three, personal communication, August 2000).

Another personal benefit identified by a participant was learning her limits and being able to work within them. She noted that "...it let me know what my limits are-it let me know that sometimes I need to lean on other people..." (Therapist Five, personal communication, August 2000).

A sense of being very fortunate with her life and her children and family was found by one of the participants. Hearing the horrific things that people endure helped to remind her that she is fortunate in many areas of her life, and she did not want to take that for granted.

> I hear stories, and I think wow, I am so fortunate I am so blessed my children are so wonderful, my family is so intact. I have been so at the right place at the right time in so many ways, it reminds me of what I have...(Therapist Six, personal communication, March 2001).

One interesting benefit that parallels the benefits a client may have was when one of the therapists became a participant in a program that helped to empower survivors of trauma. this therapist was learning to provide this service to her

clients by direct experience. She noted that what she gained from this specific experience and what has translated to other areas is a sense of empowerment, the very thing trauma therapists would wish to instill in their clients.

> I went through it as if I were a participant and climbed, rock climbing, ropes course, solo overnight camping thing out in God's country all by myself. So that piece was really a significant event for both professionally and personally, me connecting with what I can do and what my body can do, really empowering for me. I have had some good opportunities here...(Therapist Two, personal communication, August 2000).

This parallel process can be seen in other areas as well. It seems that at times the therapists experience similar emotions and difficulties as their clients, maybe at a different rate or depth, but that each needs to heal or recover from this experience.

Growth The many strains and benefits that each therapist has shared can be overlaid by his or her growth as a person and as a trauma therapist. Five of the therapists identified his or her growth in self care skills, impact of hearing the traumatic material, and just in general as a person. This reflection back over the course of their careers seemed to help solidify some beliefs but it also appeared to help illuminate other aspects that were at the time unclear.

One area that appeared to be consistently thought of when looking back over their careers was how their view of people and trauma has changed. One therapist noted how she sees people differently now, and how this is probably a result both of doing this work but also a result of just getting older.

> I see people differently, in the beginning I was in a different place and I saw people as more negatively in the victim role more helpless, more hopeless. And so where as now instead of having that instant response that this is a victim, I think

> about where is the resiliency factor. How did this person make it here...so I'm less into sitting with the affect in regards to the victimization, and more being proactive in getting into so how did you make it through that..and how are you making it through now. So really my focus has changed into building more and thinking empowerment, than staying with that victimization piece..(Therapist Six, personal communication, March 2001).

A changing perspective on people and the ways in which they manage their lives was noted by another therapist.

> A greater appreciation or tolerance for the diverse ways that people lead their lives..I don't hold up an ideal standard to which I measure success anymore..not wanting my clients to achieve a certain level of healing..but an appreciation on my part for the variety of ways that people recover..in a relatively ok fashion and they need not meet my expectations. Think abandoning those have been a significant change for me..I think I came in with a notion of what health looked like..and yet a lot of people don't necessarily meet that, and yet are doing ok. So I have come to appreciate the idiosyncratic nature of healing for people, and achieving a resolution and that need not look like anything I wanted for them (Therapist Three, personal communication, August 2000).

One therapist identified how her ability to become shocked by this work has decreased over time but has not led to callousness.

> Being less shocked I guess is a good way..for the majority of situations I hear about its like ok its horrible but yeah and then there are some like the 82 year old woman that are still shocking but I guess in the years of hearing stories I don't want to say that I'm not into it or have become jaded, because it still affects me, but I guess I'm not shocked..even the emotional impact, the intensity of it overall has decreased except in a few cases that come up..(Therapist Two, personal communication, August 2000).

A broader look at personal growth was also provided by these therapists. As I listened to each describe how they have grown, I was struck by the insight and level of growth that was experienced. One therapist explained how she has

changed personally over the years, and how this has impacted her work as a therapist.

> As a younger person I was less willing to, I don't know if I was less willing, but I don't think I had a developed support system that I trusted to bounce a lot of things off of. So as a younger person I think I did more internal processing for a much longer period of time, and as I have gotten older my life experience and my work experiences have increased. I use that as my first mode of operation but after that I am much more willing to brag about it, talk about it. So that is something that has developed over time..probably have increased my ability to trust too. I'm in a different place with different people so that person-environment interaction...(Therapist Six, personal communication, March 2001).

One therapist remarked that he has been working in this field for most of his adult life, and how he does not know if the changes he has experienced are a direct result of getting older or if they are specific to the job he does.

> Probably changed in a lot of ways that have to do with being older. It has been 18-19 years that I have been doing it, so just maturing in general, not so much being a trauma therapist..lots of changes not sure if it is a causal factor...(Therapist Three, personal communication, August 2000).

Lastly one therapist noted how her growth has led to her feeling more confident as a therapist with specific clients, and in general.

> I have gotten wiser especially in terms of my DID (Dissociative Identity Disorder) clients that I'm more relaxed, I don't take on as much responsibility as I did with the other client, and so I think I'm, I guess how I have changed is that I'm not as naive and I'm more confident and I feel too that I'm better able to challenge things with clients and not be so afraid to do that... feeling like I've evolved as a therapist-gaining confidence...(Therapist Two, personal communication, August 2000).

The final level of main themes were endorsed by a minority of the therapists. The themes of application of emotions and core values were discussed by four of the therapists. Whereas the themes of hope and personal history were discussed by three therapists. The inclusion of these themes was based on importance for these individual therapists, and also to help illustrate how individual differences color the findings of the six therapists as a group.

Coping with emotion-application An area that was discussed by four therapists was how doing this type of work impacts the decisions they make in regards to their families. One therapist defended how she uses her knowledge of trauma to talk with her daughter. She stated that she is not overly paranoid but that she does talk with her daughter about being aware of her surroundings, the types of people she associates with, and other safety techniques.

> I don't want to be paranoid, and I don't want my daughter to be, and I try not to go overboard. I don't think I am, But I ask her to be aware of her surroundings, and who she hangs around with, and if she goes someplace to watch her drink, and things like that (Therapist Five, personal communication, August 2000).

While this may not be different from what other parents are doing given the culture at this time, it does seem that her emphasis on certain aspects of safety may be informed by the horrific stories she hears on a daily basis.

A second therapist identified that one of her copings strategies was to create a safe and secure environment for her children. As she listened to the horrific experiences of her clients, she was able to make what appears to be a mental checklist of the ways she had created a safe environment for her children.

> The way I dealt with that is to say I have a structured environment, I have good food, I have a safe house, there is no one is abusing them in their lives and I know where they are 24 hours a day seven days a week and I know the people they are with, they are in a safe neighborhood and they don't talk to strangers, etc... so really putting in place and being sure I had some things in place for them-maybe some hypersensitivity with that-making sure things were in place for them (Therapist Four, personal communication, August 2000).

Again, perhaps this style is truly no different than many other parents. This therapist was able to identify specific areas where she may have responded to something because it triggered a story or an experience one of her clients shared with her. She also identified that she does not tell her children the stories or the exact reason why she makes her decisions, because she feels its not important to them and also she believes they don't need to know the traumatic experiences of others.

One therapist identified how her response to hearing the traumatic stories leads her to think about how she is raising her daughter, and how this will be impacted by the work she does on a daily basis. This therapist wondered if her feelings would be different if her child was a boy versus a girl, but she reasoned that they probably would not be different because trauma affects boys and girls.

The emotional toll that these therapists experience do not just affect sons, daughters, and partners but friends as well. One therapist noted that as a result of doing this work she is no longer sustained by superficial relationships. She identified that part of this change is because she is trying to heal from the work she does during the week, and that in her off time she just does not have the time

or energy to spend on superficial things. She articulately noted that if the relationship is not going to be additive, she finds no use for it at the current time.

> One of the things I noticed about my self since I've started this work, I have become much more isolated and withdrawn from other people, I have very little tolerance for superficial social relationships, they just don't sustain and interest me, and I think a lot of that is because in my off time when I'm not working I'm doing my own personal recovery work. In terms of trying to cope with the intensity, the high emotional level, the sadness and the horror of the stories I hear. So outside of work if relationships aren't going to add to my ability to cope, then I'm not much interested.. I'm an introvert anyway, so that just adds to a pattern in my life, but I've noticed it is much different now since starting this work...(Therapist One, personal communication, August 2000).

These are the ways that the individual therapists identified and articulated how the emotional toll informs decision making and their relationships with others. It would probably be fair to speculate that there are other ways in which being trauma therapists has impacted family and friends, that cannot clearly be defined and/or discussed. Although similar thoughts were expressed under the main theme Emotional toll, I created this minor theme to explicitly note how decision making can be affected, especially as the decisions are about the therapist's children. I think it is also important to identify how the impact or emotional toll of doing trauma work can be viewed as more mutually reinforcing rather than through a single causal relationship. For instance, a therapist can be personally affected by this work, and these effects can impact how he or she is in primary relationships. From there, the changes in relationships can also be viewed as then impacting the individual again, and the cycle or circle continues.

Core Values Another factor that helped to describe the therapist as an individual is the core values or beliefs the individual held that not only informs his or her life but the work with trauma survivors as well. Only four of the therapists shared core values during the interview, but these values helped to further the understanding of why trauma work is important to them.

These therapists discussed their core values or beliefs as part of what keeps them working with this difficult population. One therapist noted that it is her belief that helping one child is not in vain. So while she may recognize that she will not end child abuse completely, she can make a difference with one child and this is important to her. Another therapist echoed this sentiment by stating her belief that this is a rectifiable situation. Resiliency was discussed by some of the therapists as part of what helps them to keep working with this population. The belief was that people are resilient, and can overcome or move past this type of trauma. One therapist's spirituality plays a large role in how she views the problem, her clients, and her self. She noted that her spirituality provides the basis for her beliefs that her purpose is to help where she can, to use the knowledge that she possess to help another human being.

> Spirituality is based on my value system, my rules for living, my belief system about people, and my spirituality sustains me, it's what keeps me doing this work-it's not religion based- not based in any particular organized..where one group would be able to identify me as a member-but it is based on very deep values. What gives my life meaning and purpose is to be able to give assistance and to be able to guide people through experiences, to use the knowledge that I have...(Therapist One, personal communication, June 2000).

These core beliefs appear to serve as a reminder to these four therapists about what keeps them going and why, in addition to opportunity, this work appeals to them and satisfies them even through the difficult moments.

Personal History Another factor that three therapists discussed was the role of a personal trauma history or just his or her personal history that impacts who they are as a person as well as why they continue to do this type of work. These three therapists provided glimpses as to how past events have shaped or impacted them. For example, one therapist simply noted that she had a very sheltered life, and that hearing the types of stories that she did was completely outside of what she would have expected other people to have experienced. She related this to how hearing the trauma stories at first was very difficult because she just never really imagined or saw this side of life. Another therapist noted that the way she provides therapy to her clients, the clients she has chosen to work with, and her beliefs about recovery and healing are cemented in who she is as a person. She noted that she is a woman of color who has a disability. She further identified that it was the intersection of these characteristics, the environment's response to her, and her own response to herself and the environment that informs and impacts her work with trauma.

> Occasionally things that somebody had experienced, like my first blind client, brought back all kinds of stuff of what happened with my loss of vision. And so I thought about her a lot, but I wasn't really thinking about her as much as I was remembering my own stuff (Therapist Six, personal communication, March 2001).

The other therapist that spoke clearly about a personal trauma history noted how she is impacted by the trauma and how even now her behavior is altered from having experienced this trauma. As she relayed the traumatic event, she was able to identify having an acute knowledge of some of the emotions that her clients may share as a result of their trauma.

It seems less important whether the therapist has a specific trauma history in his or her work. What does seem to be important is for that therapist to be able to understand what is it about him or her that impacts the work that occurs with the clients. I think that these therapists are aware of what about themselves impacts and informs the work with their clients. I see this in their descriptions of core values, personal histories, and how they entered this work and how they describe what this says about them as people.

Hope In addition to the general benefits and the skills that some of the therapists identified as being reasons why each continues to stay in this field, a sense of hope, of giving hope to the clients appeared to be another part for four of the therapists that keeps them working.

One therapist spoke in a heartfelt manner about her beliefs about hope:

> There is another part of this that I really tried to impart to those clients I was working with at the time, not being in their shoes its really hard to do this, but these horrible things happen and we are supposed to survive them, life is supposed to go on, we can't totally stop functioning and become different people than we were before this happened. We are going to be affected by it forever and ever, never forget it, this going to hurt but we shouldn't stop living. And I look at what happened to that family and I look at the other families and look at some people who try to put the pieces back together of their lives and go on, and that's what should happen, if things can go well that's what should happen, and I have to try to remember that

> and I think all of us have to try to remember that...Yes, its hard but its probably, the thing I like doing the best, really, because I'm trying to reach a side that I see, trying to get them to see that they haven't done anything wrong, that they are a decent person, they have friends, they have done kind things to other people, and people like them, respond to them, and come back, so they are doing some things right but they are not counting them as valuable and when I get them to see that, that's rewarding they may be surprised by it, but there it is...(Therapist Five, personal communication, August 2000).

Another therapist echoed this sentiment, that providing hope to clients is one of the many joys of doing this work.

> I think it has just been really powerful to store that and to know that there is that kind of hope to getting on the other side of the trauma. And that in times when people are so hopeless and so desperate, just knowing that and providing them and trying to share my hope with them, that you can you will get on the other side of this, and I think that has probably been the most important part of that for me...(Therapist Two, personal communication, August 2000).

A third therapist shared what she specifically tries to impart to her clients, and how important this is to her was felt as she spoke.

> It translates very directly, the primary focus of my work is to help my clients even if just one session see that there is hope, and see that they can change. That they are not stuck where they are, that they can be come the person they want to be, they do anything that they want to , that is my general approach with clients. And in the very beginning with them is that what's happened in the past has happened to you but it is not a life sentence, it is not permanent, you can recover...(Therapist One, personal communication, June 2000).

The data collected from these six interviews was vast. There were many points of agreement by these therapists. The level of disagreement was not found so much in the answers to the questions but perhaps more so in the tone or use of emphasis by the therapist. Much of the data collected was consistent

with the literature found currently, however the results did not fit neatly into any one construct as outlined in the literature. The data from these interviews appeared to go beyond any one construct, and encompassed many elements of each.

In the next chapter, I will connect the results to the current literature. I will also provide a discussion of the points of agreement as well as points of difference between the cases. A model of the results based on the themes will also be provided(Figure 1). Finally, I will provide limitations and implications for future research.

Chapter Five

Discussion

The purpose of this study was to explore the impact that working with trauma survivors has on the trauma therapist. The literature to date is growing in this field. Although the majority of the literature exploring the effects of trauma focuses on the client, there are several constructs that address the effects found on the trauma therapist. The literature review found secondary traumatic stress/compassion fatigue, vicarious traumatization, countertransference, and burnout to address these effects on the trauma therapist.

Secondary traumatic stress or compassion fatigue is defined as the various symptoms a therapist may experience as a result of working with trauma survivors. Figley (1995) identified unwanted memories, a sudden re-experiencing of the traumatic event, feelings of detachment, difficulty concentrating, and sleep disturbances as encompassing this construct. As the therapists in this study described the emotional toll this work has had on them, some of Figley's (1995) elements of secondary traumatic stress/compassion fatigue were mentioned. However, the full range of effects were not fully captured by this particular construct.

Vicarious traumatization coined by Pearlman and Saakvitne (1995) identifies the various effects that trauma work has on the therapist as well, but this construct adds that it is the cumulative effects of this work that provides the basis

for the emotional toll taken on the therapist. In addition to the behavioral symptoms, vicarious traumatization addresses the cognitive schemas that are affected also. The therapists interviewed for this study were able to identify how they have been changed over the years by their work. However, this concept also appeared to only provide a part of the entire picture of how trauma therapists are affected by their work. The therapists in this study not only were able to identify the cumulative effects of this work, but they also identified how a specific case on its own affected them as well. Thus, combining several elements of vicarious traumatization and secondary traumatic stress disorder.

Countertransference is the reaction of the therapist to the client's responses to the material that is discussed in therapy, and to the therapist as well (Wilson & Lindy, 1994). According to this concept, the therapist's reactions to the client's trauma story may be directly related to the therapist's own trauma history, or simply to the horrific nature of the client's story. Wilson and Lindy (1994) note that regardless of the reason, the therapist must take caution to address these reactions with the client. Although some of the therapists in this study identified examples of reactions to their clients, countertransference did not appear to be the primary cause of the emotional strain each therapist mentioned.

The final concept that is often used to illustrate the effects of therapy on the therapist is burnout. Burnout is described as the emotional exhaustion that can result from close interpersonal relationships (Maslach, 1976). This concept, along with countertransference, differs from the others in that it can be used not only for trauma therapists but for general practitioners as well. The other

concepts were created to address the specific effects from work with trauma survivors. Many of the therapists in this study provided comments that could be identified as various levels of burnout. Similar to the other concepts, burnout was not the only effect noted by these therapists.

The results of these six interviews clearly illustrated how a single concept or phenomenon did not readily capture the experiences of all. What this study found was that parts of each concept fit for many of the therapists, and this supports the use of interviewing as a method for obtaining information that does not fall neatly into a category. As the previous chapter illustrated, these six therapists spoke at length about the various ways this work has affected them, and although there were many similarities, each therapist's response was unique. This uniqueness in describing similar or related experiences also illustrates the weight or importance each therapist places on his or her experiences. This point will be further illustrated during the discussion of the model that was created from the interviews.

The second area of inquiry was the self care skills of the therapist. The literature to date on self care skills is in its infancy. Researchers have studied the self care skills of the clients, but the self care skills of the therapist, especially the trauma therapist, is new and rather limited. What has been found in the body of literature is the importance of developing good self care skills for the trauma therapist (Bell-Gadsby & Siegenberg, 1996). The studies on self care skills identified various techniques such as, meditation, prayer, exercise, therapy, and setting limits and boundaries at work. Although the literature supports the use of

self care skills, no specific skill was identified as being the most beneficial to the trauma therapists. What appears to be consistent for these six trauma therapists is the use of a wide variety of self care skills, especially the use of support of others.

What becomes clear after reviewing all of the transcripts, is that there are shared experiences and feelings among these six trauma therapists. The common threads that emerged from these conversations illustrated more clearly that at least for these six therapists, there were several themes that were similar. These themes emerged as emotional toll, circumstances, skills, support, and self care skills. Emotional toll was defined as the impact of working with trauma survivors. The emotional toll could be physical, psychological, or spiritual. The toll could affect the therapist, family or home life, and/or work. The data showed that for each of the therapists, the emotional toll had many similar components. These shared components further support the literature that working with trauma survivors does have an impact on the therapist. As Radeke and Mahoney (2000) reported, "Therapists were more likely than researchers to feel that their work depleted them emotionally, and yet that it also increased their capacity to enjoy life" (p. 83). Some of the main examples of emotional toll were feeling tired and overwhelmed, feeling very sad for the clients, or identifying the "ugly" or "evil" side of human nature. Another way that one therapist noted the effects of this work was the way it impacted his family relationships. Several other therapists also noted that relationship issues were impacted by what they do for a living.

The next common theme for the six therapists was self care skills. Although each therapist was able to identify the use of self care skills, the exact nature of these skills was varied. They ranged from over eating to taking time alone, to exercise. Many of these identified self care skills echoed what the literature presented as being common self care skills. One study by Mahoney (1997) found that therapists reported using a variety of self care skills to address personal problems. Mahoney (1997) reported that, "pleasure reading, physical exercise, hobbies, and recreational vacations..." were cited most frequently by therapists (p. 14). Mahoney's (1997) study of how therapists use self care when dealing with personal problems found that personal therapy was sought by 87% of his sample. Of these therapists, women engaged in more personal therapy than men. Mahoney (1997) also found that women used other self care activities such as massage therapy and chiropractic services more frequently than men. Two areas of divergence from the literature on self care skills was use of spirituality or religion and use of personal therapy. One therapist spoke about her use of spirituality but it was more in the context of what her beliefs were regarding change. The use of personal therapy was not directly mentioned by any of these therapists. The closest responses centered around use of formal supervision.

The most consistent self care skill discussed was gaining support. This provided such a large amount of information that I allowed support to be its own main theme. This too supported the current literature on what is helpful to therapists. In an article by Norcross (2000), several self care strategies that in his words are " clinician recommended, research informed, and practitioner

tested" were identified (p. 710). One of the self care strategies that Norcross (2000) adds to the list is the use of support. Norcross (2000) noted that several studies support the use of helping relationships for mental health therapists. What is also similar to the findings of this project is that the use of helping relationships can range from peers to family. "As with any of these broad strategies, the number and range of techniques are impressive--peer groups, loving relationships, close friendships, clinical supervision, and so on" (p. 712). All of the therapists in this current study endorsed either informal or formal methods of gaining support. Use of supervision was mentioned as a way of coping with the strains of trauma work. Informal supervision, however, appeared to be the primary use of support for these therapists. This level of support ranged from seeking out a colleague for a quick "normalizing" conversation to seeking out a colleague to discuss the specifics of a case. One therapist noted that the use of formal case conference was built into her agency, and this was a second way for her to gain support from colleagues. The therapists did appear to differentiate from needing assistance on the specifics of a case from just needing to release the information they heard from a client. This particular self care skill appeared to be used both personally and professionally by the majority of the therapists. It did not necessarily seem to be the first self care skill used, but it was definitely identified as one that is used often.

Another main theme was the circumstances of a particular case. Each therapist was asked to recall a key event in his or her career. Five of the six therapists identified a case or an event. The common theme of each of these

cases was that the cases were historical, and each was filled with multiple layers. It appeared that what made these cases stand out for each therapist was the extreme amount of trauma or chaos that each case held. The feelings and behaviors that were evoked by the therapists also appeared to be similar. Each spoke either directly or indirectly of feelings of being horrified, overwhelmed, and taxed. The literature to date is directed more to the cumulative effects of trauma work, whereas these examples speak more towards the individual effect a particular case can have on a therapist. Although each therapist did discuss how doing this work for a long period of time does take its toll, the individual effects are also important to consider. Perhaps the toll is due to both cumulative and individual effects of working with trauma survivors.

The final main theme that was endorsed by all therapists was the area of skills. This theme encompassed direct therapy related skills such as assessment as well as larger more organizational skills such as boundaries and setting limits. Two therapists discussed gaining a set of skills that helped them to work with a specific subset of the trauma population, suicidal clients. Perhaps, given the nature of work with trauma, being able to identify a level of skill is another form of self care. If a therapist is able to easily identify skills that he or she has crafted, then perhaps a sense of mastery or competence is then born. A sense of competence would then seem to increase a therapist's ability to cope with or handle even the most overwhelming situations.

The next set of themes was endorsed by five of the six therapists. I viewed these themes as being able to define this group of therapists as a whole even

though each theme was not necessarily endorsed by all. These next themes were opportunity, altruism, benefits, and growth. It was very interesting to note that these therapists entered this particular field because of opportunity. No one sought out work with trauma survivors specifically. Each of these therapists was working in a different area of psychology or social work, and learned of a job opening working with survivors. Most noted that the interest in working with this population grew as more trauma survivors presented on the case loads. Although no one specifically sought work with survivors, a sense of altruism did emerge. This theme of altruism stemmed from the ways in which individual therapists discussed why they stay in this field, and why this field is important to them. Some discussed the importance of this work as wanting to help others understand their worth, to wanting to aide someone during recovery. Each of these therapists was reluctant to explicitly describe his or her actions as altruistic, but I felt this best encompassed what I heard.

As one therapist noted the benefits of this work were not always readily apparent but when they were it was wonderful. This, too, was supported by the literature. As Norcross (2000) identified, "most of our colleagues feel enriched, nourished, and privileged in conducting psychotherapy" (p. 712). Personal and occupational benefits comprised another theme. Some therapists identified benefits as the good aspects of their own life. The other benefits were noted as being able to fill a specific role in the community or agency. Another benefit was noted as being the types of things that could be learned from working with trauma

survivors, such as personal strength and power. Other benefits were noted as being more skill related such as setting boundaries and knowing limits.

Growth and change over time was the last common theme in this section. Five of the therapists were able to identify ways in which they have changed either as a result of doing this work, or just naturally independent of being a therapist. This area too is supported by the literature on how a therapist may grow and change as a direct or indirect result of working with trauma survivors. Bugental (1978) noted, "I am not the person who began to practice counseling or psychotherapy more than 30 years ago... And the changes in me are not solely those worked by time, education, and the life circumstances shared by most of my generation. A powerful force affecting me has been my participation in so many lives ...." (p. 149). This echoed what one therapist noted which is he knows that there have been changes in him, but he was unsure what exactly contributed to these changes.

The final main themes were endorsed by only four of the therapists. I viewed these themes as also being representative of this group but merging more towards individual differences. There were two main themes that fell into this area: coping with emotion-application and core values. Application of coping was defined as the ways a therapist may use what he or she has learned from working with survivors to inform parenting and relationships with others. Illiffe and Steed (2000) found that as a result of work with trauma survivors, the therapists found themselves to be less trusting of others, and more aware of power and control issues in relationships. These changes in beliefs can lead a

person to alter how he or she may have previously engaged in relationships. Three of the therapists spoke about parenting issues and how these are specifically impacted by the types of stories they have heard during their careers. One therapist illustrated this main theme by discussing how she views relationships, and how this is directly a result of the work she does on a daily basis. The core values theme was derived from the information provided about beliefs that helped the therapist remain in this field. This theme ranged in examples from spiritual beliefs to beliefs about resiliency. Although this theme was discussed less than others, the information gleaned was important enough to warrant its own category and should be used to represent this group of trauma therapists. Norcross (2000) supported this point in his article by reminding therapists to recall why each entered the field, and that most therapists feel their work is beneficial and satisfying.

Two main themes that I viewed as being more related to individual differences were personal history and use of hope. Each of these themes was endorsed by half of the therapists. The personal history category encompassed the sharing of personal information in regards to a trauma history by the therapist. This information was not directly sought but was provided during the interview by three therapists. Although only one therapist provided a direct example, it was important to note that at least half thought about the ways in which a personal history may impact or affect work with trauma survivors. The literature on trauma therapists often questions the existence and the impact a personal trauma history may have on the individual therapist (Elliot & Guy, 1993; Pearlman & Maclan,

1995; Schauben & Frazier, 1995;). This project did not support or refute this body of literature which has mixed findings regarding the possible impact. This project did however provide support for the speculation that a trauma history may play a role in how, and why, a person works with trauma survivors.

The final theme identified in this study was hope. This theme was created to incorporate the three therapists remarks on how they use hope in their personal and professional lives. Hope was viewed as something that is instilled as well as cultivated. It was also discussed as something that was found in the therapist, and how it sustains them when doing this work begins to take a negative emotional toll. Schauben and Frazier (1995) allowed each respondent to write in coping strategies that were used most often. Spirituality was one of the most commonly written coping strategies. The therapists in this study who discussed hope, identified hope as being a feeling they have or something they hope to instill in their clients. This category while not directly mentioned appears similar to a sense of spirituality identified in the Schauben and Frazier (1995) study.

The differences between the therapists can be noted as themes that were not addressed by all. One therapist did not identify areas that fit under the opportunity, benefits, or personal history themes. This therapist's comments were found to be more geared to the difficulties she encountered in her work setting. This therapist appeared to feel less supported and more alone in her work environment than was mentioned by the other therapists.

A second therapist's comments met all the criteria for the themes except for the core values theme. This therapist was noted as being quite insightful into her

work with trauma survivors. This particular therapist spoke a great deal about the political voice that was born out of working with trauma survivors, and how she was usually not a very out spoken person. This specific change in self was not noted by other therapists.

Therapist three did not provide comments that fit in the hope, coping with emotions, or personal history themes. What appears to separate this therapist from the others is gender. Although many of his comments were similar to the other therapists, it was noted that he appeared to take on a more active role than his counterparts. Perhaps this was related to gender or merely personality differences. Future research would do well to address these gender issues more fully.

Therapist four's comments encompassed all the themes except for the hope theme. Although no specific comments addressed hope, this therapist's tone and what appeared to be underlying sentiment was hopeful. Similar to therapist two, this therapist was very expansive and elaborate about her work and it's meaning to her.

Therapist five's comments did not address growth, personal history, or core values. This therapist appeared more reserved and introspective and was provided with prompts to help elaborate on comments. This reserved nature appeared to be more personality type than wariness of the research or researcher. However, given that the focus of this study was different, this was not addressed directly.

Therapist six's comments were encompassed under all categories except for hope, altruism, and coping with emotion. This therapist was quite open and elaborated a great deal, thus her not discussing these areas appeared to be due to a different focus in her comments. Therapist six focused a great deal on the interactions between herself and her clients, and the ways this affected her.

These differences among the therapists are difficult to identify as being more than just personality differences, and/or differences in emphasis based on the questions asked. However, these differences may warrant further research. The differences between male and female therapists would be an important addition to the literature. Research on the impact of individual differences specifically in the area of trauma may also be of importance. Although this study did not identify any differences based on client population served or type of agency, these would also be interesting lines of future inquiry.

The Model of the Impact of Working with Trauma Survivors on the Trauma Therapist

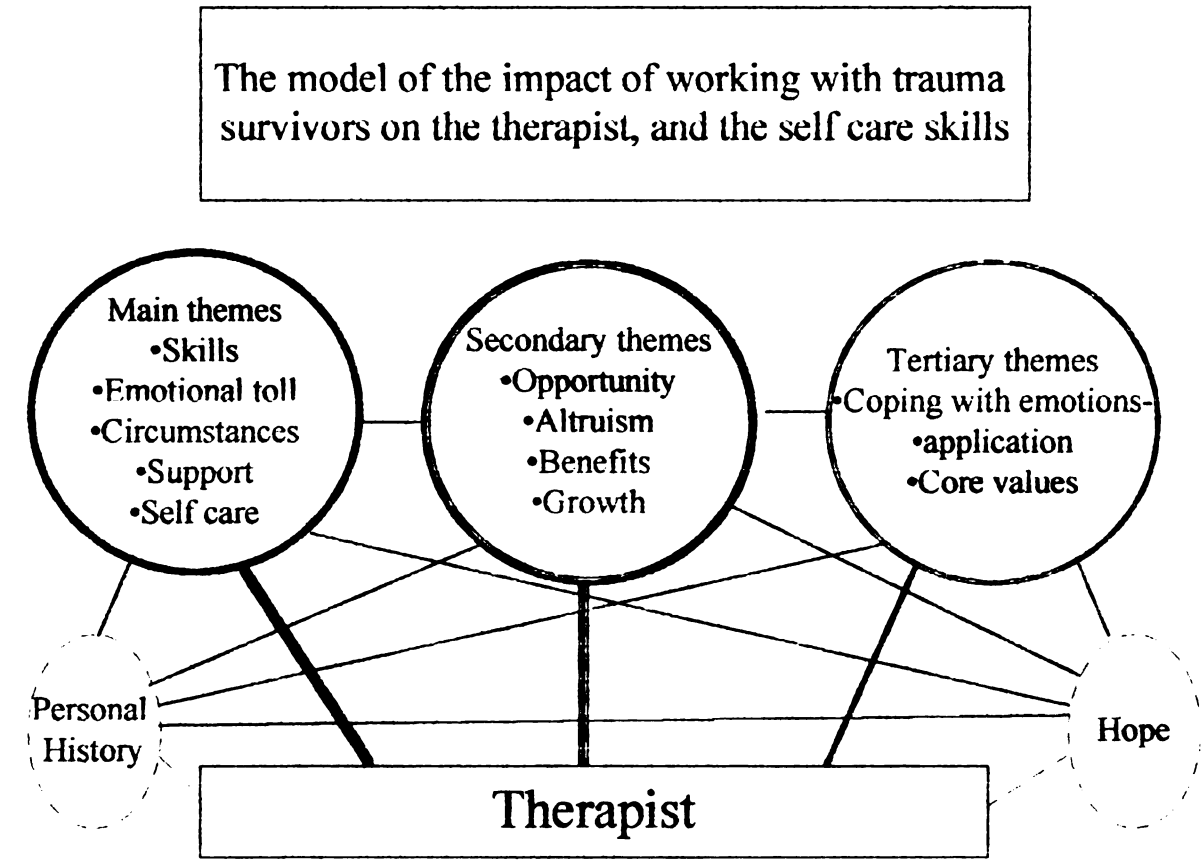

Figure 1

The model (figure 1)

In sum, this model of how trauma work impacts these six therapists, and their self care skills is mutually reinforcing rather than a single causal relationship. Emotional toll, circumstances, support, self care skills, and therapy skills were main themes that provide information about these six therapists, how this work impacts them, and how they attempt to cope with the effects. Each of these main themes appeared to interact with each other, leading to a more mutually reinforcing model for these therapists. The other main themes should be used to further identify common themes that can be found among these trauma therapists but do not fully include them all. Although the results showed the similarities among the therapists, the weight that each therapist would place on these themes was not determined. Therefore, it would be in error to assume that each therapist would place the same weight or importance on the same main themes. Given that each of these therapists have remained in the field thus far, it would seem that more weight is placed on the positive aspects of this work rather than the negative aspects. But within the positive aspects there are several, and thus the importance for each therapist may be different.

In addition to the previously identified themes, the issue of parallel process became apparent when viewing the data. There were several times when the effects on the therapist appeared to parallel what generally occurs for the client during the process of therapy and recovery. For instance, a client may have an increase in symptoms related to the trauma, then as therapy progresses the client is assisted in developing new skills and strategies to address these symptoms.

The client is provided ways to receive support from others who have experienced similar traumatic experiences. Several therapists identified these similar experiences in their work with trauma survivors. There at first is the emotional toll of this work, and then the therapist learns to develop and utilize more effective coping and self care strategies. The self care skill support is identified as being the most utilized by the therapists, which is similar to the client seeking out others with similar experiences. The need to talk with others who have had similar experiences is shared by the therapist and the client.

Another example of the parallel process was when one therapist identified that the work she does with her clients often mimics the types of parenting strategies she uses with her own children. She identified how this is quite difficult to endure given the difficult and taxing nature of both trauma therapy and parenting. This therapist noted that the similarities are there due to the clients being close in age to her children both chronologically as well as emotionally.

These examples of a parallel process provide good information about the needs and experiences of the trauma therapist. This information can be used to inform new therapists of possible effects of doing trauma work. Training and supervision may also benefit from understanding the presence of parallel processes in trauma work.

Interaction of domains and themes

Domains	Themes		
	Main	Secondary	Tertiary
Self	X	X	X
Family/friends	X	X	X
Work	X	X	X

X Heavily weighted
X Less weighted

Table 1

Another layer of this model was where each therapist identified the main themes as occurring(Table 1). The three domains identified were self, family/friends, and at work. Although several therapists differentiated how each of these domains were impacted, there was no overriding consistency among the therapists in this area. Table 1 provides a visual clarification of how each of the three main themes(see Figure 1) may be captured in the three domains. Therefore, the model provides clarification that work with trauma survivors affects the therapist in all three domains, but that there is not a consistent pattern that emerged. What this information does provide, is the knowledge that trauma work can invade all areas of a therapist's life, and should be monitored.

Returning to my initial hypothesis that work with trauma survivors would have an impact on trauma therapists, and that their self care skills would help lessen this effect, I realize now that I was initially too simplistic in my thinking. This many level interactional model supports a more complex relationship than cause and effect. I believe that in addition to my initial hypothesis being too simplistic, so too

is it simplistic to believe that the effects of trauma work can be encompassed by one construct or theory. As noted earlier, these therapists identified many aspects of all of the constructs that were created to identify the effects of trauma work on the trauma therapist. Therefore, it would stand to reason that the prescription or the intervention for the therapist, would also be multi-faceted and varied. This supports the literature on self care skills which as reported previously, states that no one self care strategy is more beneficial, but that it is important for the therapist to be comfortable with the self care strategies that are chosen.

Limitations

There were several limitations that I identified as being specific to this project. First, the pool of therapists was identified through personal and/or professional contacts. This group of therapists may have more in common with each other than another group of therapists as a result of my contacts and relationships. Although the therapists did not necessarily know each other, they each knew of another person who is a contact of mine. This could have impacted my findings indirectly by including a common characteristic of the therapists that could change the findings. A second limitation of this project is that all of the therapists are from either central or western Michigan. This could have implications for the standard of practice that is provided in these areas. Perhaps therapists from other regions would have a different set of norms by which they practice which may influence responses to the questions. For example, the prevalence of managed care, length of time trauma survivors engaged in therapy, or multiple

agencies that specifically served trauma survivors. These regional differences could influence how a trauma therapist views his or her work. A third limitation is specific to interviewing. Although every attempt was made to provide consistency among interviews, these interviews were not standardized. There may have been subtle differences between the interviews that led to different responses or disallowed certain responses. A fourth limitation may be the types of questions used during the interviews. This can have both positive and negative effects. I provided clarification as needed to each therapist during the interviews but recognized that each question was essentially left to the individual interpretation of the therapists. Although the questions appeared to be rather straightforward, the individual interpretations could have resulted in different responses that had little to do with the information gleaned and more to do with the way in which the question was asked. A fifth limitation for this project is the lack of more male therapists. Although there tends to be more female therapists than male therapists working with trauma survivors, the unique experiences of the male trauma therapist should be identified. Perhaps if more male therapists were used in this study, more could be said or learned about these unique experiences. The sixth limitation is generalizability. Although the aim of qualitative designs is not to provide a statement that is generalizable to the greater population, generalizability can be extended to a smaller group (Erickson, 1985). This project illustrated the impact for this specific group of trauma therapists, and should be viewed with caution as representing the entire population of trauma therapists. However, given that there is literature support from quantitative designs that do support

some of this project's findings, some of the characteristics of these trauma therapists can help inform, in part, how the impact of work with survivors can be seen in other therapists. Firestone (1993) provides support for qualitative designs having adequate generalizability, especially when the researcher uses the data to generalize to a theory, and not necessarily to a population. Firestone (1993) refers to this as analytic generalization. He notes that,

> Analytic generalization has more promise, partly because there are more ways to make links between cases and theories. One can look for threats to generalizability within cases. Critical and deviant cases can be used to explore or extend existing theories (p. 22).

This definition of generalizability is fitting for this project in that I used the various cases to illustrate how the current concepts, regarding the impact of trauma work on trauma therapists, possibly do not provide the full explanation for what occurs for trauma therapists alone. Therefore, the issue of generalizability becomes less prominent under Firestone's (1993) use of analytic generalization.

Implications

This project does provide implications for future research as well as ideas that could be incorporated in trauma training workshops and in educational settings. Future research would benefit simply from more projects that addressed the needs and concerns of therapists who work with trauma survivors. This field is growing, and the hope is that this area will gain more knowledge that can be used to support these therapists. Radeke and Mahoney (2000) illustrate this point by the following statement:

> Persons considering a career in psychotherapy should be informed that it will be likely to result in changes in their personal lives. Their development may be accelerated, their emotional life may be amplified, and they are likely to feel both stressed and satisfied by their work. In continuing professional education, there should be a sensitivity to the demands of clinical work and the complexities of life as a practitioner. Given those demands and complexities, therapists should be encouraged to prioritize their own self-care and to establish networks of support for one another (p. 83).

Given that an emotional toll was found among these therapists, education regarding the possible hazards of this type of work, and identified buffers would be warranted. This could come in the form of basic master's or doctoral education, or in trauma specific workshops and conferences. A review of self care skills and the importance of cultivating these would also be beneficial in the training of new therapists. Another area that was briefly touched on by this project was the agency or administrative support that is needed by therapists working with this population. Several studies provided support for administrative support of trauma therapists (Kramen-Kahn & Hansen, 1998; Pearce & Pezzot-Pearce, 1997). Issues such as supervision, collegial support, vacation, and work hours may be ways that an agency could provide support for therapists. It also

seems that providing a built-in informal or non case-driven group supervision would fit well with what these six therapists identified as means of coping.

Future research would also benefit from a longitudinal study that addressed where these therapists are in regards to work as well as self care skills in a year from this study. This would help identify what keeps people working in this area, and would also provide beneficial information regarding what is helpful in regards to education, the agency, and peer support in helping people stay in this field.

Conclusion

The task of interviewing these six therapists was intriguing and inspiring. Listening to the open and honest stories of the therapists, and how this work affects them was fascinating. The ways in which each of the therapists made sense of their experiences both the positive and the negative was commendable. It was clear that doing this type of work had many drawbacks yet each found ways to stay engaged and helpful to the clients. The desire to help others who were in crisis was apparent. It also became increasingly more clear that each therapist held a great deal of respect and admiration for the types of adversities the clients overcame. The sense of being privileged to be a part of the recovery process was also evident. Through this project I became aware that for these six trauma therapists this was not just work to be done but it was work that they were passionate about, and work that they each felt was truly important not only to them but to their clients as well.

APPENDICES

APPENDIX A

Consent Form

Consent Form

You are being asked to participate in a research project, which will provide information about the impact of working with trauma survivors on the clinician. Brooke VanBuren-Hay from Michigan State University is conducting this project. The project involves a face-to-face interview that will last approximately ninety minutes. Each participant will be contacted one week later for follow-up. This second contact will be done by phone. During the interview, you will be asked about your work with trauma survivors, and its impact on you. All interviews will be audiotaped, and notes reflecting therapist responses will be taken during the interview by the researcher. Your name will not be on the audiotape or interview notes. Audiotapes and notes will be identified by codes assigned to interviewees. Your privacy will be protected to the maximum extent allowable by law. Audiotape responses and interview notes will be kept in a locked cabinet while not in use. Audiotapes will be destroyed once data have been transcribed, and tapes are no longer useful.

Your participation is voluntary, you may refuse to answer any question and you may withdraw from the study at any time. If during the interview you choose to share information that you do not want audiotaped, the recorder can be turned off. A summary of the results of this study can be requested by contacting Brooke VanBuren-Hay, M.A., 927 Cleo, Lansing, MI 48915 after July 2001. If you have any concerns about this research project, you can contact Brooke VanBuren-Hay at (517)485-1795 or at the above address. Any concerns or questions regarding your role and your rights as a subject should be directed to: UCRIHS Chair: David E. Wright 355-2180.

Please sign both copies of this form, keep one for your records and return the other one to the interviewer.

I,_____ (Print), voluntarily agree to participate in a study about the impact of working with trauma survivors. As a participant in this study, I will meet with a researcher from Michigan State University for an interview that will last approximately ninety minutes, and I understand the nature of the questions that will be asked during this interview. Brooke VanBuren-Hay will contact me one week later for follow-up. Interviews will be audiotaped and the researcher will take notes during the interview.

_____

(Signature) (Date)

APPENDIX B

Research Questions

Research Questions

1. Describe how and why you chose to work with trauma survivors? Why is this work important to you?

2. Describe the impact that working with trauma survivors has had on you- professionally and personally.

3. Describe a key event in your career/work as a trauma therapist that stands out for you. Describe the event in detail, what did you do, what were you thinking and feeling during the event? How did this event impact you personally and professionally? Did this event change you in any way? How?

4. Describe the ways in which you take care of yourself at work when you have a hard day, or hear a particularly hard story. How similar/dissimilar are the ways you take care of yourself from your personal life? How have these changed over the years you have been working with trauma survivors?

5. Describe how you have changed, if at all, over the years from the time you began work as a trauma therapist to now.

REFERENCES

REFERENCES

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: APA.

Bell-Gadsby, C., & Siegenberg, A. (1996). Reclaiming herstory: Ericksonian solution focused therapy for sexual abuse. New York: Brunner/Mazel.

Bogdan, R., & Biklen, S. (1982). Qualitative research for education: An introduction to theory and methods. Boston: Allyn and Bacon, Inc.

Brown, C., & O'Brien, K. (1998). Understanding stress and burnout in shelter workers. Professional Psychology: Research and Practice, 29(4), 383-385.

Bugental, J. (1978). Psychotherapy and process. Massachusetts: Addison-Wesley.

Charney, A., & Pearlman, L. (1998). The ecstasy and the agony: The impact of disaster and trauma work on the self of the clinician. In P. Kleespies (Ed.), Emergencies in mental health practice: Evaluation and management.(pp 38-64). New York: The Guilford Press.

Creswell, J. (1994). Research design: Qualitative & quantitative approaches. Thousand Oaks: SAGE Publications.

Danielli, Y. (1988). Confronting the unimaginable: Psychotherapists' reactions to victims of the Nazi Holocaust. In Wilson, J., Harel, Z., & Kahana, B. (Eds.), Human adaptation to extreme stress from the Holocaust to Vietnam. (pp. 57-76). New York: Plenum Press.

Elliott, D., & Guy, J. (1993). Mental health professionals versus non-mental health professionals: Childhood trauma and adult functioning. Professional Psychology: Research and Practice, 24, 83-90.

Erickson, F. (1985). Qualitative methods in research on teaching. In M. Wittrock, (Ed.), Handbook of research on teaching. (pp. 119-161). New York: Macmillan.

Faunce, P. (1990). Self-care and wellness of feminist therapists. In H. Lerman & N. Porter (Eds.), Feminist ethics in psychotherapy. (pp. 75-99). New York: Springer Publishing Co.

F.B.I. (1998). Statistics of violent crimes. Department of Justice, Washington, D.C.

REFERENCES

Figley, C. (1995). Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized. New York: Brunner/Mazel.

Firestone, W. (1993). Alternative arguments for generalizing from data as applied to qualitative research. Educational Researcher, 22(4), 16-23.

Follette, V., Polusny, M., & Milbeck, K. (1994). Mental health and law enforcement professionals: Trauma history, psychological symptoms, and impact of providing services to child sexual abuse survivors. Professional Psychology: Research and Practice, 25, 275-282.

Fox, R., & Carey, L. (1999). Therapists' collusion with the resistance of rape survivors. Clinical Social Work Journal 27(2), 185-201.

Iliffe, G., & Steed, L. (2000). Exploring the counselor's experience of working with perpetrators and survivors of domestic violence. Journal of Interpersonal Violence, 15(4), 393-412.

Johnson, C., & Hunter, M. (1997). Vicarious traumatization in counsellors working in the new south Wales sexual assault service: An exploratory study. Work & Stress, 11(4), 319-328.

Kramen-Kahn, B., & Hansen, N. (1998). Rafting the rapids: Occupational hazards, rewards, and coping strategies of psychotherapists. Professional Psychology: Research and Practice, 29(2), 130-134.

Mahoney, M. (1997). Psychotherapists' personal problems and self-care patterns. Professional Psychology: Research and Practice, 28(1), 14-16.

Maslach, C. (1976). Burned out. Human Behavior, 5, 16-22.

McCann, I.L., & Pearlman, L. (1999). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. In M. Horowitz (Ed.), Essential papers on posttraumatic stress disorder. New York: University Press.

McCann, I.L., & Pearlman, L. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. Journal of Traumatic Stress, 3(1), 131-149.

REFERENCES

Medeiros, M., & Prochaska, J. (1998). Coping strategies that psychotherapists use in working with stressful clients. Professional Psychology: Research and Practice, 19(1), 112-114.

Morse, J. (1991). Approaches to qualitative-quantitative methodological triangulation. Nursing Research, 40(1), 120-123.

Neumann, D., & Gamble, S. (1995). Issues in the professional development of psychotherapists: Countertransference and vicarious traumatization in the new trauma therapist. Psychotherapy, 32(2), 341-347.

Norcross, J. (2000). Psychotherapist self-care: Practitioner-tested, research-informed strategies. Professional Psychology: Research and Practice, 31(6), 710-713.

Pearce, J., & Pezzot-Pearce, T. (1997). Psychotherapy of abused and neglected children. New York: The Guilford Press.

Pearlman, L. (1995). Self-care for trauma therapists: Ameliorating vicarious traumatization. In B. Stamm (Ed.), Secondary traumatic stress: Self care issues for clinicians, researchers, and educators. Lutherville: Sidran Press.

Pearlman, L., & Maclan, P. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. Professional Psychology: Research and Practice, 26, 558-565.

Pearlman, L., & Saakvitne, K. (1995). Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors. New York: W.W. Norton & Co., Inc.

Pearlman, L., & Saakvitne, K. (1995). Treating therapists with vicarious traumatization and secondary traumatic stress disorders. In R. F. Charles (Ed.), Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized. Brunner/Mazel psychological stress series, No. 23. (pp. 150-177). New York: Brunner/Mazel.

Pines, A., & Maslach, C. (1978). Characteristics of staff burnout in mental health settings. Hospital and Community Psychiatry, 29.

Radeke, J., & Mahoney, M. (2000). Comparing the personal lives of psychotherapists and research psychologists. Professional Psychology: Research and Practice, 31(1), 82-84.

REFERENCES

Saakvitne, K. (1995). Therapists' responses to dissociative clients: Countertransference and vicarious traumatization. In Lewis, M. and Cohen, J.(Eds.), Dissociative identity disorder: Theoretical and treatment controversies. (pp. 467-492). New Jersey: Jason Aronson, Inc.

Saakvitne, K., & Pearlman, L. (1996). Transforming the pain: A workbook on vicarious traumatization. New York: WW Norton & Company.

Schauben, L., & Frazier, P. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence survivors. Psychology of Women Quarterly, 19, 49-64.

Schwandt, T. (2001). Dictionary of qualitative inquiry. London: Sage Publications.

Wilson, J., & Lindy, J.(Eds.). (1994). Countertransference in the treatment of PTSD. New York: Guilford Press.