EXPLORING VICARIOUS TRAUMA AND VICARIOUS RESILIENCE IN COUNSELORS-IN-TRAINING

By

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To my mentor and dear friend, Dr. Roberta “Berta” Seldman, a woman who I aspire to emulate through my life and practice, both on and off the mat

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LIST OF ABBREVIATIONS

ACA	American Counseling Association
APA	American Psychological Association
ACEs	Adverse Childhood Experiences
CACREP	Council for the Accreditation of Counseling and Related Educational Programs
CITs	Counselors-in-training
CSDT	Constructivist self-development theory
IRB	Institutional Review Board
PTSD	Posttraumatic stress disorder
SAMHSA	Substance Abuse and Mental Health Services Administration
SPSS	Statistical Package for the Social Sciences
THQ	Trauma History Questionnaire
VR	Vicarious resilience
VRS	Vicarious Resilience Scale
VT	Vicarious trauma
VTS	Vicarious Trauma Scale

LIST OF DEFINITIONS

Compassion fatigue	A state of biological, psychological, and social exhaustion and dysfunction that is the result of repeated exposure to client experiences, when mental health care providers feel overwhelmed or hopeless in their ability to alleviate their client's suffering (Figley, 1995).
Compassion satisfaction	The positive feelings experienced by helping professionals when witnessing clients' strength and resilience (Stamm, 2002).
Constructivism	Constructivism theory is rooted in the understanding that human development is socially constructed through interactions with others.
Counselors-in-training	A graduate student at a masters-level program in the mental health counseling fields.
Indirect trauma	The experience of witnessing a traumatic event or traumatic material secondhand.
Occupational hazards	Another term for "burnout", also known as the "cost of caring". The potential results or symptoms that may occur through working with vulnerable populations (Freudenberger, 1977).
Posttraumatic growth	A positive change that someone may experience as a direct result from experiencing some form of trauma (Tedeschi & Calhoun, 1996).
Resilience	The process of adapting well in the face of adversity, trauma, tragedy, threats or even significant sources of stress (APA, 2013).
Secondary traumatic stress	The natural behavioral consequences that result from knowing about traumatic event(s) endured by an individual, that results from wanting to help alleviate the suffering of that individual (Figley, 1995).
Vicarious posttraumatic growth	The indirect exposure to traumatic material which has the potential to lead to growth.

Vicarious resilience	A specific process that may occur in trauma counselors as a result from being exposed to the resilience displayed by their clients when healing from traumatic events (Hernández, Gangesi, & Engstrom, 2007).
Vicarious trauma	Alterations in a therapist's cognitive schemas (e.g., beliefs, assumptions, and expectations of self, other, and the world) resulting from empathic engagement with clients' traumatic material (McCann & Pearlman, 1990).

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EXPLORING VICARIOUS TRAUMA AND VICARIOUS RESILIENCE IN COUNSELORS-IN-TRAINING

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Emerging trends have begun to highlight the effects of trauma across occupational domains, including psychotherapy, social work, and other health care professions. Individuals working in these vocations are exposed to high rates of indirect trauma due to their frequent empathic engagement with clients who may have experienced traumatic hardships throughout their lives. Research has indicated that counselors working with trauma survivors have the potential to be positively or negatively transformed by either their clients' trauma or resilience. However, empirical studies of vicarious trauma (VT) in counselors-in-training (CITs) are minimal, and currently, there are no studies of vicarious resilience (VR) in CITs. Therefore, it is necessary to address these critical gaps in the field of counseling in order to gain an understanding of how working with trauma survivors might impact counseling trainees. The purpose of this quantitative study was to examine the presence of VT and VR in CITs. Additionally, the researcher was interested in the relationships between (a) VT, (b) VR, (c) personal trauma history, and (d) previous therapy experience in CITs. A national sample of CITs from CACREP-accredited (Council for the Accreditation of Counseling and Related Educational Programs) programs were recruited. A survey

design methodology was utilized via an internet-based system to administer a demographic questionnaire, Vicarious Trauma Scale, Trauma History Questionnaire, and Vicarious Resilience Scale. Multiple regression analyses were utilized to examine the relationships between variables. As the first study to examine VT and VR in CITs, findings revealed that both VT and VR were present in the sample population. Results also highlighted the impact of the interaction effect of previous therapy experiences and personal trauma history on current levels of VT. Experiences of trauma were also related to current levels of VR. The results from this study have potential implications regarding counselor preparation programs.

CHAPTER 1
INTRODUCTION AND STATEMENT OF PURPOSE

Emerging trends highlight the effects of trauma across occupational domains, including psychotherapy, social work, and other health care professions. Individuals working in these vocations are exposed to high rates of indirect trauma due to their frequent empathic engagement with clients who may have experienced traumatic hardships throughout their lives (Aparicio, Michalopoulous, & Unick, 2013; Bride, Radey, & Figley, 2007; Newell & MacNeil, 2010; Pryce, Shakleford, & Pryce, 2007; Robinson-Keilig, 2014). Research has indicated that licensed mental health providers who work with trauma survivors have the potential to be positively or negatively transformed by either their clients' trauma or resilience (Hernández-Wolfe, Killian, Engstrom, & Gangsei, 2015). However, empirical studies of vicarious trauma (VT) in counselors-in-training (CITs) are minimal (Adams & Riggs, 2008); and currently, there are no studies of vicarious resilience (VR) in CITs. Therefore, it is necessary to address this critical gap in the field of counseling in order to gain an understanding of how working with trauma survivors might impact novice counseling trainees.

The purpose of this study was to address that gap in the literature by examining the presence of VT and VR in CITs. Additionally, the researcher was interested in the relationships between (a) VT, (b) VR, (c) personal trauma history, and (d) previous therapy experience in CITs. Understanding the prevalence of and risk factors for indirect trauma in CITs is imperative to maintaining and promoting the health and well-being of this population. In fact, the American Counseling Association (ACA) Code of Ethics expressed that as a part of their professional responsibility, counselors must engage in self-care practices to help "maintain their own emotional, physical, mental, and spiritual

well-being” in order to adhere to their professional responsibilities (C, 2014). Furthermore, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) 2016 standards explicitly stated that the curriculum within counseling programs must address human growth and development through various strategies to promote “resilience and optimum development and wellness” of the counseling trainees (F.3.i., 2016).

Consequently, this study quantitatively examined the presence of VT and VR in a national sample of CITs who attend master-level CACREP-accredited training programs. This study also contributed to the current literature by identifying the correlation between personal trauma history, previous therapy experiences, VT, and VR for CITs. The following chapter 2 is a full, manuscript-style dissertation that includes a brief literature review, methods, results, discussion, and implications for counselor education and supervision. Chapter 2 is followed by a summary and discussion chapter.

CHAPTER 2
JOURNAL STYLE MANUSCRIPT PRESENTATION

Within the United States, trauma experienced at childhood occurs in approximately two-thirds of individuals (Center for Disease Control and Prevention [CDC], 2016). In fact, it is estimated that between 82% to 94% of the clients seeking services in community mental health centers have experienced some form of traumatic event (Bride, 2004). Due to the high prevalence of trauma experienced across the globe, trauma is now considered to be a public health epidemic (Baker, Brown, Wilcox, Overstreet, & Arora, 2016; Women and Trauma Federal Partners Committee & United States of America, 2013). According to the Adverse Childhood Experiences (ACE) study, which involved over 17,000 participants, higher incidents of childhood trauma predicted adult smoking, obesity, alcoholism, risky sexual behavior, and intravenous drug use (Felitti, 1998; Herman, 2015). Thus, incidents of trauma, specifically childhood trauma, are directly linked to potential maladaptive behaviors that many adult clients struggle with when entering counseling. Therefore, the likelihood that most therapists will work with or are trauma survivors themselves is high (Bride, 2004; Trippany, White Kress, & Wilcoxon, 2004).

Counselors working with trauma survivors have the potential to be positively or negatively transformed by either their clients' trauma or resilience (Hernández-Wolfe et al., 2015). More specifically, due to the nature of the therapeutic relationship (e.g., empathic connection), counselors have likely experienced various psychological, physiological, emotional, and cognitive effects related to the exposure to the traumatic stories of clients (Bercier & Maynard, 2015; Bride, 2004, Conrad & Kellar-Guenther, 2006; Figley, 1995; Levine, 1997; van der Kolk, 2014). Secondary traumatic stress,

compassion fatigue, and vicarious trauma (VT) are terms to describe the adverse impact of therapeutic work with clients who are trauma survivors (Bercier & Maynard, 2015; Figley, 1995). In fact, some social service communities are referring to these risks as occupational hazards for the individuals providing these services (Pryce, Shakleford, & Pryce, 2007). In addition to the negative effects that may be experienced by therapists working with traumatic material, for some counselors, there may be an array of positive impacts of working with trauma survivors (e.g., vicarious resilience).

As counselors-in-training (CITs) are at a critical place in their development, they may be particularly susceptible (either positively or negatively) to working with trauma survivors (Chrestman, 1999; Devilly, Wright, & Varker, 2009; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995; Tabor, 2011). However, empirical studies of VT in CITs are minimal (Adams & Riggs, 2008); and currently, there are no studies of vicarious resilience (VR) in CITs. As research has also shown that personal trauma history and level of clinical experience may be contributing factors in the development of either VT or VR, this study focused on trauma in a novice population; specifically, addressing personal trauma history, previous counseling experience, and the interaction of the two, as predictors of VT and VR in a national sample of CITs. The aim of this study was to contribute to the understanding of predictors of VT and VR in CITs who attend CACREP-accredited master-level counseling training programs in an effort to help better support counseling trainees as they are exposed to trauma survivors in the field.

Trauma Explored

Trauma, generally defined in Western psychology, refers to exposure to an event that involves actual or threatening death, serious injury, or a threat to self or other's

physical well-being, often resulting in emotional distress (American Psychiatric Association, 2013). Simply put, trauma can include any experience that overwhelms an individual's ability to cope. Trauma may have an array of effects on the individual, such as depression, anxiety, interpersonal distress, and difficulty with emotion regulation. These symptoms may, in turn, lead to specific coping behaviors aimed at reducing the experiences of distress, such as self-injury, dissociation, suicidal ideation, aggression, and impulsive or addictive behaviors (Briere, 2004, 2015; Courtois & Ford, 2012; van der Kolk et al., 1996). In addition to the macro-level reorientation of how an individual perceives and responds to the world, trauma is also experienced on the micro-level within the body. According to the ever-growing body of research, trauma gets stored in the body as an incomplete fight or flight response (e.g., Levine, 1997; Ogden, 2015; van der Kolk, 2014). Individuals become traumatized when their ability to respond to a perceived threat becomes thwarted in some way (Levine, 2008). In addition to the direct experience of trauma that overwhelms an individual's system, trauma can be indirectly experienced and still wreak havoc on one's cognitive, psychological, and physiological systems. VT is one such example of the indirect trauma response.

VT

Originally introduced by McCann and Pearlman (1990), VT has been widely researched in order to understand the potentially adverse and long-term effects of indirect trauma on health care providers (Aparicio, Michalopoulous, & Unick, 2013). Following Pearlman and Saakvitne (McCann & Pearlman, 1990; Pearlman, 1999; Pearlman & Saakvitne, 1995; Saakvitne, 1996; Saakvitne & Pearlman, 1996), this study conceptualized VT as the alterations in the therapist's cognitive schemas (e.g., beliefs, assumptions, and expectations of self, other, and the world) resulting from empathic

engagement with clients' traumatic material. Cognitive symptoms of VT include shifts in schemas in the individual's frame of reference, which can present as disturbances in one's identity, self-perception, ego resources, psychological needs, spiritual connection, and overall worldview (Aparicio, Michalopoulous, & Unick, 2013). Consequently, VT can lead to compromised therapeutic boundaries, wrongful diagnoses, inability to attend to the client's needs, as well as loss of energy and commitment (Sexton, 1999; Trippany et al., 2004).

Factors Influencing VT

The degree of VT experienced by mental health professionals is influenced by a number of factors, namely personal trauma history and level of clinical experience (Chrestman, 1999; Devilly, Wright, & Varker, 2009; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995; Tabor, 2011). Other contributing factors may include: negative coping strategies, level of personal stress, gender (with women indicating higher degrees of symptomology), lack of personal therapy, and percentage of trauma work in caseload (Beck, 2011; Brady, Guy, Poelstra, & Brokaw, 1999; Cornille & Meyers, 1999; Follette, Polusny, & Milbeck, 1994; Kassam-Adams, 1995; Sabin-Farrell & Turpin, 2003). There are a few studies dating back to the early 1990's that indicated a high probability that many mental health providers have their own personal trauma histories (Elliott & Guy, 1993; Pearlman & Mac Ian, 1995; Pope & Feldman-Summers, 1992). As personal trauma is related to a variety of mental health concerns (Felitti, 1998; Herman, 2015), it is possible that CITs who have experienced trauma may have also experienced therapy (Pack, 2010). Therapy has been linked to reducing trauma-related symptoms (Sloan, Gallagher, Feinstein, Beck, & Keane, 2013). Additionally, in an international study of 14 countries and 4000 therapists,

personal therapy was rated as one of the top three beneficial influences on professional development (Orlinsky, Botermans, & Rønnestad, 2001); and as such, considerations of personal therapy experiences were necessary for the present study.

Current research also highlighted that having a personal trauma history could be an indicator for experiencing VT (Baird & Kracen, 2006; Collins & Long, 2003; Nelson-Gardell & Harris, 2003). However, some empirical findings regarding the connection between personal trauma history and VT are mixed (Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995; Way, VanDeusen, Martin, Applegate, & Jandle, 2004). For example, Pearlman and Mac Ian (1995) interviewed trauma therapists, and those with a personal trauma history displayed higher degrees of VT than those without a personal trauma history. Conversely, when Schauben and Frazier (1995) conducted research with counselors that worked with sexual assault survivors, a personal trauma history was not a significant factor in higher degrees of VT. Furthermore, Adams and Riggs (2008) argued that the contradictory evidence of whether or not personal trauma history is related to VT may be explained by different defense styles. The researchers found that defense styles played a "moderating role in the relationship between personal history and VT" (Adams & Riggs, 2008, p. 31). Consequently, based upon this conflicting information, more research is needed to contribute to the argument of whether or not having a personal trauma history does, in fact, make counselors more likely to display characteristics of VT. Another factor that may be complicating the findings could be the level of experience or trauma education of the counselor.

In relation to counseling experience, early professionals who are newer to their jobs or have less trauma education tend to experience more indirect trauma when

working with trauma survivors (Adams & Riggs, 2008; Adams, Matto, & Harrington, 2001; Baird & Jenkins, 2003; Meyers & Cornille, 2002; Pearlman & Mac Ian, 1995; Steed & Bicknell, 2001). For example, VT has been found to be more common in younger and less experienced social workers than in their seasoned counterparts (Adams, Matto, & Harrington, 2001). Additionally, when looking at training programs, students who were unprepared and uneducated about working with client's traumatic material or were not invited to speak openly about their reactions to clients' trauma in the classroom, were more likely to experience VT (Knight, 2010). These studies indicate the prevalence of VT in young professionals and inferences can be drawn as to the impact on CITs; however, only one study was found that examined a direct link between VT and CITs (Adams & Riggs, 2008). In that study, novice clinicians with 0-2 semesters of applied clinical work with trauma survivors experienced more distress than trainees with more than 2 semesters of clinical work (Adams & Riggs, 2008). The presence of distress in CITs after working with traumatized clients may be a symptom of VT; however, more research is needed to understand the array of effects that CITs experience when working with trauma.

VR

In addition to the trauma that may be indirectly experienced by counselors, resilience may also be vicariously internalized into the helping professional. Not only are counselors exposed to clients' pain and suffering, but additionally, clients' strength and perseverance. Originally coined by Hernández, Gangesi, and Engstrom (2007), VR highlights the positive transformation(s) of trauma counselors by witnessing clients' ability to overcome adversity throughout the healing therapeutic process (Hernández, Engstrom, & Gangsei, 2010). VR, like VT, originates from the therapists' empathic

engagement in the traumatic material disclosed by their clients. As such, the client's traumatic material can be viewed as paradoxical—a source of both VT and VR (Pack, 2014). Consequently, VR can be perceived as an "ability to bounce back" after working with traumatized individuals (Pack, 2014, p. 18), highlighting the need to understand what may influence VR in CITs.

Coincidently, preliminary research indicates that VT and VR coexist simultaneously within a counselor resulting from clinical trauma work (Hernández-Wolfe et al., 2015). While Hernández-Wolfe and colleagues (2015) were not suggesting that VT and VR are parallel processes, they are accounting for the strengths-based, positive transformation that some trauma counselors may experience through their work with clients. Furthermore, this coexistence may occur similarly to the way resilience can be experienced alongside the suffering associated with trauma-related symptoms (Hernández-Wolfe et al., 2015). For example, sleep disruption, irritability, and intrusive thoughts co-occurred in trauma counselors with increased hopefulness, change in spiritual beliefs, and increased self-care practices (Hernández-Wolfe et al., 2015). However, these studies did not investigate the presence of VR in CITs. Furthermore, since psychotherapy is a space that can provide new meaning making, positive coping strategies, and promote clients' strengths, there is a potential correlation that personal experiences as a client in therapy may be a contributing factor in the ability of counselors to experience VR (Hernández et al., 2007; Seligman & Peterson, 2003).

Based upon the likelihood of CITs being exposed to traumatic material during their clinical training, and the potential for VT and VR to coexist with counselors, it becomes imperative to address the prevalence of trauma during counseling training and

development. As such, the current study had four primary hypotheses: (1) VT will be moderately present in half of CITs in the sample population during practicum or internship experiences, (2) VR will be moderately present in half of CITs in the sample population during practicum or internship experiences, (3) the relationship between personal trauma history, previous therapy experiences, and VT will be dependent on the interaction of personal trauma history and previous therapy experiences for CITs, and (4) the relationship between personal trauma history, previous therapy experiences, and VR will be dependent on the interaction of personal trauma history and previous therapy experiences for CITs.

Methodology

Procedures

This study utilized a correlational, survey-based research design. Potential participants were recruited using a randomized sampling method. All study participants in the sample were recruited through CACREP's list of accredited programs in the United States (*n* = 776) after Institutional Review Board (IRB) approval. After placing the programs into a spreadsheet, the primary investigator created a randomized list of programs to contact using a number generator. Next, program directors of identified universities were contacted to request that a recruitment email be distributed to their counseling students currently enrolled in practicum or internship. See Appendix A and B for recruitment emails. Of these programs, the researcher received 49 responses, a 13.61% response rate. Program directors from 40 institutions (11.11%) agreed to share the recruitment email with their students. The 9 programs not selected either declined to participate in the study or needed the study to go through their respective IRB.

Interested individuals who consented to participate in the study were directed to an online, self-report survey portal, powered by Qualtrics. The study was described to all potential participants, they were informed the survey may take up to 30 minutes to complete, and every 10th participant would have the opportunity to receive a $10 Amazon gift card as compensation. Participants were screened based on identified selection criterion (discussed below) and redirected to the end of the survey if they did not meet qualifications. Participation in this study was voluntary and was not expected to cause any negative effects in regard to physical, mental, or emotional harm. Within the study survey, data collection was anonymous and participant names were not collected. Participants had the opportunity to opt out of the study at any time without repercussions.

Participants

There were several eligibility requirements to participate in this study. To participate, an individual needed to (a) be at least 18 years of age; (b) able read and understand English; (c) be able to access the internet to complete online questionnaires; (d) be a CIT in a CACREP-accredited program; (e) be currently involved in clinical practice through practicum or internship; and (f) have experience working with traumatized client(s). Study participants were CITs in Clinical Mental Health Counseling (*n* = 100, 62.11%), Clinical Rehabilitation Counseling (*n* = 19, 11.80%), School Counseling (*n* = 17, 10.56%), Marriage, Couple, and Family Counseling (*n* = 16, 9.94%), Addiction Counseling (*n* = 2, 1.24%), College Counseling and Student Affairs (*n* = 1, 0.62%), and other (*n* = 2, 1.24%).

Demographics of the sample are included in Appendix H and I. Of the 131 participants in the sample population, the gender identity included: females (*n* = 116,

88.55%), males (*n* = 12, 9.16%), other (*n* = 2, 1.52%), and preferred not to answer (*n* = 1, 0.76%). Participants years of age varied as follows: 22-24 years (*n* = 43), 25-27 years (*n* = 36), 28-33 years (*n* = 27), 34-40 years (*n* = 29), and 41-62 years (*n* = 14). When asked about their racial/ethnic identification, participants indicated they were: Caucasian/White—not of Hispanic/Latinx origin (*n* = 102; 77.86%), Hispanic/Latinx (*n* = 13; 9.92%), African American/Black (*n* = 7; 5.43%), Multi-racial (*n* = 7; 5.43%), or Asian or Pacific Islander (*n* = 2; 1.53%). When asked about their sexual orientation, participants indicated that they identified as: heterosexual (*n* = 96; 73.28%), bisexual (*n* = 15; 11.45%), pansexual (*n* = 5; 3.82%), asexual (*n* = 3; 2.29%), lesbian (*n* = 3; 2.29%), questioning (*n* = 3; 2.29%), gay (*n* = 2; 1.53%), prefer not to answer (*n* = 2; 2.29%), queer (*n* = 1; 0.76%), and heteroflexible (*n* = 1; 0.76%). When asked about being currently involved in personal therapy, the majority indicated no (*n* = 83, 63.36%), while the remaining participants indicated yes (*n* = 48, 36.64%). See Appendix H for table samples and Appendix I for figure depictions of additional descriptive statistics.

Vicarious Trauma Scale (VTS)

VT was measured using the 8-item VTS (Vrklevski & Franklin, 2008). The VTS was designed to measure distress resulting from repeated exposure working with traumatized clients (Aparicio, Michalopoulos, & Unick, 2013). The VTS is a 7-point Likert scale, ranging from 1 (strongly disagree) to 7 (strongly agree). Example questions included “My job involves exposure to traumatized or distressing clients” and “I find myself thinking about distressing material at home” (Vrklevski & Franklin, 2008). Total scores on the VTS range from 8 to 56, with cut off scores indicating various levels of VT (Vrkleski & Franklin, 2008). Specifically, a score between 8 and 28 indicated low VT, a score between 29 and 42 indicated moderate VT, and a score between 43 and 56

indicated higher levels of VT (Aparicio, Michalopoulos, & Unick, 2013). Vrklesvki and Franklin (2008) reported a Cronbach's alpha of .88 in their initial study of VT in the legal profession (*n* = 100). Similarly, when the VTS was utilized with a sample of social workers (*n* = 157), good internal consistency was reported (Cronbach's alpha = .77) (Aparicio, Michalopoulos, & Unick, 2013). The VTS was found to have an average internal consistency reliability (.69) in the current study. See Table H-2 for descriptive statistics for each instrument.

Trauma History Questionnaire (THQ)

The THQ (Green, 1996) was used to assess personal trauma history. The THQ was developed to be utilized with diverse populations to gather information about a lifetime of exposure to a range of potentially traumatic experiences (Hopper, Stockton, Krupnick, & Green, 2011). The THQ is a 24-item instrument that measures history of or exposure to potentially traumatic events, approximately how often the traumatic events occurred, and at what age the traumatic events happened. Different potentially traumatic events included in this measure are: crime-related events, accidents, general disasters (including work-related and nature-related disasters), life-threatening illnesses, military service, physical and/or sexual traumatic experiences, and death of a loved one. Example questions included "Have you ever had a spouse, romantic partner, or child die? (If yes, please specify relationship below)" and "Has anyone every touched private parts of your body, or made you touch theirs, under force or threat? (If yes, please indicate nature of relationship with person [e.g., stranger, friend, relative, parent, sibling] below)" (Hopper et al., 2011). The THQ can generate a total score and subscale scores by calculating the items associated with the three different categories: crime-related events (4 items), general disaster and traumatic experiences (13 items), and physical

and sexual experiences (6 items). Furthermore, since the THQ was not a traditional scale, there has been no establishment of internal consistency or construct validity (Hopper et al., 2011). However, based upon the results from the current study sample, the THQ was found to have a moderate internal consistency for the current sample (Cronbach's alpha = .74.).

Vicarious Resilience Scale (VRS)

The VRS (Killian, Hernández-Wolfe, Engstrom, & Gangsei, 2017) was utilized to measure VR. This 27-item self-report instrument assessed specific ways in which counselors working with traumatized clients may be positively impacted by their clients' resilience and recovery. The content of the VRS scale was influenced by four national and international qualitative studies (Edelkott, Engstrom, Hernández-Wolfe, & Gangsei, 2016; Engstron et al., 2008; Hernández et al., 2007; Hernández-Wolfe et al., 2014). Responses were given on a 6-point Likert scale ranging from 0 (did not experience this) to 5 (experienced this to a very great degree). The VRS can generate a total score and subscale scores by calculating the items of the 7 subscales. The scoring of the 7 subscales is as follows: (a) Increased Capacity for Resourcefulness, with 0-15 indicating low scores, 16-21 middle scores, and 22-30 high scores; (b) Changes in Life Goals and Perspectives, with 0-14 indicating low scores, 15-22 middle scores, and 23-30 high scores; (c) Increased Self-Awareness and Self-Care Practices, with 0-9 indicating low scores, 10-13 middle scores, and 14-20 high scores; (d) Client-Inspired Hope, with 0-10 indicating low scores, 11-12 middle scores, and 13-15 high scores; (e) Increased Recognition of Spirituality as a Client Resource, with 0-8 indicating low scores, 9-11 middle scores, and 12-15 high scores; (f) Increased Capacity to Remain Present During Trauma Narratives, with 0-8 indicating low scores, 9-11 middle scores,

and 12-15 high scores; and (g) Increased Consciousness around Social Location and Power, with 0-5 indicating low scores, 6-7 middle scores, and 8-10 high scores (Killian et al., 2017). Statement questions include the following examples: since beginning to work with clients presenting with trauma-related symptoms were you “Better able to cope with uncertainties,” and were you “Better able to assess level of stress” (Killian et al., 2017). The VRS was developed and tested with trauma therapists (*n* = 190) and had strong internal consistency, with a Cronbach’s alpha of .94 (Killian et al., 2017). Furthermore, each of the seven subscales had moderate to strong internal consistency scores ranging from .79 - .86. The VRS was found to have strong total scale internal consistency for the current sample (Cronbach’s alpha = .95). The Cronbach’s alphas for the subscales of the VRS for the current study were moderate to high (range = .70 = .90); however, the subscale, “increased consciousness around social location and power,” had low reliability in this sample, with a Cronbach’s alpha of .41.

Data Analysis

The data obtained for this study was analyzed using the Statistical Package for the Social Sciences (SPSS; IBM, 2012). Descriptive statistics and multiple linear regressions were used to answer the research questions. A multiple ordinary least squares regression analysis was conducted for the outcome variables VT (as measured by the VTS) and VR (as measured by the VRS). The predictor variables in both cases were (a) previous trauma history (as measured by the THQ), (b) personal therapy experience (as measured by the demographic questionnaire), and the interaction between the two independent variables. To determine sample size and reach statistical power, an a priori G*Power analysis was conducted (Faul, Erdfelder, Buchner, & Lang, 2009; Lenth, 2007). For this study, the power analysis indicated that to detect a medium

effect size, power of .80, and α = .05, the target sample size would have to be 113 individuals (Cohen, 1992; Lenth, 2007); therefore, the researcher attained a sample size of 131 individuals to gain replicable results (Norman & Streiner, 2003).

Preliminary Analyses. Before conducting the primary analyses for this study, the data was screened to access for missing data, outliners, and assumption of normality. A total of 275 surveys were started by participants; however, 144 (52.36%) were excluded due to participants (a) not being currently enrolled in a CACREP-accredited program (*n* = 21; 7.64%), (b) not currently enrolled in practicum or internship (*n* = 85; 30.91%), (c) did not have experience working with clients that presented with trauma-related symptoms (*n* = 16; 5.82%), or (d) did not complete the study (*n* = 22; 8.00%). Therefore, the researcher examined data from 131 participants that constituted the final sample, 47.64% of the original total surveys started.

Results

Research Hypothesis One

Descriptive statistics for each measure are included in Table H.2. The VTS was utilized to examine research hypothesis one: VT will be moderately present in half of CITs in the sample population during practicum or internship experiences. Based upon the results of the VTS, VT was found to be present in the CIT population. Of the 131 participants included in the original dataset, surveys with missing data from the VTS (*n* = 9; 6.87%) were discarded, leaving (*n* = 122) remaining participants. The majority of the sample fell into the category of experiencing moderate levels of VT (*n* = 91; 74.59%); however, many participants indicated experiencing low levels of VT (*n* = 14; 11.48%) or high levels of VT (*n* = 17; 13.93%). These results validate research hypothesis one, and indicate an overall moderate to high presence of VT in CITs.

Research Hypothesis Two

The VRS was utilized to examine research hypothesis two: VR will be moderately present in half of CITs in the sample population during practicum or internship experiences. Of the 131 participants included in the original dataset, surveys with missing data from the VRS (*n* = 13; 9.92%) were discarded. The majority of the remaining sample (*n* = 118) fell into the category of experiencing low levels of VR (*n* = 57; 48.31%); however, many participants indicated experiencing medium levels of VR (*n* = 39; 33.05%) or high levels of VR (*n* = 22; 18.64%). Results for the subscales indicated that participants experienced: (*n* = 48; 11.02%) low for the increased capacity for resourcefulness subscale, (*n* = 52; 44.07%) moderate for the change in life goals and perspectives subscale, (*n* = 47; 39.83%) low for the increased self-awareness and self-care practices subscale, (*n* = 59; 50.00%) low client inspired hope, (*n* = 70; 59.32%) low for the increased recognition of spirituality as a client resource subscale, (*n* = 54; 45.76%) low for the increased capacity to remain present during trauma narratives subscale, and (*n* = 44; 37.29%) moderate for the increased consciousness around social location and power subscale. These results validate research hypothesis two, and indicates an overall low to moderate presence of VR in CITs.

Research Hypothesis Three

Research hypothesis three stated: The relationship between personal trauma history, previous therapy experiences, and VT will be dependent on the interaction of personal trauma history and previous therapy experiences. The total sample analyzed for this research questions was 118 participants. An ordinary least squares regression equation was utilized to address research question three, where the dependent variable was VT, and the independent variables were previous therapy, personal trauma, and

the interaction of the two variables (previous therapy and personal trauma). Statistical results indicated a significant interaction between previous therapy and personal trauma history (p = 0.034); therefore, the effect of personal trauma history on VT varies over levels of previous therapy experience, $t(114) = 2.146$, p = 0.034, b = 0.151. The conditional slope for the relationship between personal trauma history and VT is -1.004 + 151 (previous therapy experience). The relationship between personal trauma history and VT is negative; therefore, as personal trauma history increases, the VT score decreases. However, the positive interaction between previous therapy and personal trauma history means increased therapy experience will positively affect the relationship between personal trauma history and VT. In short, more therapy experience leads to a stronger effect of personal trauma history on VT. However, it is noteworthy that only 1% of the variance is explained by this model; therefore, interpretations must be made with caution. Results from Partial Eta Squared calculations (.836) indicated a small effect size for the model, when the significance level was .05 and confidence intervals were held at 95.0%. Small effect sizes and low variance percentages warrant caution with interpretation of results. Yet, the significant model findings validate research hypothesis three, and indicate the relationship between personal trauma history and VT is dependent on previous therapy experience. Results of the multiple regression analyses for research hypotheses three and four are included in Table H.3.

Research Hypothesis Four

Research hypothesis four stated: The relationship between personal trauma history, previous therapy experiences, and VR will be dependent on the interaction of personal trauma history and previous therapy experiences. The total sample analyzed for this research question was 118 participants. There were two ordinary least squares

regression equations utilized to address research question four. In the first model, the dependent variable was VR, and the independent variables were previous therapy, personal trauma, and the interaction of the two variables (previous therapy and personal trauma). Statistical results indicated this model was significant, $F(3,114) = 3.550$, $p = .017$. However, the interaction between personal trauma history and previous therapy experience was not significant, indicating that the effect of personal trauma history is constant across levels of previous therapy experience. Therefore, the interaction term was removed and a new regression analysis was conducted. In the second model, the new independent variables were personal trauma history and previous therapy experience. Statistical results indicated personal trauma history and previous therapy experience as significant predictors of VR; $F(2,115) = 5.30$, $p = .006$. On average, a one point increase in personal trauma history resulted in a 2.306 increase in the VR score, when holding previous therapy experience constant, $t(115) = 3.277$, $p = .0005$, $b = 2.306$. There was a positive relationship between personal trauma history and VR, when holding previous therapy experience constant. There was a negative relationship between previous therapy experience and VR, when holding personal trauma history constant, but it was not significant. However, it is noteworthy that only 7% of the variance is explained by this model. Furthermore, results from Partial Eta Squared calculations (.542) indicated a small effect size for the model, when the significance level was .05 and confidence intervals were held at 95.0%. Small effect sizes and low variance percentages warrant caution with interpretation of results. Yet, these model results indicate that there is a relationship between personal trauma history, previous

therapy experience, and VR; yet, that relationship is not dependent on the interaction of previous therapy and personal trauma histories.

Discussion

This study examined the prevalence of VT and VR in CITs enrolled in clinical experiences in CACREP-accredited programs, with an emphasis on understanding the relationship of these variables to previous therapy and personal trauma histories. The VTS results showed that the majority of the sample fell into the category of experiencing moderate levels of VT (*n* = 91; 74.59%); however, many participants indicated experiencing high levels of VT (*n* = 17; 13.93%), while the remaining participants indicated low levels of VT (*n* = 14; 11.48%). These findings validate previous research that highlight early professionals tend to experience more VT when working with trauma survivors (Adams & Riggs, 2008; Adams, Matto, & Harrington, 2001; Baird & Jenkins, 2003; Meyers & Cornille, 2002; Pearlman & Mac Ian, 1995; Steed & Bicknell, 2001). Furthermore, comparative studies are warranted to discover the impact of trauma-training on CITs experience of VT.

Analyses revealed that the relationship between personal trauma history and VT is negative, which indicates that higher levels of a personal trauma history correlates with a lower VT score, when controlling for previous therapy experience. These results echo the findings of previous studies that a personal trauma history was not a significant factor in higher degrees of VT (Schauben & Frazier,1995). Furthermore, these findings highlight the importance of personal therapy experience to mitigate the adverse effects of VT. Specifically, the findings from this study indicate that short-term therapy (less than six months) had a significant impact on the presence of VT in the sample population. Research has highlighted that many mental health professionals believe

personal therapy is an integral component of their personal lives (Mahoney, 1997; Stevanovic & Rubert, 2004) and professional development (Pope & Tabachnick, 1994; Williams, Coyle, & Lyons, 1999). While there are numerous studies that highlighted the degree to which seasoned professionals seek personal therapy, research regarding CITs' personal therapy is limited (Dearing, Maddux, & Tangney, 2005; Orlinsky, Schofield, Schroder, Kazantzis, 2011). In one study, 70.2% of psychology trainees (*n* = 262) indicated that they had been in personal therapy prior to or during their graduate studies, and 47% had in engaged in therapy during their counseling training (Dearing, Maddux, & Tangney, 2005). The results from this study suggest that *n* = 112 of the sample population (85.50%), participated in previous therapy. Furthermore, studies indicated that CITs would be more inclined to participate in personal therapy if their professors viewed it more favorably (Dearing et al., 2005). This present study may contribute to the importance of counselor educators encouraging CITs to seek personal therapy, especially if there is a personal trauma history. However, more research is needed to elaborate on the connection between previous therapy and decreased levels of VT in CITs.

This study also sought to examine the impact of VR, along with personal trauma history and previous therapy experience among CITs. The VRS reported that the majority of the sample fell into the category of experiencing low levels of VR (*n* = 57; 48.31%); however, many participants indicated experiencing medium levels of VR (*n* = 39; 33.05%) or high levels of VR (*n* = 22; 18.64%). According to the VRS, low scores may indicate a lack of joy or hopefulness in the trainee's work, a decrease in positive changes in how they view their lives as a professional, struggle to remain present during

clients' trauma stories, not utilizing effective self-care practices, and potentially minimal social support in the work environment (Killian et al., 2016). Analyses revealed that there is a positive relationship between personal trauma history and VR, when controlling for previous therapy experience. These findings suggest that previous therapy experience may be an important indicator of VR when there is a personal trauma history. While no previous studies on VR address the incorporation of therapy experience, the current findings may address an important area in need of further research. Furthermore, prior research indicated that counselors may be most profoundly affected by working with trauma survivors in the beginning years of clinical practice (Pack, 2014). As the first research of its kind, examining VR in CITs, more studies are needed to explore patterns of this phenomenon in this population.

Counselor Education and Supervision Implications

Based on the current study's findings, there are trauma-informed education and supervision implications. Specifically, CACREP-accredited programs are expected to provide students with knowledge, skill, and experience in order to effectively function as professional counselors. The present study and associated findings contribute to the knowledge and understanding regarding VT and VR, which has potential implications that influence both positive and negative psychological outcomes for CITs. Due to the likelihood of traumatic material that CITs will experience in their clinical training, educators have an ethical obligation to warn their students about the potential harm associated with working with trauma survivors, as well as teach them how to effectively cope with such exposure (Munroe, 1999). In the most recent publication of the CACREP Standards (2016), the importance of trauma education is addressed in eight different standards (e.g., CACREP Standards F.3.g, F.5.m, F.7.d, C.2.f, D.2.h, E.2.b, F.2.g, and

G.2.e). Given that VT and VR were reported by CITs, the findings of this study underscore the importance of addressing the effects of working with trauma survivors in CACREP-accredited training programs.

The efforts on educating CITs about the effects of personal trauma and working with clients that present with trauma-related symptoms can be helpful not only for CITs, but for the therapeutic work that CITs will do with clients in their professional career. In addition, personal trauma history and previous therapy experience were also found in this study to be associated with lower levels of VT. Although causality was not addressed in this study, the relationships between these variables highlight important areas for counselor educators to address. For example, increasing CITs' education on the effects of working with trauma survivors and encouraging personal therapy of the CIT might also enhance the positive psychological outcomes, such as VR, and decrease the negative psychological outcomes, such as VT. Due to the developmental levels of CITs, they could benefit from understanding how to prioritize addressing the effects of indirect trauma throughout the counselor preparation training period. Researchers highlight trauma-specific recommendations for reducing VT and increasing VR in CITs throughout counselor preparation programs.

Many researchers (Munroe, 1999; Pearlman & Saakvitne, 1995; Sommer, 2008; Trippany et al., 2004) argue that one of the most beneficial approaches of addressing VT in CITs is through trauma-sensitive supervision by qualified practitioners. Additional trauma-specific interventions include incorporating: (a) trauma training in counselor preparation programs, (b) support for trainees who have experienced personal trauma, (c) sound theoretical foundations of the effects of trauma, (d) relational perspectives in

program, (e) specific attention to countertransference and VT, and (f) a safe space to process graphic stories that are inevitable when working with trauma survivors (Pearlman & MacIan, 1995; Pearlman & Saakvitne, 1995). When addressing the incorporation of trauma education into counseling programs, one study discovered that single lectures or discussions about trauma were not sufficient in educating CITs and mitigating the adverse effects of VT (Adams & Riggs, 2008). Therefore, semester-long workshops or classes may be the most effective way to weave trauma training into already established CACREP programs. Consequently, results from this present study advocate for the incorporation of trauma-specific educational series offered continuously throughout counselor preparation training programs, in addition to program and faculty encouragement of personal therapy for CITs during their training program. Overall, the present findings provide counselor educators with valuable information regarding the experiences and consequences of CITs exposure to traumatic material in the clinical training period of their programs.

Limitations

In this study, there were a few noteworthy limitations regarding: (a) sample, (b) design, and (c) instrumentation. First, the obtained sample population for this study may not be fully representative of all CITs; therefore, lack of generalizability of the sample to larger population due to the self-selection bias is a limitation to consider. Second, the correlational nature of the study means that causality cannot be determined. In addition, self-report measures can create unwanted response bias, as participants may want to be viewed a certain way, or may also be unaware, or not honest about their experiences (Creswell, 2008). Finally, in terms of instrumentation, although each measure was intentionally selected, there were certain limitations associated with each measure. All

three measures, were normed using licensed professionals. Therefore, these instruments were being utilized with a population (CITs) other than the originally intended population (licensed professionals). However, since there were no measures normed with a trainee population regarding VT or VR, the researcher deemed the chosen measures to be the best fit for this study. Also, although the THQ displayed strength as an appropriate choice to measure personal trauma history, more evidence is needed on the construct validity, cultural validity, and generalizability of the THQ (Hopper et al., 2011). Additionally, since there was no standard for scoring the THQ, there are no developed norms from which to base the psychometric properties.

Future Research

A major finding in the current study is the moderate to high presence of VT in nearly 90 percent of the CITs in the sample. Although VT has been previously explored in CITs in one study, (Adams & Riggs, 2008), this present study is the first one known to demonstrate a link between VT, VR, personal trauma history, and previous therapy experience in CITs. Future researchers could attempt to replicate the present findings using different methods to measure previous trauma history and personal therapy experience. Particularly, it would be important to examine the effects of long-term trauma-specific therapy, when compared to this present study, which was predominately short-term therapy or less than six months.

Since the cumulative and transforming effects of working with trauma survivors may lead to shifts of schemas leading to experiences of VT (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995), it is necessary to examine preventative measures and interventions to protect professional mental health providers and CITs. Future research may benefit from examining if particular self-care and wellness approaches to

mitigate the experiences of indirect trauma are equally as effective with CITs as they are with licensed professionals. Furthermore, additional research should examine the presence of VT in CITs with exposure to different forms of trauma education throughout their training program to discover what types of trauma training are most effective in moderating the adverse effects of indirect trauma, while increasing the beneficial effects of working with trauma survivors.

Conclusion

The results from this study indicate that both VT and VR were present within the study's sample population of CITs. VT specifically was found in moderate to high levels in the CITs examined. Regarding the correlation between personal trauma history and VT, previous qualitative and quantitative studies have provided inconclusive evidence. Some studies indicated that a personal trauma history may not impact the degree of VT experienced; however, other studies concluded that a personal trauma history increases the probability of VT (Linley & Joseph, 2007; Tedeschi & Calhoun, 1996, 2004). Various studies indicate the high probability that many mental health providers have their own personal trauma histories (Elliott & Guy, 1993; Pearlman & MacIan, 1995; Pope & Feldman-Summers, 1992). Findings from this study indicate that a personal trauma history leads to higher instances of VT, if there was no previous therapy experience.

CHAPTER 3
CONCLUSION

Studies have explored the prevalence of indirect trauma on many mental health and care giving professions, such as social work (Adams, Matto, & Harrington, 2001), nursing faculty (Raingruber & Kent, 2003), child welfare workers (Dane, 2000; Schauben & Frazier, 1995), and domestic violence workers (Iliffe, 2000). However, few studies have specifically focused on the presence of VT in CITs (Adams & Riggs, 2008). The purpose of this study was to discover if VT and/or VR were present within a national sample of CITs. Furthermore, an additional goal was to examine VT and VR in relation to personal trauma history and previous therapy experience. The researcher examined these constructs within CITs currently enrolled in practicum or internship at a CACREP-accredited master program(s) in the United States. Understanding what contributes to either VT or VR can help the training of counselors, which can directly effect the clinical care provided to clients.

The results from this study indicate that both VT and VR were present within the study's sample population of CITs. VT specifically was found in moderate to high levels in the CITs examined. Regarding the correlation between personal trauma history and VT, previous qualitative and quantitative studies have provided inconclusive evidence. Some studies indicated that a personal trauma history may not impact the degree of VT experienced; however, other studies concluded that a personal trauma history increases the probability of VT (Linley & Joseph, 2007; Tedeschi & Calhoun, 1996, 2004). Various studies indicate the high probability that many mental health providers have their own personal trauma histories (Elliott & Guy, 1993; Pearlman & MacIan, 1995; Pope &

Feldman-Summers, 1992). Findings from this study indicate that a personal trauma history leads to higher instances of VT, if there was no previous therapy experience.

Previous research (Adams & Riggs, 2008) argued that education and trauma training early on in counselor development is essential for the reduction of the adverse effects of the psychological impact of VT. Furthermore, helping CITs develop both preventative measures and coping methods (self-care or wellness practices) early in their careers is an important step when working with trauma survivors (Brady et al., 1999). This present study not only supports this practice, but underscores the importance of such an integrative approach to clinical training and counselor education. Additionally, results of this study suggest the importance of personal therapy experience for CITs to mitigate the adverse effects of VT.

In conclusion, findings from this study indicate that a potential occupational hazard for CITs is VT. CITs risk disruption to cognitive schemas if the effects of working with trauma survivors is not addressed in their training. Therefore, attention to counselor education and preparation on the potential results of empathically engaging with clients who present with trauma-related symptoms is warranted. Learning to integrate coping strategies and self-care practices ought to be a consideration for training programs to protect and inform novice counselors. Specific curriculum, trauma-sensitive supervision, and continuing education opportunities may benefit the professional longevity and clinical service of trauma counselors.

APPENDIX A
PROGRAM DIRECTOR RECRUITMENT EMAIL

Dear Dr. (Name of Program Director),

My name is Keri Johnson, a doctoral candidate at the University of Florida, and I am writing to ask for your assistance in distributing a research participant request to master students in your program(s). The study has IRB approval. The purpose of this study is to gain a better understanding about the presence of vicarious trauma and vicarious resilience in counselors-in-training.

Your program was randomly selected as a potential participant because of your CACREP accreditation.

If you decide to participate in this dissertation research study, would you please pass on the email below to your master students? Alternatively, if there is a more convenient way to contact your master students, such as a student list serv, or if there is someone else more appropriate to address this, please direct me to them. The estimated time to complete the survey is approximately 20-30 minutes.

There are no risks associated with this study. There is no compensation for participating in the study, however every 10th participant will receive a $10 Amazon gift card.

If you have any questions or concerns, please contact me at keriljohnson@ufl.edu or my research supervisor at kdepue@coe.ufl.edu.

If you have any questions regarding rights as a research participant, contact the Institutional Review Board by calling 352-392-0433 and reference IRB Protocol #201702968.

Thank you in advance for your consideration.

Sincerely,

Keri Johnson, M.Ed./Ed.S., M.A.
Doctoral Candidate, Counselor Education
University of Florida

APPENDIX B
COUNSELOR-IN-TRAINING RECRUITMENT EMAIL

Dear Counselors-in-Training,

Have you ever considered the impact your counseling work has on your personal and professional life? Have you ever had moments where you experienced either trauma or resilience vicariously from your work with clients? If so, this study may be a great fit for you.

My name is Keri Johnson, and I am doctoral candidate at the University of Florida. I am conducting a quantitative research study that examines the presence of vicarious trauma and vicarious resilience in counselors-in-training that work with or have worked with clients who have personally been impacted by traumatic events. I will be analyzing answers to questionnaires in order to discover whether or not other counselors-in-training experience trauma and/or resilience vicariously through working with and processing through client's traumatic material.

Participants in this study will be asked to answer questions via an online database. The questionnaires may take up to 30 minutes to complete. Specific topics of these questions will include: general demographics, whether you are in practicum or internship, what academic program you are in, whether or not you have previous therapy experience, whether or not you have any personal history of traumatic events in your life, what type of caseload of clients you have, what type of setting you work in, and to what degree to you feel impacted by the work that you do.

There will be several requirements to participate in this study. Participants must be (a) at least 18 years of age, (b) able to read and understand English, (c) able to access the internet to complete online questionnaires, (d) a counselor-in-training at a CACREP accredited program; (e) currently involved in clinical practice through practicum or internship, and (f) have experience working with client(s) who have a history of trauma.

There are no risks associated with this study. There is no compensation for participating in the study, however every 10th participant will receive a $10 Amazon gift card.

If you are interested in participating in this study, or would like any additional information, please either follow the link to the online assessments, or email me at keriljohnson@ufl.edu. If you have any questions regarding rights as a research participant, contact the Institutional Review Board by calling 352-392-0433 and reference IRB Protocol #201702968.

https://ufl.qualtrics.com/jfe/form/SV_204r2BbpEPV7uE5
Thank you for your time and consideration. Your assistance in completing the questionnaires is greatly appreciated.
Warmly,

Keri Johnson, M.Ed./Ed.S., M.A.
Doctoral Candidate, Counselor Education
University of Florida

APPENDIX C
INFORMED CONSENT

Protocol Title: Exploring Vicarious Trauma and Vicarious Resilience in Counselors-in-Training

Please read this informed consent document in entirety before agreeing to participate.

About the Study: The purpose of this study is to gain a better understanding about the presence of vicarious trauma and vicarious resilience in counselors-in-training. The researcher is also interested in the factors that lead to vicarious trauma and vicarious resilience, such as level of clinical training, personal trauma history, and previous therapy experience.

Your Participation: Your participation in this study is completely voluntary. Should you consent to participate, you will be asked to answer questions through an online portal lasting approximately 15-30 minutes. There, you will be invited to answer a series of questions about your clinical training experiences, personal history with trauma, prior therapy, and general demographic information. You are not required to complete the questionnaire if you feel uncomfortable at any time. You may discontinue your participation at any time without penalty.

Benefits and Risks: The benefit of your participation is to contribute information to the counselor education community about your experience with vicarious trauma and/or vicarious resilience. This may assist the future training procedures of counseling students, and thus directly effecting clients' well-being who are seen by counselors-in-training. There are no risks associated with participating in this study. However, reflecting on previous traumatic experiences may bring up memories and associated emotions, and therefore you may withdrawal from the study at any time.

Confidentiality: The study is anonymous, meaning that although the answers to the questionnaires will be recorded, your name and identifying information will not be collected. All of your responses will be kept in a protected computer and no one will ever be able to connect your identity to your responses. The researcher will not share your individual responses with anyone other than the research supervisor, Dr. Kristina DePue.

If you have concerns, please contact me at keriljohnson@ufl.edu or the research supervisor at kdepue@coe.ufl.edu.

By clicking the box below you are indicating that you have read the above paragraphs and that you have had the opportunity to ask any questions about the study, your participation, and your rights that you may have, and that you agree to participate in the study.

☐ I agree to participate in this study

☐ I do not agree to participate in this study.

APPENDIX D
DEMOGRAPHIC QUESTIONNAIRE

Please answer the following questions:

1. What is your age? _____

2. What was your assigned sex at birth?
    a. Male
    b. Female
    c. Other

3. Which of the following best describes your current gender identity? “Trans” refers to an individual who identifies as a different gender than the sex one was assigned at birth. Therefore, a trans-male was assigned the sex of female at birth, but currently identifies as male. Whereas a current male identity means that one was assigned the sex of male at birth and still identifies his gender as male. (Select only one)
    a. Male
    b. Female
    c. Trans-male
    d. Trans-female
    e. Other (please specify): _____
    f. Prefer not to answer

4. How would you identify your racial/ethnic background?
    a. African American/Black
    b. American Indian or Alaskan Native
    c. Asian or Pacific Islander
    d. Caucasian/White—not of Hispanic/Latinx origin
    e. Hispanic/Latinx
    f. Middle Eastern
    g. Multi-Racial
    h. Other (please specify): _____
    i. Prefer not to answer

5. How would you identify your religious/spiritual affiliation?
    a. Agnostic
    b. Atheist
    c. Buddhist
    d. Catholic
    e. Christian
    f. Hindi
    g. Jewish
    h. Muslim
    i. Spiritual not Religious
    j. Other (please specify): _____

k. Prefer not to answer

6. How would you identify your sexual orientation?
    a. Asexual (an individual who experiences little or no sexual attraction to others and/or a lack of interest in sexual relationships/behavior)
    b. Bisexual (an individual who is emotionally, physically, and/or sexually attracted to males/men and females/women)
    c. Gay (an individual who is primarily emotionally, physically, and/or sexually attracted to members of the same sex and/or gender)
    d. Heterosexual (an individual who is primarily emotionally, physically, and/or sexually attracted to members of the opposite sex)
    e. Lesbian (a woman who is primarily emotionally, physically, and/or sexually attracted to some other women)
    f. Pansexual (an individual who experiences emotional, romantic, physical, and/or spiritual attraction for members of all gender identities/expressions)
    g. Questioning (an individual who is unsure about or exploring their own sexual orientation or gender identity)
    h. Other (please specify): _____
    i. Prefer not to answer

7. Have you ever participated in individual counseling? (Check all that apply)
    a. Prior to high school
    b. During high school
    c. During undergraduate college
    d. After college, but before entering the counseling program
    e. During the counseling program, but not during practicum or internship
    f. During the counseling program, only during practicum or internship
    g. Throughout the entire counseling program thus far

8. Are you currently participating in individual counseling?
    a. Yes
    b. No

9. If you did participate in individual counseling prior to starting your counseling training, how long did you seek counseling services?
    a. 0-2 months
    b. 3-6 months
    c. 6 months-1 year
    d. 1-2 years
    e. 3-5 years
    f. 5 or more years

10. If you did participate in individual counseling prior to starting your counseling training, how old were at the time of seeking counseling services?
    a. 4-9 years old
    b. 10-15 years old

c. 16-18 years old
d. 19-23 years old
e. 24-30 years old
f. Other (please specify): _____

11. Did you go right from undergraduate to graduate school?
    a. Yes
    b. No

12. If you did not go right from undergraduate to graduate school, how long was it until you continued higher education?
    a. 1 semester-1 year
    b. 2-3 years
    c. 4-5 years
    d. 6-8 years
    e. 9 or more years

13. What CACREP-accredited counseling program are you currently enrolled in? (Check all that apply)
    a. Clinical Mental Health Counseling
    b. Marriage, Couple, and Family Counseling
    c. Clinical Rehabilitation Counseling
    d. Addiction Counseling
    e. School Counseling
    f. Career Counseling
    g. College Counseling and Student Affairs
    h. Other (please specify): _____

14. How many face-to-face, direct service clinical hours have you provided counseling services to clients thus far in your training?
    a. 0-30 hours
    b. 30-60 hours
    c. 60-90 hours
    d. 90-120 hours
    e. 120-150 hours
    f. 150-180 hours
    g. 180-210 hours
    h. 210-240 hours
    i. 240-270 hours
    j. 270-300 hours
    k. Other (please specify): _____

15. Approximately, how many face-to-face, direct service clinical hours were with clients presenting with trauma-related symptoms?
    a. 0-30 hours
    b. 30-60 hours

c. 60-90 hours
d. 90-120 hours
e. 120-150 hours
f. 150-180 hours
g. 180-210 hours
h. 210-240 hours
i. 240-270 hours
j. 270-300 hours
k. Other (please specify): _____

16. What type of setting are you currently seeing clients in?
    a. Community Mental Health
    b. University Counseling Center
    c. Career Resource Center
    d. Disability Resource Center
    e. Crisis Center
    f. Private Practice
    g. Children's Center
    h. High School Counseling
    i. Other (please specify): _____

17. On average, how many clients do you treat per week? _____

18. On average, how many clients do you treat per week with traumatic stress symptoms? _____

19. On average, how many clients have you treated who have symptoms of traumatic stress? _____

20. In general, do the majority of your clients presenting with symptoms of traumatic stress have which of the following?
    a. Mildly distressing traumatic symptoms
    b. Moderately distressing traumatic symptoms
    c. Severely distressing traumatic symptoms
    d. A mixture of mild to severely distressing traumatic symptoms

21. How supported do you feel by your supervisors or faculty members with regard to your work with trauma survivors?
    a. Not Supported
    b. Mildly Supported
    c. Moderately Supported
    d. Very Supported

22. How well do you feel your academic and training program prepared you to work with trauma survivors?
    a. Not Prepared

b. Mildly Prepared
c. Moderately Prepared
d. Very Well Prepared

23. How confident do you feel in your ability to treat clients with traumatic stress symptoms?
    a. Not confident
    b. Mildly Confident
    c. Moderately Confident
    d. Very Confident

24. Have you pursued any additional programs in regard to trauma-specific trainings outside of your graduate school?
    a. Yes
    b. No

25. If yes, which trauma-specific training did you attend?
    _____

APPENDIX E
VICARIOUS TRAUMA SCALE

Instructions: Please read the following statements and indicate on a scale of 1 (*strongly disagree*) to 7 (*strongly agree*) how much you agree with them.

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Slightly Disagree	Neutral	Slightly Agree	Agree	Strongly Agree

1. My job involves exposure to distressing material and experiences.
2. My job involves exposure to traumatized or distressed clients.
3. I find myself distressed by listening to my clients' stories and situations.
4. I find it difficult to deal with the content of my work.
5. I find myself thinking about distressing material at home.
6. Sometimes I feel helpless to assist my clients in the way I would like.
7. Sometimes I feel overwhelmed by the workload involved in my job.
8. It is hard to stay positive and optimistic given some of the things I encounter in my work.

APPENDIX F
TRAUMA HISTORY QUESTIONNAIRE

The following is a series of questions about serious or traumatic life events. These types of events actually occur with some regularity, although we would like to believe they are rare, and they affect how people feel about, react to, and/or think about things subsequently. Knowing about the occurrence of such events, and reactions to them, will help us to develop programs for prevention, education, and other services. The questionnaire is divided into questions covering crime experiences, general disaster and trauma questions, and questions about physical and sexual experiences.

For each event, please indicate (circle) whether it happened and, if it did, the number of times and your approximate age when it happened (give your best guess if you are not sure). Also note the nature of your relationship to the person involved and the specific nature of the event, if appropriate.

Crime-Related Events		**Circle one**		***If you circled yes, please indicate***	
				Number of times	**Approximate age(s)**
1	Has anyone ever tried to take something directly from you by using force or the threat of force, such as a stick-up or mugging?	No	Yes		
2	Has anyone ever attempted to rob you or actually robbed you (i.e., stolen your personal belongings)?	No	Yes		
3	Has anyone ever attempted to or succeeded in breaking into your home when you were <u>not</u> there?	No	Yes		
4	Has anyone ever attempted to or succeed in breaking into your home while you <u>were</u> there?	No	Yes		
General Disaster and Trauma		**Circle one**		***If you circled yes, please indicate***	
				Number of times	**Approximate age(s)**

5	Have you ever had a serious accident at work, in a car, or somewhere else? (**If yes**, please specify below) _____ _____	No	Yes		
6	Have you ever experienced a natural disaster such as a tornado, hurricane, flood or major earthquake, etc., where you felt you or your loved ones were in danger of death or injury? (**If yes**, please specify below) _____ _____	No	Yes		
7	Have you ever experienced a “man-made” disaster such as a train crash, building collapse, bank robbery, fire, etc., where you felt you or your loved ones were in danger of death or injury? (**If yes**, please specify below) _____ _____	No	Yes		
8	Have you ever been exposed to dangerous chemicals or radioactivity that might threaten your health?	No	Yes		
9	Have you ever been in any other situation in which you were seriously injured? (**If yes**, please specify below) _____ _____	No	Yes		
10	Have you ever been in any other situation in which you feared you might be killed or seriously injured? (**If yes**, please specify below) _____ _____	No	Yes		

11	Have you ever seen someone seriously injured or killed? (**If yes**, please specify who below) _____ _____	No	Yes		
12	Have you ever seen dead bodies (other than at a funeral) or had to handle dead bodies for any reason? (**If yes**, please specify below) _____ _____	No	Yes		
13	Have you ever had a close friend or family member murdered, or killed by a drunk driver? (**If yes**, please specify relationship [e.g., mother, grandson, etc.] below) _____ _____	No	Yes		
14	Have you ever had a spouse, romantic partner, or child die? (**If yes**, please specify relationship below) _____ _____	No	Yes		
15	Have you ever had a serious or life-threatening illness? (**If yes**, please specify below) _____ _____	No	Yes		
16	Have you ever received news of a serious injury, life-threatening illness, or unexpected death of someone close to you? (**If yes**, please indicate below) _____ _____	No	Yes		

17	Have you ever had to engage in combat while in military service in an official or unofficial war zone? (**If yes**, please indicate where below) _____ _____	No	Yes		

Physical and Sexual Experiences		**Circle one**		***If you circled yes, please indicate***	
				Repeated?	**Approximate age(s) and frequency**
18	Has anyone ever made you have intercourse or oral or anal sex against your will? (**If yes**, please indicate nature of relationship with person [e.g., stranger, friend, relative, parent, sibling] below) _____ _____ _____	No	Yes		
19	Has anyone ever touched private parts of your body, or made you touch theirs, under force or threat? (**If yes**, please indicate nature of relationship with person [e.g., stranger, friend, relative, parent, sibling] below) _____ _____ _____	No	Yes		

20	Other than incidents mentioned in Questions 18 and 19, have there been any other situations in which another person tried to force you to have an unwanted sexual contact?	No	Yes		
21	Has anyone, including family members or friends, ever attacked you with a gun, knife, or some other weapon?	No	Yes		
22	Has anyone, including family members or friends, ever attacked you without a weapon and seriously injured you?	No	Yes		
23	Has anyone in your family ever beaten, spanked, or pushed you hard enough to cause injury?	No	Yes		
24	Have you experienced any other extraordinarily stressful situation or event that is not covered above? (**If yes**, please specify below) _____ _____	No	Yes		

APPENDIX G
VICARIOUS RESILIENCE SCALE

Directions: Please reflect on your experience working with persons who have survived severe traumas (e.g., physical and sexual assault, domestic violence, war, torture, displacement, kidnapping, and human-made and natural disasters). **Since you began this work**, you may have undergone changes in how you view your clients, your approach to this work, and/or your own experience or worldview. Please read each of the following 27 statements about how your attitudes, experiences, and your view of life may have changed since you began this work, and indicate the degree to which you experienced each item by circling the appropriate response to the right. The response options are:

Did <u>not</u> experience this (0), Experienced this to a *very small* degree (1), Experienced this to a *small* degree (2), Experienced this to a *moderate* degree (3), Experienced this to a *great* degree (4), Experienced this to a *very great* degree (5)

0	1	2	3	4	5
Did not experience this	Experienced this to a *very small* degree	Experienced this to a *small* degree	Experienced this to a *moderate* degree	Experienced this to a *great* degree	Experienced this to a *very great* degree

1. I am more hopeful about peoples' capacity to heal and recover from traumas.
2. My ideas about what is important in life have changed.
3. I am inspired by people's capacity to preserver through awful circumstances.
4. My life goals are priorities have evolved.
5. I am better able to keep my perspective when things go wrong.
6. I am more connected to people in my life.
7. I feel more compassionate to people in my life.
8. I am more hopeful and engaged when I focus on clients' strengths alongside their suffering.
9. I invest more time and energy into all my relationships.
10. I am more mindful and reflective.
11. I increasingly recognize spirituality as an important component in clients' survival and path to recovery.
12. When I experience distressing thoughts or images from work, I am able to just notice them without reacting.
13. I am better able to remain present when hearing trauma narratives.
14. I make more time for meditative, mindful or spiritual practices in my life.
15. When appropriate, I highlight clients' spiritual/religious beliefs to promote their resilience.
16. I am more in tune with my body (i.e., presence of tension, relaxation, etc.).

17. I am better at self-care (e.g., practices such as meditation, yoga, walks, exercise, massage).
18. Some clients' spiritual practices are a source of inspiration and feed my own resilience.
19. I have become more resourceful as a result of this work.
20. I am better able to cope with the uncertainties that come with my work.
21. I see my life as more manageable than before I started this work.
22. I am better able to reassess the dimensions of my own problems.
23. I have learned how to deal with difficult situations associated with this work.
24. I am better able to assess my level of stress or fatigue.
25. I am able to notice distressing memories of clients' trauma narratives without getting lost in them.
26. Therapists' and clients' ethnicity, gender, class, sexual orientation, and religion inform their relative power and privilege in the therapy room and beyond.
27. Clients' race, class, gender, sexual orientation, and accompanying privilege and marginalization organize their access to resources for overcoming adversity.

APPENDIX H
TABLE SAMPLES

Table H-1. Descriptive statistics for demographic variables of sample population

	Percentage (%) or SD	Number of Participants (or Mean)
Current Clinical Setting		
Community mental health	39.88%	65
University counseling center	24.54%	24
High school counseling	14.72%	10
Hospital/hospitalization setting	6.13%	10
Crisis center	5.52%	9
Elementary school	5.52%	9
Substance abuse treatment facility	4.29%	7
Private practice	4.29%	7
Other (Please specify)	4.29%	7
Disability resource center	1.84%	3
Children’s center	1.84%	3
Corrections	1.84%	3
Residential treatment	1.84%	3
Career resource center	1.23%	2
Age When Participated in Previous Therapy		
4-9 years old	2.29%	3
10-15 years old	15.27%	20
16-18 years old	11.45%	15
19-23 years old	31.30%	41
24-30 years old	12.98%	17

Table H-1. Continued

	Percentage (%) or SD	Number of Participants (or Mean)
Over age 31	7.63%	10
Multiple Occasions	19.08%	25
Length of Time in Previous Therapy		
0-2 months	21.5%	28
3-6 months	22.3%	29
6 months-1 year	9.2%	12
1-2 years	11.5%	15
3-5 years	10.8%	14
5 or more years	10.0%	13
Did not attend	14.6%	19
Trauma-Related Symptoms Presented by Clients Seen by Sample CITs		
Mildly distressing traumatic symptoms	23.66%	31
Moderately distressing traumatic symptoms	24.43%	32
Severely distressing traumatic symptoms	3.05%	4
A mixture of mildly to severely distressing traumatic symptoms	48.85%	64

Table H-2. Descriptive statistics by instrument

Instruments and Subscales	*Cronbach's alpha*	*Mean*	*SD*	*Range*
VTS*	0.69	35.76	6.83	2.78
THQ**	0.74	29.22	3.52	0.61
Crime-Related Traumatic Events	0.62	4.73	1.01	0.21
General Disaster and Trauma	0.63	15.88	2.1	0.61
Physical and Sexual Traumatic Experiences	0.54	8.61	1.50	0.26
VRS***	0.95	75.43	26.02	1.96
Increased Capacity for Resourcefulness	0.86	16.60	6.67	0.73
Change in Life Goals and Perspectives	0.90	16.69	7.41	1.09
Increased Self-Awareness and Self-Care Practices	0.83	10.30	5.09	0.62
Client Inspired Hope	0.70	10.19	2.76	1.04
Increased Recognition of Spirituality as a Client Resource	0.79	6.80	4.15	0.68
Increased Capacity to Remain Present During Trauma Narratives	0.81	8.75	3.32	0.99
Increased Consciousness Around Social Location and Power	0.41	6.11	2.35	0.77

Note. *N = 122. **N = 119. ***N = 118.

Table H-3. Results from multiple regression analyses by model

Model	*t*	*p*	β	*F*	R_2	*adj.* R_2	*Mean*	*SD*
Model 1*								
Regression		0.154		1.786				
Previous Therapy	-2.048	0.043	-0.331					
Personal Trauma	-2.198	0.030	-0.504					
Interaction	2.146	0.034	0.609					
Model 2**					0.006	-0.011	35.93	6.70
Regression		0.696		0.364				
Previous Therapy	-0.503	0.616	-0.048					
Personal Trauma	-0.576	0.566	-0.055					
Model 3***								
Regression		0.017		3.550				
Previous Therapy	-0.413	0.680	-0.065					
Personal Trauma	1.288	0.201	0.289					
Interaction	0.046	0.964	0.013					
Model 4****					0.085	0.070	75.43	26.02
Regression		0.006		5.370				
Previous Therapy	-0.654	0.514	-0.060					
Personal Trauma	3.277	0.001	0.298					

Note. N = 118 for analyses. *Dependent Variable: VT; Predictor Variables: Previous Therapy, Personal Trauma, and Interaction. **Dependent Variable: VT; Predictor Variables: Previous Therapy and Personal Trauma. ***Dependent Variable: VR; Predictor Variables: Previous Therapy, Personal Trauma, and Interaction. ****Dependent Variable: VR; Predictor Variables: Previous Therapy and Personal Trauma.

APPENDIX I
FIGURE SAMPLES

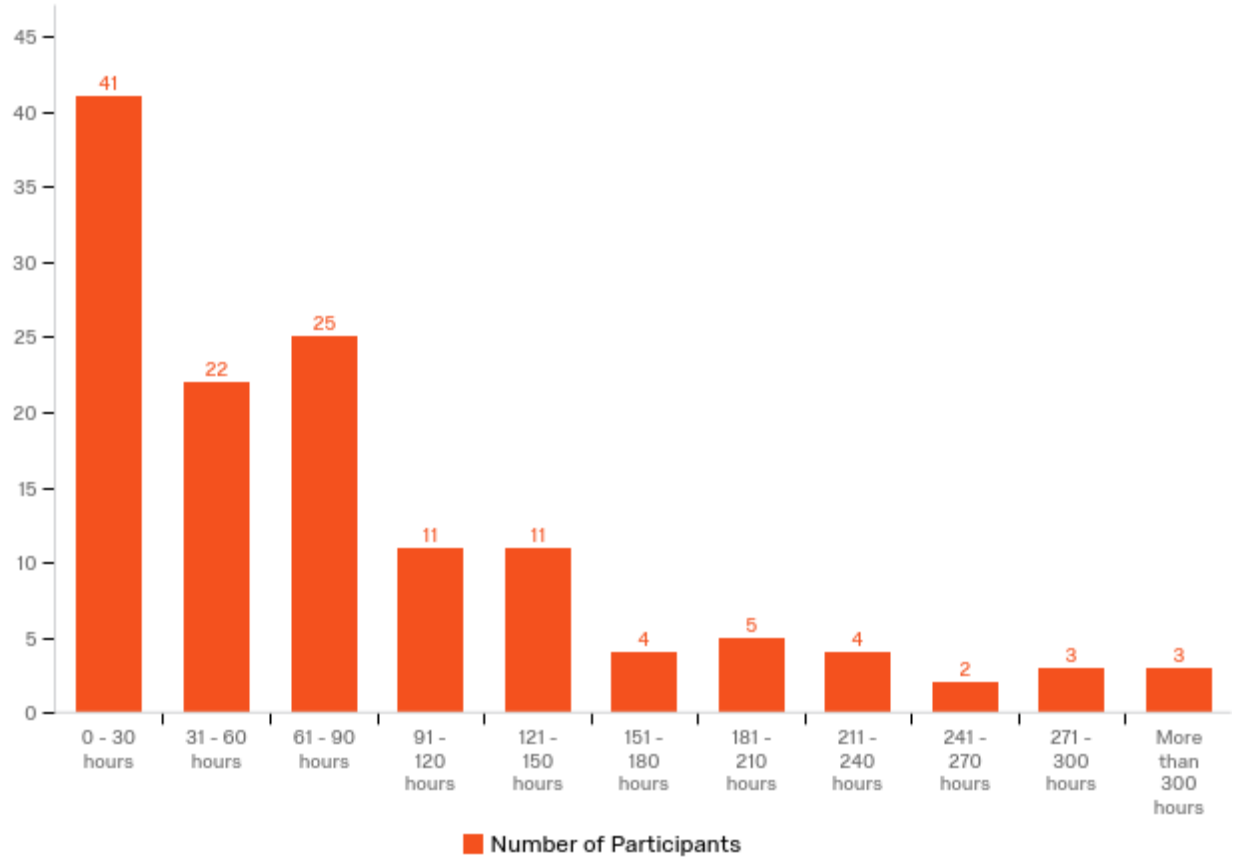

Figure I-1. Approximate number of face-to-face, direct service, clinical hours with clients presenting with trauma-related symptoms in sample population

APPENDIX J
COMPREHENSIVE LITERATURE REVIEW

Within this chapter, the theoretical model that will situate the study presented. Next, the researcher discusses the constructs trauma, vicarious trauma (VT), and vicarious resilience (VR), as well as a few additional terms that are found in the literature when exploring trauma-related effects of mental health professionals. Finally, the researcher concludes the chapter by presenting research on the two chosen constructs, and thus, the rationale for choosing vicarious trauma and vicarious resilience.

Due to the high prevalence of trauma experienced across the globe by diverse populations, some researchers now consider trauma to be a *public health epidemic* (Baker, Brown, Wilcox, Overstreet, & Arora, 2016; Women and Trauma Federal Partners Committee & United States of America, 2013). Within the United States, trauma experienced at childhood occurs in approximately two-thirds of individuals (Center for Disease Control and Prevention [CDC], 2016). According to the Adverse Childhood Experiences (ACE) study, which involved over 17,000 participants, higher incidents of childhood trauma predicted a, greater likelihood of suffering from one of the 10 leading causes of death in the United States (Herman, 2015). Furthermore, higher ACE scores are connected to smoking, obesity, alcoholism, risky sexual behavior, and intravenous drug use (Felitti, et al., 1998; Herman, 2015). Therefore, incidents of trauma, specifically childhood trauma, are directly linked to potentially maladaptive behaviors that many adult clients struggle with when entering therapy. It is estimated that between 82% to 94% of the clients seeking services in community mental health centers have experienced some form of traumatic event (Bride, 2004). This statistic is

not surprising considering the results of the ACE study, which indicated that nearly two-thirds of individuals experienced trauma in childhood (CDC, 2016). Therefore, the likelihood that most therapists will work with trauma survivors in their career is high (Bride, 2004; Trippany, White Kress, & Wilcoxon, 2004).

Constructivism Theoretical Framework

Constructivism theory, a postmodern paradigm, is rooted in the understanding that human development is socially constructed through interactions with others. Therefore, reality is created and co-created through the subjective perspective of life experiences (Lincoln, Lynham, & Guba, 2013). The term “social construction” was originally coined by Berger and Luckmann in *The Social Construction of Reality* (1966) and was influenced by Scheler’s (1926) term *wissenssoziologie* or the “sociology of knowledge”. Constructivism suggests that an individual’s beliefs and assumptions are products of the meaning attributed to social interactions (Nelson & Neufeldt, 1998). Constructivist theory fundamentally opposes the existence of any static, knowable, or observable truth. Therefore, according to constructivism, it is necessary to remain curious about, question, and evaluate information presented for knowledge is understood to be individual or collective reconstructions of lived experiences (Lincoln, Lynham, & Guba, 2013).

Constructivism was chosen as the theoretical paradigm for this study due to the inherent focus on the reconstructed nature of the social world. Constructivism aims to understand and interpret information through the construction and reconstruction of lived experience (Lincoln, Lynham, & Guba, 2013). A consensus and deeper understanding of society can be obtained through inquiry around individual and

collective reconstructions. Thus, in order to better understand the impacts of trauma and resilience on counseling trainees, it becomes necessary to investigate how novice counselors construct their realities around working with traumatized populations.

Theoretical Models for VT and VR

Both *VT* and *VR* are conceptualized under the framework of constructivism. Specifically, according to constructivism, an individual is shaped by lived experiences, and trauma is one form of lived experience. Exposure to trauma can be experienced in one of three ways: (a) assimilation, or no change to previous perceptions of themselves and the world, (b) positive assimilation, or positive change to previous perceptions of themselves and the world, or (c) negative accommodation, or negative change to previous perceptions of themselves and the world (Tedeschi & Calhoun, 1995, 2004). Constructivists believe that discomfort is a necessary component to the processes of growth and change (Mahoney, 1991, 1996). The opportunity for personal growth following exposure to trauma work can be conceptualized under the framework of posttraumatic growth (PTG), which can be defined as any significant positive psychological change as a result from major crisis or trauma (Tedeschi & Calhoun, 1995; Tedeschi, Calhoun, & Cann, 2007). This process of PTG is understood through a similar constructivist theoretical lens as Constructivist Self Development Theory (CSDT). When developing the construct of VT, McCann and Pearlman (1990) conceptualized VT within the framework of CSDT (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). The following section will provide a brief overview of CSDT.

Constructivist Self Development Theory (CSDT)

CSDT is a theoretical framework that weaves together psychoanalytic theories (self-psychology and object relations theory) with social cognition theories (Pearlman & Mac Ian, 1995). CSDT suggests that individuals construct their understanding of reality through cognitive schemas (Cohen & Collens, 2012; Pearlman & Mac Ian, 1995). These schemas, which include an individual's assumptions, beliefs, and expectations regarding themselves, others, and the world, are used to make sense of and interpret the world, events, and experiences they have (Cohen & Collens, 2012; McCann & Pearlman, 1990). CSDT provides a developmental foundation for conceptualizing the experiences of surviving traumatic life events (Pearlman & Mac Ian, 1995). Furthermore, CSDT situates the way survivors adapt to trauma through their own personality traits, such as defensive and coping styles, in addition to their own psychological needs. These characteristics then interact with the memories of the traumatic events within social and cultural contexts that shape the individual's responses to the event(s) (Pearlman & Mac Ian, 1995). Simply put, CSDT suggests that individuals create their experience of reality through the development of different cognitive schemas (Cohen & Collens, 2012). However, when trauma or VT is experienced, some of the fundamental schemas may be challenged, invalidated, or shattered (Janoff-Bulman, 1992; McCann & Pearlman, 1990). In terms of VT, these schemas and ways of viewing the world are often adversely affected, which may cause further distress (Cohen & Collens, 2012; McCann & Pearlman, 1990). As some research has shown, a personal trauma history may be a contributing factor in the

development of either VT or VR (Ghahramanlou & Brodbeck, 2000; Frey et al., 2017; Pearlman & MacIan,1995; Schauben & Frazier, 1995; Slattery & Goodman, 2009).

Framework for VT

Trauma may have an array of effects on the individual, such as depression, anxiety, interpersonal distress, and difficulty with emotion regulation. These symptoms may, in turn, lead to specific coping behaviors aimed at reducing the experienced distress, such as substance use, self-injury, dissociation, suicidal ideation, aggression, and impulsive or addictive behaviors (Briere, 2004, 2015; Courtois & Ford, 2012; van der Kolk et al., 1996). Throughout this paper, particular attention will be on the psychological effects of trauma and the interventions that have the potential for navigating through the complicated symptoms experienced by trauma survivors and trauma therapists.

Definitions and Concepts

The experience of chronic exposure to clients' distressing and traumatic material may become emotionally, mentally, physically, and psychologically taxing on mental health providers (Bercier & Maynard, 2015; Bride, Radey, & Figley, 2007; Conrad & Kellar-Guenther, 2006; Figley, 1995). One of the earliest acknowledgements to this cost of caring was from Carl Jung, when he addressed the challenges of *countertransference*, or a counselor's conscious and unconscious reactions to a client's story (Jung, 1907). Three common professional trauma-related conditions are cited in contemporary literature that describes the posttraumatic stress-like symptoms that result from the exposure to various traumatic material shared by clients: *VT* (McCann & Pearlman, 1990)*, secondary traumatic stress* (Figley, 1995), and *compassion fatigue*

(Figley, 1995). These risks can be conceptualized as two different phenomena: trauma-related stress and professional burnout. *Professional burnout*, while a more general phenomenon than the three trauma-related stressors mentioned above, is another important concept to unpack when discussing the adverse effects of working in the mental health profession. Although there can be distinctions made between VT, secondary traumatic stress, and compassion fatigue, all three terms refer, in one way or another, to the adverse impact of therapeutic work with traumatized clients (Bercier & Maynard, 2015; Bride, Radey, & Figley, 2007). Throughout the literature these terms are at times used interchangeably (Craig & Sprang, 2010; Sprang, Clark, & Whitt-Woosley, 2007), however, there are distinct differences worthy of addressing. Some researchers argued that the interchangeable use of these terms is erroneous and downplays the complexity of each phenomenon and the comprehensive nature of these trauma-related stressors (Eastwood & Ecklund, 2008; Jenkins & Baird, 2002; Newell & MacNeil, 2010; Van Hook & Rothenberg, 2009). Regardless of the title used for this phenomenon, some social services communities are referring to these risks as *occupational hazards* for the individuals providing these services (Pryce, Shakleford, & Pryce, 2007). To begin, the nuances of the term *trauma* will be explored to set the foundation of this literature review.

Trauma

Generally defined in Western psychology, trauma refers to an exposure to a situation when an individual is confronted with an event that involves actual or threatened death, serious injury, or a threat to self or other's physical well-being, often resulting in emotional distress (American Psychiatric Association, 2013). Simply put,

trauma can include any experience that overwhelms an individual's ability to cope. Trauma, an extreme form of stress, is a phenomenon that has the potential to affect a person's quality of life across numerous areas (Felitti et al., 1998). If stress can be predictable and moderate, it is likely that the individual experiencing it may develop resilience (Perry, 2007). However, if the stress is unpredictable, severe, and over an extended period of time, the individual may develop a vulnerability to the physiological stress response within the body, thus affecting all aspects of life—physical, mental, emotional, social, and behavioral (Center for Youth Wellness, 2014; Wolpow, Johnson, Hertel, & Kincaid, 2009). In addition the adverse effects trauma may have on an individual's system listed above, there are specific components involved with the experience of trauma.

The Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) delineated three components to the definition of trauma—the "three e's"—events, experience, and effects. First, there is an *event* that is *experienced* that has a wide range of potential adverse *effects* on an individual's system. Second, the event situates the experience during a specific time and place, which may or may not be experienced as traumatizing. Lastly, the effects of trauma can include adverse physical, mental, emotional, or social consequences. The effects of trauma can fundamentally reorganize the way the mind perceives the world (van der Kolk, 2014). Therefore, trauma not only effects how and what one thinks about, but quite literally changes one's ability to think (van der Kolk, 2014). In addition to changes in cognition, the physiology of a trauma survivor can change. The body itself can provide important information about where and how trauma gets stuck through the physical expressions or "somatic narrative"—

gesture, posture, facial expressions, or movement (Ogden, 2015). Ogden states that this somatic narrative is an important resource in psychotherapy that is largely underutilized. Some researchers suggested that the somatic narrative may provide more significant information than the narrative of spoken words (Levine, 1997, 2008; Ogden, 2015; van der Kolk, 2014). In addition to the macro-level reorientation of how an individual perceives the world, trauma is also experienced on the micro-level within the body.

According to the ever-growing body of research, trauma gets stored in the body as an incomplete fight or flight response (e.g., Levine, 1997, 2008; Ogden, 2015; van der Kolk, 2014). Individuals become traumatized when their ability to respond to a perceived threat becomes thwarted in some way (Levine, 2008). There are three distinct levels of exposure to trauma: (a) acute, (b) chronic, and (c) complex trauma (Department of Children and Families [DCF], 2017). Acute trauma is associated with one single event, such as a natural disaster, automobile accident, or loss of a loved one. Chronic trauma is the prolonged exposure to physical, mental, or emotional abuse, such as repeated physical abuse, sexual assault, or interpersonal domestic violence. Complex trauma often refers to exposure to chronic trauma and the exposure of such trauma over the lifespan (DCF, 2017). In addition to the direct experience of trauma that overwhelms an individual's system, trauma can be indirectly experienced and still wreak havoc on one's cognitive, emotional, psychological, and physiological systems. One term for this indirect trauma response is known as *vicarious trauma/traumatization*.

Risks of Working with Trauma

Due to the fact that trauma literally changes the body and mind (Levine, 1997, 2008; Ogden, 2015; van der Kolk, 2014), it becomes imperative to consider the constructivism model when exploring how trauma effects individual and collective perceptions of the world. In this section, the distinguishing features of the risks of trauma-related stress and professional burnout will be further delineated.

Professional burnout

First coined by Freudenberger (1974), burnout was described as a state frustration or fatigue connected to the individual's passion to a particular way of life that did not meet their expectations. The general term *burnout* can be conceptualized as an individual's negative experiences with their job, such as exhaustion, cynicism, and inefficacy (Maslach, Leiter, & Jackson, 2011). Burnout has been called the "cost of caring" (Maslach, 1982) and an "occupational hazard" (Freudenberger, 1977). It can be associated with feelings of hopelessness with regard to one's work (Stamm, 2005). Specifically, *professional burnout* is the state of physical, mental, emotional, psychological, and spiritual exhaustion that results from working with vulnerable or suffering populations (Pines & Aronson, 1988). Burnout has been found to include three domains: (a) emotional exhaustion, (b) depersonalization, and (c) reduced sense of personal accomplishment (Maslach, 1976; Maslach & Jackson, 1981; Vredenburgh, Carlozzi, & Stein, 1999). Furthermore, burnout has been associated with different feeling states, such as anger, alienation, depression, detachment, hopelessness, numbness, worthlessness, and job attrition (Irving, Dobkin, & Park, 2009; Pines & Maslach, 1978). Warning signs of burnout include when these emotions, particularly

anger, frustration, or impatience are directed toward the clinician's clients. Thus, directly affecting the therapeutic relationship in helping professionals.

VT

Originally introduced by McCann and Pearlman in 1990, VT has been widely researched in order to understand the potentially adverse and long-term effects of indirect trauma on health care providers (Aparicio, Michalopoulous, & Unick, 2013). Following Pearlman and Saakvitne (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Saakvitne, 1996; Saakvitne & Pearlman, 1996), this proposal study will conceptualize VT as the alterations in the therapist's cognitive schemas (e.g., beliefs, assumptions, and expectations of self, other, and the world) resulting from empathic engagement with clients' traumatic material.

Researchers have defined VT to include the following three components: (a) the individual requires chronic exposure to traumatic material, (b) that individual will experience cognitive and affective distress following the repeated exposure, and (c) a negative shift in cognitive schemas will result (Aparicio, Michalopoulous, & Unick, 2013; Pearlman & Saakvitne, 1995). Therefore, VT refers to cognitive and affective changes that result from empathic engagement with survivors of trauma (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Saakvitne, 1996; Saakvitne & Pearlman, 1996; Pearlman, 1999). Cognitive symptoms of VT include shifts in schemas in the individual's frame of reference, which can present as disturbances in one's identity, self-perception, ego resources, psychological needs, spiritual connection, and overall worldview (Aparicio, Michalopoulous, & Unick, 2013). The defining features of VT stated above

indicate only some of the adverse effects that can occur when working with traumatized populations.

According to Robinson-Keilig (2013), cognitive schemas can be considered systems of thought that center on one's meaning making of self-identity and the world. Specifically, certain schemas are more vulnerable than others to be impacted by VT, which include safety, trust, esteem, control, and intimacy. McCann and Pearlman (1990) further explain that it is understood that these five primary schemas can become fundamentally altered if the therapists are exposed to repeated traumatic material. From a constructivist perspective, VT may result in considerable disruptions in an individual's sense of meaning making, connection to self and others, personal identity, and worldview. Pearlman and Saakvitne (1995) highlighted that VT can adversely affect one's emotion tolerance, psychological needs, perception of self and other, interpersonal relationships, and sensory memory. Additionally, VT is associated with symptoms resembling post-traumatic stress disorder (PTSD), such as flashbacks, depression, and avoidance behaviors. Specifically, the effects of VT may include similar symptoms to the originally traumatized client, such as nightmares, and fearful and intrusive thoughts or images (McCann & Pearlman, 1990) and difficulty coping with emotional distress and feelings of anger toward perpetrators (Schauben & Frazier, 1995). Iliffe and Steed (2000) found that out of 18 participants who worked with perpetrators or survivors of domestic violence interviewed for their study, more than half experienced decreased sense of safety in the world and changed worldviews, while many participants recognized an increased sense of awareness around power dynamics.

Secondary traumatic stress

The phenomenon of secondary traumatic stress originally stemmed from systems theory (Figley, 1983). Figley first identified the concept of secondary trauma, which was later named *secondary traumatic stress* or *secondary traumatization* (Adams & Riggs, 2008; Dunkley & Whelan, 2006). Since the debut of STS in 1995, Figley has refined and revised the concept of secondary traumatic stress based upon current literature and research (Ludick & Figley, 2017). Secondary traumatic stress can be defined as the natural behavioral consequences that result from knowing about traumatic event(s) endured by an individual, that results from wanting to help alleviate the suffering of that individual (Figley, 1995). Secondary traumatic stress is highly complex and the effects of experiencing the trauma of others and feeling responsible for helping them can often feel unavoidable (Ludick & Figley, 2017). Therefore, it may result from the empathic engagement with a suffering individual who has endured traumatic experiences. VT and secondary traumatic stress have similar characteristics; however, a conceptual distinction is that VT results in a shift of cognitive schemas (thoughts and beliefs), whereas secondary traumatic stress results in behavioral changes of the practitioner (Figley, 1995). The symptoms of secondary traumatic stress tend to mirror the symptoms of posttraumatic stress disorder (PTSD), such as intrusive thoughts, traumatic memories or flashbacks, insomnia, fatigue, difficulty concentrating, avoidance, and hypervigilance (APA, 2014; Bride, Radey, & Figley, 2007; Figley, 1995; Newell & MacNeil, 2010). When originally conceived, secondary traumatic stress was an umbrella term that included compassion fatigue (Figley, 1995).

Compassion fatigue

Initially coined in conjunction with secondary traumatic stress, the term *compassion fatigue* can be defined as a state of biological, psychological, and social exhaustion and dysfunction that is the result of repeated exposure to client experiences, when mental health care providers feel overwhelmed or hopeless in their ability to alleviate their client's suffering (Figley, 1995). Additionally, compassion fatigue is a state of preoccupation and re-experiencing of the traumatized clients' stories, including avoidance of anxiety associated with the client (Figley, 2002). Furthermore, compassion fatigue can be understood as a syndrome that includes a combination of symptoms from secondary traumatic stress and professional burnout (Adams, Boscarino, & Figley, 2006; Bride, Radney, & Figley, 2007; Figley, 1995; Newell & MacNeil, 2010). Thus, it can be a term used to describe secondary traumatic stress symptoms (Bride, Radey, & Figley, 2007; Figley, 1995, 2002). However, clinicians can experience compassion fatigue, such as emotional and physical fatigue due to chronic engagement of empathy with suffering clients without ever experiencing secondary traumatic stress (Newell & MacNeil, 2010). Compassion fatigue can be understood as the depletion of internal emotional support and resources followed by acute emotional pain that is the consequence of caring for and wanting to help the suffering of others (Alkema, Linton, & Davies, 2008; Merriman, 2014; Rank, Zaparanick, & Gentry, 2009).

Rationale for VT

Overall, these aforementioned symptoms are not only concerning for the mental health professionals, but can also adversely effect the counselor's ability to provide adequate care to their clients. For the purpose of this proposed study, the trauma-

related construct under consideration is VT. The rationale behind this decision is because out of three trauma-related stressors discussed—VT, secondary traumatic stress, and compassion fatigue—VT is the primary form of trauma that directly effects the counselor's sense of self and personal worldview, which may lead to decreased self-efficacy and higher rates of clinical errors. Both secondary traumatic stress and compassion fatigue emphasize the emotional and behavioral changes of the trauma therapist, whereas VT involves shifts to the cognitive schemas and meaning making systems of the mental health professional.

Factors Influencing VT

Researchers have shown that the degree of VT experienced by mental health professionals is influenced by a number of factors, namely level of clinical experience and personal trauma history (Chrestman, 1999; Devilly, Wright, & Varker, 2009; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995; Tabor, 2011). Other contributing factors may include: negative coping strategies, level of personal stress, gender (with women indicating higher degrees of symptomology), and percentage of trauma work in caseload (Beck, 2011; Brady, Guy, Poelstra, & Brokaw, 1999; Cornille & Meyers, 1999; Follette, Polusny, & Milbeck, 1994; Kassam-Adams, 1995; Sabin-Farrell & Turpin, 2003).

Clinical experience

Previous research has found that early professionals who are newer to their jobs or have less trauma education tend to experience more indirect trauma when working with trauma survivors (Adams & Riggs, 2008; Adams, Matto, & Harrington, 2001; Baird & Jenkins, 2003; Meyers & Cornille, 2002; Pearlman & Mac Ian, 1995; Steed & Bicknell,

2001). For example, VT has been found to be more common in younger and less experienced social workers than in their seasoned counterparts (Adams, Matto, & Harrington, 2001). In addition, when looking at counseling training programs, students that were unprepared and uneducated about working with client's traumatic material or were not invited to openly speak about their reactions to trauma clients in the classroom, they were more likely to experience VT (Knight, 2010). In general, graduate school is a stressing environment without the additional pressure of working trauma clients. Stress is a noteworthy concern for graduate students as they struggle with a variety of academic, financial, personal, and social concerns (Di Pierro, 2010; Oswalt & Riddock, 2007). Therefore, CITs are in a unique place in their development and may already experience higher levels of stress and anxiety than their more experienced counterparts. As such, this adds additional risks for VT due to their vulnerable emotional states as they work with clients for the first time. Adams and Riggs (2008) discovered that lectures or discussions about trauma were not sufficient in educating counseling trainees and mitigating the adverse effects of VT. Not having a strong support system could play a role in the likelihood that CITs experience VT. Specifically, professionals without a strong support system in their work environment are at greater risk for experiencing of VT (Ortlepp & Friedman, 2002). Furthermore, Wilson and Brwynn (2004) suggested that therapists that experience VT may have more poignant countertransference reactions, may have less awareness around these reactions, and therefore may make more clinical errors, which likely would hinder treatment progress. As CITs are more likely to experience countertransference than their more experienced

counterparts (Tobin & McCurdy, 2006), this puts them at higher risk for experiencing VT.

These studies indicate the prevalence of VT in young professionals and inferences can be drawn as to the impact on CITs; however, only one study was found that examined a direct link between VT and CITs. In that study, novice clinicians with 0-2 semesters of applied clinical work with traumatized clients experienced more distress than trainees with more than 2 semesters of clinical work (Adams & Riggs, 2008). The presence of distress in CITs after working with traumatized clients is a symptom of VT; however, more research is needed to understand the array of adverse effects that CITs experience when working with trauma. In addition to level of clinical experience, personal trauma history is another important factor that has been found the presence of VT in clinicians.

Personal trauma history

There are a few studies dating back to the early 1990's that indicate a high probability that many mental health providers have their own personal trauma histories (Elliott & Guy, 1993; Pearlman & Mac Ian, 1995; Pope & Feldman-Summers, 1992). Other, more current research has highlighted that having a personal trauma history could be an indicator for experiencing VT (Baird & Kracen, 2006; Collins & Long, 2003; Nelson-Gardell & Harris, 2003). However, some empirical findings regarding the connection between personal trauma history and VT are mixed (Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995; Way, VanDeusen, Martin, Applegate, & Jandle, 2004). For example, Pearlman and Mac Ian (1995) interviewed self-identified trauma therapists (n = 188) and those with a personal trauma history displayed higher disturbance than

those without a personal trauma history. Conversely, when Schauben and Frazier (1995) conducted research with counselors that worked with sexual assault survivors, a personal trauma history was not a significant factor in higher degrees of VT. More recently, Cosden, Sandford, Koch, and Lepore (2016) discovered that in a group of substance abuse counselors (*n* = 51), VT was significantly associated with a personal history of trauma. However, this study is limited due to its reliance of convenience sampling and the majority of the clinicians had previous training or supervision in trauma-informed approaches (Cosden et al., 2016).

Cohen and Collens (2013) metasynthesis of VT provided a list of 20 qualitative or mixed methods articles that investigated the impact of being exposed to traumatic material through trauma work. One of the primary limitations of most of these articles was small sample size of the group participants. Of the 20 articles, only 2 included more than 40 participants, one of which was Schauben and Frazier's seminal study in 1995. Furthermore, based upon Adams and Riggs (2008) exploratory study including 54 counseling trainees, the contradictory evidence of whether or not personal trauma history is related to VT may be explained by different defense styles. The researchers found that defense styles played a "moderating role in the relationship between personal history and VT" (Adams & Riggs, 2008, p. 31). Consequently, based upon this conflicting information, more research is needed to contribute to the argument of whether or not having a personal trauma history does make counselors and counseling trainees more susceptible to VT.

Personal trauma history in mental health professionals

As identified above, there is conflicting evidence that suggests whether or not having a personal trauma history makes an individual more or less vulnerable to VT. Therefore, it will be necessary to establish a conceptual understanding about the presence of personal trauma history in mental health professionals. Various studies indicate the high probability that many mental health providers have their own personal trauma histories (Elliott & Guy, 1993; Pearlman & MacIan, 1995; Pope & Feldman-Summers, 1992). In a 1990 national survey of 500 clinical and counseling psychologists (250 men and 250 women) over two-thirds of women (69.93%) and one-third of men (32.85%) stated that they had personal experiences of sexual or physical abuse (Pope & Feldman-Summers, 1992). Furthermore, the perceived quality of graduate or internship training in sexual and nonsexual abuse was low for both men and women (Pope & Feldman-Summers, 1992). However, more recent graduates indicated slightly higher ("very poor") rating of both the graduate and internship trainings (Pope & Feldman-Summers, 1992). In a study comparing mental health professionals to non-mental health professionals, Elliott and Guy (1993) found that when compared to other professionals, psychotherapists indicated higher rates of physical abuse, sexual molestation, parental alcoholism, psychiatric hospitalization of a parent, death of a parent or sibling, and overall greater dysfunction in their families of origin. In another study, Pearlman and MacIan (1995) found of the 188 self-identified trauma therapists, 60% (80 women and 32 men) reported to have had a personal trauma history.

Two of the earliest studies on VT (Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995) indicated that therapists with less clinical experience tended to have

more disruption in feelings of safety, control, intimacy, trust, and self-esteem than their more experienced counterparts. More specifically, Pearlman and Mac Ian (1995) reported that individuals with less than 2 years of experience in the field exhibited more trauma-related symptoms than individuals with more experience. Subsequently, the researchers discovered that sexual violence counselors who had their own personal history of sexual trauma tended to display the highest levels of trauma-related symptoms (Pearlman & Mac Ian, 1995). In their study on VT in the legal profession, Vrklevski and Franklin (2008) found that individuals with multiple personal trauma experiences were more likely to display higher levels of VT. Furthermore, in addition to level of clinical experience and personal trauma history, Pearlman and Saakvitne (1995) suggested that a lack of formal trauma education in program coursework and maladaptive defense styles in therapists may lead to increased vulnerability of VT.

VT Research Limitations

Significant research on the adverse effects of working with traumatized individuals has several limitations that must be addressed before presenting study results (Adams, Figley, & Boscarino, 2008). Specifically, five limitations are important to highlight when discussing research on this topic (Adams et al., 2008). Those limitations are: (a) lack of conceptual clarity on secondary trauma, (b) numerous secondary trauma-related scales that differ in conceptualization and measurements, (c) research studies have neither fully address the originally conceptualization of secondary trauma, nor chosen predictor variables within a solid theoretical framework, (d) studies have not been random samples, limiting generalizability, and (e) many studies do not relate secondary trauma to psychological distress. Despite these limitations, some preliminary

evidence does highlight that there are consequences of working with traumatized populations. In Cohen and Collens' (2013) metasynthesis of VT, they provided a list of 20 qualitative or mixed methods articles that investigated the impact of being exposed to traumatic material through trauma work. A primary limitation in most of these articles was small sample size of the group participants. Of the 20 articles, only 2 included more than 40 participants, one of which was Schauben and Frazier's seminal study in 1995. Due to the small sample sizes, results must be interpreted with caution and generalizeability is limited. It is evident that more studies are needed to explore the factors involved with VT on mental health professionals. Despite these limitations, preliminary evidence reviewed highlights that there are consequences of working with traumatized populations.

Framework for Vicarious Resilience (VR)

In addition to the negative effects that may be experienced by trauma counselors, for some, there may be an array of positive results of working with traumatized clientele. Clinicians often report benefits, such as faith in humanity, increased sense of self-worth, enhanced sense of purpose, and satisfaction in their work (Herman, 2015; Pearlman & Saakvitne, 1995). Therapists not only hold space for clients' pain and suffering, but additionally, their strength and perseverance. In short, therapists have the potential to experience pleasurable results from sitting with their clients as they overcome adversity. Rather than just examining the adverse consequences of working with traumatic material, this proposal aims to move away from a deficit-based approach to counselor education, toward a more inclusive, strengths-based model (Southwick, Bonanno, Masten, Panter-Brick, & Yehuda 2014).

Definitions and Concepts

The experience of chronic exposure to clients' distressing and traumatic material may become emotionally, mentally, physically, and psychologically taxing on mental health providers. Conversely, there may also be transformation, growth, and resiliency experienced. Recently, researchers have been increasingly interested in the positive impacts on trauma counselors. Three common professional conditions are cited in the literature that describes the benefits of working with traumatized populations: *VR* (Hernández, Gangsei, & Engstrom, 2007)*, vicarious posttraumatic growth* (Arnold, Calhoun, Tedeschi, & Cann, 2005), and *compassion satisfaction* (Stamm, 2002). Although there have been some distinctions made between these three constructs, definitional overlap has been found (Frey et al., 2017). Therefore, each of these phenomena will be briefly defined to discuss areas of distinction and overlap. To begin, a definition of resilience will be a necessary construct to explore to set the foundation of this section of the literature review.

Resilience

The study of resilience was spearheaded by researchers when they began to notice certain children flourishing when others did not, even in the middle of adversity (Anthony, 1974; Garmezy, 1974; Murphy & Moriarty, 1976; Rutter, 1979; Werner & Smith, 1982). According to the American Psychological Association (APA; 2013), *resilience* is defined as "the process of adapting well in the face of adversity, trauma, tragedy, threats or even significant sources of stress" (para. 4). Furthermore, resilience can be broadly defined as the ability for an individual or system to successfully adapt to various struggles that threaten it's ability to function, remain viable, or develop in a

particular manner (Masten, 2014, 2016). In other words, resilience is the capacity to do well, even in the face of challenges or adversity (Masten, 2016). Southwick and colleagues (2014) contend that it is necessary, when defining resilience, to take into account the various biological, psychological, social, and cultural aspects that influence how an individual or system may respond in stressful circumstances. Some researchers even suggested that resilience most likely exists on a continuum that may fluctuate across developmental stages of one's life (Pietrzak & Southwick, 2011; Southwick et al., 2014). Additionally, resilience can be perceived as an ability to make the decision and consciously choose to move forward integrating insight from adverse experiences (Southwick et al., 2014). Furthermore, researchers contend that resilience is a complex construct that may have various manifestations depending on the context in which it is being observed (Southwick et al., 2014).

VR

While a relatively new and less established concept, *VR* is gaining recognition in the field of psychotherapy. Originally coined in 2007 by Hernández, Gangesi, and Engstrom, VR is a specific process that may occur in trauma counselors as a result from being exposed to the resilience displayed by their clients when healing from traumatic events. Therefore, mental health professionals that work with traumatized populations, have the potential to be "transformed by their clients' trauma and resilience in ways that are positive, even if not pain-free" (Hernández-Wolfe, Killian, Engstrom, & Gangsei, 2015, p. 166).

VR highlights the positive transformation(s) of trauma counselors by witnessing clients' ability to overcome adversity throughout the healing therapeutic process

(Hernández, Engstrom, & Gangsei, 2010). In this light, the client's traumatic material can be viewed as paradoxical—a source of both VT and VR (Pack, 2014). VR, like VT, originates from the therapists' empathic engagement in the traumatic material disclosed by their clients. Therefore, VR can be perceived as an "ability to bounce back" after working with traumatized individuals (Pack, 2014, p. 18). Current research suggested that VR occurs in therapists through the process of interoception, or the practice of becoming aware of one's sensations or body-based feelings (Engstrom, Hernández, & Gangsei, 2008; van der Kolk, 2014, p. 95). When the clinician is able to apply the lessons witnessed through the clients' resilience to their own personal lives, it has the potential to allow them to reframe personal difficulties to take better care of themselves (Engstrom, Hernández, & Gangsei, 2008).

Vicarious posttraumatic growth

The term *posttraumatic growth* is defined as a positive change that someone may experience as a direct result from experiencing some form of trauma (Tedeschi & Calhoun, 1996). Furthermore, research has indicated that the *vicarious* exposure to traumatic material also has the potential to lead to growth. This phenomenon is also known as *vicarious posttraumatic growth*. While Tedeschi and Calhoun (1996) first created an inventory for assessing for posttraumatic growth, they do not claim to have discovered it (Calhoun & Tedeschi, 1999). They defer to different philosophical, religious, and spiritual traditions (ancient Greeks, Hebrews, early Christianity, Buddhism, Hinduism, and Islam) as well as social scientists, such as Frankl (1963), Fromm (1947), Caplan (1964), Dohrenwend (1978), and Yalom (1980), all of whom highlighted the possibility of experiencing positive change when faced with various life

struggles (Calhoun & Tedeschi, 1999). When Tedeschi and Calhoun (1996) addressed the notion of posttraumatic growth, they highlighted at least three general positive beneficial categories of experience through the exposure of traumatic events. These categories of change included: (a) self-perception (increased vulnerability, increased sense of capabilities and self-reliance); (b) interpersonal relationships (deeper relationships, increased compassion and sympathy, and greater ability to express emotions); and (c) philosophy of life (greater appreciation of life, changed set of life priorities, and positive changes in religious, spiritual, or existential concerns) (Calhoun & Tedeschi, 1999; Tedeschi & Calhoun, 1996). Additional potential areas of growth included becoming a better professional, developing greater awareness of social injustices, and becoming involved in social justice (Calhoun & Tedeschi, 2013).

Compassion satisfaction

The term *compassion satisfaction* refers to the positive feelings experienced by helping professionals when witnessing clients' strength and resilience (Stamm, 2002, 2005, 2010). Compassion satisfaction is a term used to describe the satisfactory experience and personal fulfillment of working with and helping others cope with stressful circumstances (Stamm, 2002, 2005, 2010). Examples of pleasurable experiences working with traumatic material included: (a) sense of personal achievement, (b) increased confidence, and (c) humanistic benevolence (Stamm, 2002). Additional personal gains included: increased capacities for compassion, insight, sensitivity, tolerance, empathy, and interpersonal relationships (Arnold, Calhoun, Tedschi, & Cann, 2005). These positive experiences have the potential to buffer against any of the adverse effects of working with trauma. In contrast to VR and vicarious

posttraumatic growth, compassion satisfaction is situated within a model that includes a negative perspective (e.g., compassion fatigue and burnout) on professional work (Frey et al., 2017).

Rationale for VR

Overall, these aforementioned constructs highlighted the possible benefits of working with traumatized individuals. For the purpose of this proposed study, the positive trauma-related construct under consideration is VR. The rationale behind this decision is because out of three phenomenon discussed—VR, vicarious posttraumatic growth, and compassion satisfaction—VR focuses on the therapist's enhancement of their own resilience as a direct result of supporting clients through adversity (Tassie, 2015). Furthermore, VR is rooted in the counselor's personal growth and self-development throughout valuing one's therapeutic work with trauma clients.

VR Research

As a relatively new construct there has been limited research on VR, though studies are continuing to unfold in the past few years. VR was first introduced in 2007 when Hernández, Gangsei, and Engstrom conducted a qualitative study with 12 Colombian trauma therapists that worked with survivors of torture, kidnapping, and political violence. This study revealed a number of elements that supported the empowerment clinicians experienced through the process of observing clients' survival stories. Several of these elements included: (1) witnessing and reflecting on human beings incredible ability to heal; (2) revaluating the significance of the therapists' own hardships; (3) cultivating distress and frustration tolerance; and (4) developing the use of self in therapy (Hernández et al., 2007, p. 238).

These authors expanded upon the concept further, this time focusing on clinicians in the United States (Engstrom, Hernández, & Gangsei, 2008). Specifically, 11 therapists were interviewed that worked in the treatment of torture in the United States. Similar findings were uncovered from the previous study. The researchers highlighted three primary themes: (1) being positively affected by the resilience of clients and their ability to thrive, (2) clinicians indicated an altered perspective on their own life, and (3) therapists acknowledged a deeper value of the therapy work performed (Engstrom et al., 2008). Additionally, the authors discovered that another aspect of VR was the ability to revaluate one's work. Therefore, the authors hypothesized that professionals that did experience this revaluation may be able to overcome work-related stressors, such as burnout (Engstrom et al., 2008). Thus, they concluded that awareness of and knowledge about VR and VT may be valuable resources in their own personal and professional resilience and survival. While the researchers were able to reach saturation with a small sample size (*n* = 11), generalizability in this qualitative study is limited due to the lack of diversity in their population studied. Additionally, the defining factors of VR outlined in this study may not be relevant in other forms of trauma treatment not related to working with survivors of torture (Engstrom et al., 2008).

Pack (2014) studied the prevalence of VR with sexual abuse counselors. Pack observed VR when interviewing 22 mental health providers specializing in sexual abuse work in New Zealand. Her studies indicated that the counselors were most profoundly affected by working with trauma survivors in the beginning years of clinical practice (Pack, 2014). She highlighted that the presence of "protective factors", specifically, clinical supervision, support, humor, spirituality, and ongoing trainings were key factors

that helped clinicians buffer themselves from VT, leading to more personal and professional resiliency (Pack, 2014, p. 18). Similarly to the limitation stated in regard to the previous study, the generalizability is limited due to the qualitative nature of the study and the lack of diversity in the sample population.

In contrast to a small sample size, Frey, Beesley, Abbott, and Kendrick (2016) explored the lived experiences of sexual assault or domestic violence advocates (*N* = 222). Their results indicated that instances of personal trauma and peer relational quality increased the presence of VR (Frey et al., 2016). While the sample size in this study was substantially larger than the previous studies, the majority of the participants were female (*n* = 212), heterosexual (82%), and European American or White (79%), which limits generalizability (Frey et al., 2016). Additionally, Frey and colleagues acknowledged that since their study was correlational, the findings are "associational, not causal" (Frey et al., 2016, p. 50).

Hernández-Wolfe, Killian, Engstrom, and Gangsei (2015) conducted a qualitative study and interviewed 13 mental health providers working at torture treatment centers in the United States. Six themes emerged from this study that are congruent with and in addition to previous findings: (1) changes in goals or priorities; (2) increased hopefulness and client-based inspiration, (3) change in spiritual beliefs and practices through the therapeutic process; (4) increase in self-care practices; (5) increased resilience and perspective taking on personal challenges; (6) increased racial, cultural, and structural consciousness, and awareness of relative privilege, marginalization, and oppression (Hernández-Wolfe et al., 2015, p. 161).

In light of the previous studies, scholars indicated 7 different themes that arose from the research: (1) reflecting on individual's capacity to heal; (2) reaffirming the value of therapy; (3) regaining hope; (4) reassessing the dimensions of one's own problems; (5) understanding and valuing spiritual dimensions of healing; (6) discovering the power of community in healing; and (7) making the professional and lay public aware of the impact and multiple dimensions of violence (Hernández, Engstrom, & Gangsei, 2010, p. 72-73). Furthermore, researchers indicated that VR "counteracts the fatiguing processes" that many therapists that work with traumatic material experience (Hernández, Engstrom, & Gangsei, 2010, p. 67). Therefore, VR may strengthen trauma therapists' experiences, by supporting motivation, inspiring new meanings, and facilitate new avenues for self-care (Hernández, Engstrom, & Gangsei, 2010; Hernández, Gangsei, & Engstrom, 2007).

While these initial studies are hopeful in operationally defining the construct of VR, there are a few limitations that are necessary to address. First, each of the studies are limited in generalizability due to the qualitative approach to the studies. Moreover, the studies examined individuals that self-identified as trauma counselors. At this time, the research does not appear to address the presence of VR in individuals who may be exposed to some traumatic material, but not full caseloads. Additionally, to date, all of the research that has emerged on VR has been qualitative in nature (Frey et al., 2017). Lastly, the aforementioned studies highlighted VR in licensed professionals, they do not discuss the potential for trainees to experience VR through their clinical work. Therefore, this proposed quantitative study aims to include a larger sample size,

trainees that may have some trauma clients, and conduct the research specifically regarding the experiences of CITs.

Counselor Preparation and VT

Pearlman and MacIan (1995) argued that these findings have incredibly important clinical implications for counselor educators and counseling programs. Specifically, they highlighted the need for trauma training for CITs, trauma-sensitive supervision by qualified practitioners, and support for trainees that have experienced personal trauma (Pearlman & MacIan, 1995). Further suggestions included: sound theoretical foundations of the effects of psychological trauma, relational perspectives, specific attention to countertransference and VT, and a safe space to process the horrific and graphic stories that are inevitable when working with a traumatized population (Pearlman & MacIan, 1995; Pearlman & Saakvitne, 1995).

Previous researchers have found that early professionals who are newer to their jobs or have less trauma education tend to experience more indirect trauma when working with trauma survivors (Adams & Riggs, 2008; Baird & Jenkins, 2003; Meyers & Cornille, 2002; Pearlman & Mac Ian, 1995; Steed & Bicknell, 2001). In one study, VT was more common in younger and less experienced social workers than in their seasoned counterparts (Adams, Matto, & Harrington, 2001). In another study, Knight (2010) found that when students were unprepared and uneducated about working with client's traumatic material or were not invited to openly speak about their reactions to trauma clients in the classroom, they were more likely to experience VT. Adams and Riggs (2008) discovered that lectures or discussions about trauma were not sufficient in educating counseling trainees and mitigating the adverse effects of VT. Additionally,

another study reported that professionals without a strong support system in their work environment were also at greater risk for experiencing of VT (Ortlepp & Friedman, 2002). Furthermore, Wilson and Brwynn (2004) suggested that therapists that experience VT may have more poignant countertransference reactions, may have less awareness around these reactions, and therefore may make more clinical errors, which likely would hinder treatment progress.

These studies indicate the prevalence of VT in young professionals; however there are fewer studies that highlighted any link between VT and CITs. For example, CITs with 0-2 semesters of applied clinical work with traumatized clients have been found to experience more distress than CITs with more than 2 semesters of clinical work (Adams & Riggs, 2008). The presence of VT in CITs is highlighted in the aforementioned study; however, more research is needed to understand the adverse effects of working with traumatized clients in CITs. In addition to researching VT in the counseling trainee population, there is also a need to investigate the presence of resilience factors in CITs. Furthermore, one demographic that is minimally researched, is whether or not engagement in personal therapy acts as a protective factor from VT or an enhancing factor for VR.

Personal Therapy in CITs

Research has highlighted that many mental health professionals believe personal therapy is an integral component of their personal lives (Mahoney, 1997; Stevanovic & Rubert, 2004) and professional development (Pope & Tabachnick, 1994; Williams, Coyle, & Lyons, 1999). While there are numerous studies that highlighted the degree to which seasoned professionals seek personal therapy, research regarding CITs'

personal therapy is limited (Dearing, Maddux, & Tangney, 2005; Orlinsky, Schofield, Schroder, Kazantzis, 2011). In one study that explored the experience of graduate counseling psychology trainees, 70.2% (*n* = 262) indicated that they had been in personal therapy prior to or during their graduate studies and 47% had in engaged in therapy during their counseling training (Dearing, Maddux, & Tangney, 2005).

Grimmer and Tribe (2001) identified four themes that counseling trainees discussed in regard to the benefits of personal therapy: reflecting on the role as a client (e.g., increased understanding to clients' needs), socialization experiences (e.g., validation of therapy and convictions of its efficacy), support for novice professionals (e.g., stress management), and interactions between personal and professional development (e.g., understanding personal values, beliefs, and ideas about therapy). Furthermore, some studies indicated that counseling trainees would be more inclined to participate in personal therapy if their professors viewed it more favorably (Dearing, Maddux, & Tangney, 2005). However, trainees' stated that barriers to personal therapy included cost, time, and confidentiality concerns (Dearing, Maddux, & Tangney, 2005). An additional list of benefits of personal therapy included: self-awareness, self-esteem, enhanced relationships, elevation of personal distress, and therapeutic effectiveness (Bellows, 2007; Orlinsky, Norcross, Rønnestad, & Wiseman, 2005; Rake & Paley, 2009; Williams, Coyle, & Lyons, 1999; Wiseman & Egozi, 2006). Therefore, personal therapy can provide an opportunity for CITs to explore the role of the client, which in turn can give the trainee deeper insight into their own successes and struggles experienced both personally and professionally.

Ethical Implications for Counselor Educators

Researchers have indicated that very few mental health professionals receive adequate trauma training in the education programs (Knight, 1997; Shackelford, 2007). Furthermore, Knight (2010), highlighted that there has been minimal attention to VT in any mental health professional student in their practicum or internship field experiences. Courtois and Gold (2009) argued for the inclusion of trauma training into the curriculum of all mental health training programs. Therefore, the aforementioned research substantiates the importance of education and adequate preparation in training programs to potentially diminish the adverse effects of VT on CITs (Knight, 2010). Butler, Carello, Maguin (2016) highlighted the benefits for CITs to be educated about trauma-informed training. Two specific benefits discussed included were that clients will be better served and understood, and CITs will gain knowledge and skills in key aspects of clinical work (Butler et al., 2016). However, the secondary exposure to traumatic material, whether done in a clinical training setting or in professional practice, has its risks, as discussed throughout this literature review.

Based upon the likelihood of traumatic material CITs will be exposed to in their clinical training, educators have an ethical obligation to warn their students about the potential harm associated with working with traumatized populations, as well as teach them how to effectively cope with such exposure (Munroe, 1999). In the most recent publication of the Council for Accreditation of Counseling and Related Educational Programs (CACREP) Standards (2016), the importance of trauma education is addressed in eight different standards. In the human growth and development section of the professional counseling identity, Standard F.3.g addresses the importance of

knowing about the “effects of crisis, disasters, and trauma on diverse individuals across the lifespan” (CACREP, 2016). Additionally, Section F.5.m addresses the importance of community-based strategies, crisis intervention, and trauma-informed care in the counseling and helping relationship. Standard F.7.d acknowledges the necessity of being able to identify trauma and abuse within assessment procedures. In section five, Entry-Level Specialty Areas, Standards C.2.f, D.2.h, E.2.b, F.2.g, and G.2.e, underscore the importance that clinical mental health counselors, clinical rehabilitation counselors, college counselors, marriage, couple, and family counselors, and school counselors are adequately educated about the impact of crisis and trauma for their particular populations.

According to the *ACA Code of Ethics* (ACA, 2014), it is essential for counselor educators to address trauma in their clinical training programs. Specifically, Standards C.2.a and C.2.b underscore the importance of adequate and relevant education, training, and supervisory experiences prior to licensure. Additionally, Standards A.4.a and F.1.a speak to the importance of both counselors and supervisors avoiding doing harm to either the client or supervisee. Many researchers (Munroe, 1999; Pearlman & Saakvitne, 1995; Sommer, 2008; Trippany, et al., 2004) argued that one of the most beneficial approaches of addressing VT in CITs is through trauma-sensitive supervision. Therefore, Standard F.2.a becomes critically important in regard to the adequate training of supervisors, specifically in trauma-informed approaches to counseling and supervision.

In addition to having VT affect the clinician’s worldview and sense of self, VT can also lead to compromised therapeutic boundaries, wrongful diagnoses, inability to

attend to the client's needs, as well as loss of energy and commitment (Sexton, 1999; Trippany et al., 2004). These experiences, may, in turn, contribute to experiences of professional burnout for mental health professionals. Some researchers have suggested that clinicians with pre-existing disorders, such as anxiety disorders, mood disorders, or personal trauma history (specifically childhood abuse or neglect), may be more vulnerable to experiencing STS, CF, and VT (Dunkley & Whelan, 2006; Nelson-Gardell & Harris, 2003; Lerias & Byrne, 2003). Therefore, it becomes necessary to explore the various means available in supporting these professionals, whether that is through trainings, trauma-sensitive supervision, or self-care practices.

Based upon this information, and the fact that VT effects the therapist's sense of self and view of the world, it becomes imperative to address the prevalence of trauma during counseling training and development. Trauma-sensitive supervision has been strongly encouraged to address VT (Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995; Trippany et al., 2005; Woodard Meyers & Cornille, 2002). Pearlman and Saakvitne (1995) underscore the importance of four components of supervision to address VT successfully: (a) a strong theoretical foundation in the impacts of trauma, (b) awareness of the conscious and unconscious components to treatment, (c) mutual respect in the supervisory relationship, and (d) educational constructs that directly address VT. Furthermore, it is recommended that supervisors of trauma clinicians pay attention to: (a) any changes that may occur in the counselor's behaviors or reactions to clients, (b) thoughts or images of the client's experience that begins to feel intrusive in the clinician's life, (c) symptoms of burnout or overwhelm in the clinician, (d) any signs of the counselor withdrawing from either supervisory or counseling relationships, and (e)

any indications that the clinician is unable to engage in self-care practices (Etherington, 2000). While the research indicates the possibility of adverse effects of working with traumatized clients, there is also the potential to become inspired and more resilient by witnessing client's strengths in the face of adversity.

Chapter Summary

Research has indicated various vicarious effects of working with traumatized populations—VT and VR. Studies have explored the prevalence of VT on many mental health and care giving professions, such as social work (Adams, Matto, & Harrington, 2001), nursing faculty (Raingruber & Kent, 2003), child welfare workers (Dane, 2000; Schauben & Frazier, 1995), and domestic violence workers (Iliffe, 2000). However, few studies have specifically focused on the presence of VT in CITs (Adams & Riggs, 2008). Both qualitative and quantitative studies have provided inconclusive evidence that suggests a personal trauma history and level of clinical experience may and may not be related to the presence of either VT or VR. Studies have indicated that while in some cases a personal trauma history may not increase the degree of VT experienced, other studied have concluded that a personal trauma history increases the possibility of VR (Linley & Joseph, 2007; Tedeschi & Calhoun, 1996, 2004). Few studies have suggested that novice CITs may be more vulnerable to VT than their seasoned colleagues. Specific limitations in current literature are whether or not the presence of VT or VR is found in counseling trainees, does personal trauma history impact the development of VT or VR, and does involvement with personal therapy help protect from VT or enhance development of VR. Understanding what contributes to either VT or VR can help the training of counselors, which can directly effect the clinical care provided to clients. The

aim of this proposed study is to address these gaps and explore the relationship of VT and VR in CITs.

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BIOGRAPHICAL SKETCH

Keri Lynn Johnson earned her Bachelor of Arts degree in environmental studies from the University of Vermont, graduating in spring of 2007. She moved south to pursue a Master of Arts degree in Religion and Nature at the University of Florida, where she studied from 2010-2013. Her master's thesis examined Yoga philosophy, environmental stewardship, and social activism, entitled, "Contemplating Modern Ecological Yoga: Wild Practices for the Preservation of the World". In the fall of 2013, Keri joined the Counselor Education doctoral program at the University of Florida. Keri's professional interests include implementing trauma-informed mindfulness-based interventions for counselors-in-training. She is passionate about clinical training and supervision, as well as working in her community utilizing the various trainings she has undergone during her tenure in higher education. She incorporates Mindfulness-Based Stress Reduction, Somatic Experiencing®, and Dr. Brené Brown's curriculums The Daring Way™ and Rising Strong™ in her private therapy practice when she is not practicing yoga, playing in nature, or snuggling her cats.