

**The perceptions and experiences of mental health professionals involved in the response
and recovery following the April 16th, 2007 campus shootings at Virginia Tech**

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Abstract

The breadth of interpersonal violence is continuously expanding. According to Broman-Fulks et al. (2006), current epidemiological studies estimate that between 50% and 70% of individuals in the United States have experienced some form of interpersonal violence during their lifetime. The occurrence of “traumatic incidents may create powerful affective responses in those who rescue, care for, and counsel the individuals directly affected” (Wilson & Lindy, 1994, p. 333). This emotional reactivity is especially prevalent among those that work with survivors of violent traumatic events (McCann & Pearlman, 1990). The variety of issues that mental health professionals encounter are multidimensional and include their work context, characteristics of their clients, and therapist variables. Due to such complexity, it is critical to consider the broad ramifications and scope of professional quality of life when addressing the outcomes of trauma work on mental health professionals.

The purpose of this study was to analyze, through qualitative methodology, the professional quality of life of mental health professionals directly involved in the recovery efforts after the campus shootings that occurred at Virginia Tech on April 16th, 2007. A phenomenological research design was used to gather information regarding the experiences and perceptions of various mental health professionals. Two in-depth interviews were conducted to examine therapists’ experiences regarding the vicarious exposure and growth potential involved in this work. Analysis from the data revealed two primary themes; changed perception due to

shared traumatic exposure and the costs and benefits derived from trauma work. These themes depicted the professional consequences for mental health workers who have been directly affected by traumatic events and serve clients exposed to the same event. Findings indicate that self-awareness is a critical component to enhancing therapeutic lenses and professional and personal wellness. Further research considering the influence of shared exposure to trauma on mental health professionals could further our understanding of the professional and personal consequences of such work. This research could provide a guide for preparing current and future counselors and supervisors when working during times of crisis.

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CHAPTER ONE

Introduction

The impact of traumatic experiences on individuals is multidimensional and influences emotions, cognitions, and behaviors (Pat-Horenczyk & Brom, 2007). Those who are exposed to traumatic events directly and indirectly have a heightened potential for psychological distress, and may also develop positively after such experiences (Calhoun & Tedeschi, 1991). The occurrence of “traumatic incidents may create powerful affective responses in those who rescue, care for, and counsel the individuals directly affected” (Wilson & Lindy, 1994, p. 333). This emotional reactivity is especially prevalent among those that work with survivors of violent traumatic events (McCann & Pearlman, 1990). In addition, mass community catastrophes add a further dimension to the therapists’ reactions, because they are working within the context of the trauma while personally impacted.

Events, such as mass shootings, shock the community’s response capacity as the edges of human maliciousness and suffering are stretched (Wilson & Lindy, 1994). In such instances, the impact of mass shootings extends beyond the individual victims and survivors to include the local and national communities (Norris, 2007). As such, mental health professionals’ responses will be influenced by their professional and personal roles, as well as cultural and societal contexts (Wilson & Lindy, 2004). It is conceivable that mental health professionals working with survivors of interpersonal violence have a higher likelihood of experiencing professional stress and professional growth (Calhoun & Tedeschi, 1991; Cunningham, 2003). It is an unfortunate certainty that human induced violence is increasing (Satcher, Friel & Bell, 2007) and by extension there is a high likelihood that therapists in essentially all settings will work with clients who are survivors of varying forms of trauma (Trippany, White Kress, & Wilcoxon, 2004). While there appears to be an

extensive knowledge base regarding the mental and emotional wellbeing following traumatic events for survivors, less attention has focused on the lasting psychological costs for therapists exposed to the traumatic events of survivor clients (McCann & Pearlman, 1990). Due to the rise in violence and lack of guidance on the affect on both survivors and helpers, it is critical to further research regarding the affects of traumatic exposure on professionals in the mental health field.

Problem statement

As previously mentioned, the vulnerability to be powerfully affected by clinical work is *especially* prevalent among those that work with survivors of violent traumatic events (McCann & Pearlman, 1990). Recent research has begun to focus on the impact of providing such services on the mental health professionals themselves, especially in the field of trauma work (Arnold et al., 2005). The variety of issues that mental health professionals encounter are multidimensional and include one's work context, characteristics of his or her client, and psychotherapist variables. Due to such complexity, it is critical to consider the broad ramifications and scope of professional quality of life when addressing the outcomes of trauma work on mental health professionals.

Professional quality of life “includes both positive and negative variables at the individual, organizational, and societal levels that influence the well-being and effectiveness of the professional” (Larsen & Stamm, 2008, p. 275). As such it is crucial to consider both the rewarding and detrimental results derived from this work. Compassion fatigue or secondary traumatic stress (STS), countertransference, vicarious traumatization, burnout, compassion satisfaction and post traumatic growth are some of the prominent terms used to define the professional derivatives of working with trauma survivors (Figley, 1995; Maslach, Schaufeli, & Leiter, 2001; McCann & Pearlman, 1990, Pearlman & Saakvitne, 1995, Stamm, 2002; Tedeschi & Calhoun, 1995).

Although the literature is growing, less light has been shed on the professional and personal ramifications of the psychotherapist who is simultaneously affected by the same trauma as his or her client. Faust, Black, Abrahams, Warner, & Bellando (2008) provided personal narratives regarding the impact Hurricane Katrina had on their practice as psychologists. These authors identified that “most of the research on compassion fatigue or secondary (vicarious) trauma describes the impact on the psychologist or counselor who regularly provides services to populations who are themselves directly traumatized but with whom the therapist typically does not share the experience” (Faust et. al, 2008, p. 4).

As of late, little research has personalized counselors’ professional experiences during times of crises (Piercy et al., 2008). Given the breadth of trauma the Virginia Tech shootings had on the local and professional communities, it seems important to provide an in-depth analysis of the experiences of the mental health professionals who provided clinical and supervisory services following the shootings; not only to gain insight, but also to provide guidance for colleagues, future counselor educators, and supervisors, as it seems a tragic certainty that this will not be a sole occurrence (Gore-Felton, Gill, Koopman, & Spiegel, 1999).

Purpose of the study

The April 16th, 2007 shootings at Virginia Tech were unanticipated, undeserved, and unbiased in regards to the emotional suffering inflicted upon the Virginia Tech, local, national, global, educational, and mental health communities. “Questions immediately arose about what the psychological impacts of the shootings would be on the survivors, witnesses, their families, first responders, and the entire Virginia Tech community” (Norris, 2007, p. 1). I sought to provide mental health professionals’ perspectives regarding the ramifications of being so intimately

involved in the recovery efforts and how this exposure impacted their professional role and quality of life.

The purpose of this study was to explore, through qualitative methodology, the professional quality of life of mental health professionals directly involved in the recovery efforts after the campus shootings that occurred at Virginia Tech on April 16th, 2007. General concepts that were explored during the interview process include how the psychotherapists' personal experiences during the aftermath of the campus shootings informed their work with their clients and supervisees, how their perception of clinical role has transformed over time since the shootings, and the meaning derived from such trauma work. I was interested in exploring the unique aspects of growth and professional challenges that arose for each mental health professional as they assisted clients in healing while they were also recovering from the tragic events that occurred.

Methodology

The purpose of this study was to capture the essence of particular therapists' experiences working with clients impacted by the Virginia Tech shootings. As such, a qualitative research paradigm was deemed most suitable to gather the participants' stories as this is critical to the meaning making process (Seidman, 2006). Since the focus was on gathering the collective meaning derived from this event, a phenomenological method of inquiry was utilized. This form of inquiry "requires methodologically, carefully, and thoroughly capturing and describing how people experience some phenomenon—how they perceive it, describe it, feel about it, judge it, remember it, make sense of it, and talk about it with others" (Patton, 2002, p. 104). In-depth, open ended interviews were conducted with those that directly experienced the phenomenon of interest in order to gather such data for analysis. The theoretical backbone of this investigation comprised concepts pertaining to professional quality of life, vicarious traumatization, and post traumatic growth. To

highlight such concepts, refer to Appendices G and H for structured interview protocols. Due to the nature of the topic, I included a conversational component to the interview process to allow for centralized questions that are unique to each participant's experience. The results of the data analysis are to be used to contribute to the current literature pertaining to the fields of varying mental health professionals who work with traumatized clientele as well as traumatology and quality of life literature.

Identifying terminology

There are multiple terms referenced in this study that have various definitions and interpretations throughout the traumatology literature. For the purpose of clarification, the following terms will be defined. *Trauma* is generally defined as exposure to an event in which a person is confronted with actual or threatened death or serious injury, or a threat to self or others' physical well-being. (American Psychiatric Association [APA], 2000). One diagnosis in the fourth edition of the text revised diagnostic statistical manual (DSM-IV-TR, APA, 2000) that is directly related to trauma is post traumatic stress disorder (PTSD). PTSD symptoms are rooted in the exposure to a "markedly distressing personal experience involving actual or threatened death, serious injury, other threat to one's personal integrity, witnessing a traumatic event that involves death or serious injury, learning of threats or actual injury resulting in acute harm or death of a family member or close associate, or sudden destruction of one's home or community" (APA, 2000, p. 463). In addition the following criteria must be met and persist for more than one month:

- A. The person has been exposed to a traumatic event in which his or her response includes intense fear, helplessness, or horror.
- B. The traumatic event is consistently reexperienced via intrusive thoughts, recurrent nightmares about the incident, feeling or acting as if the past event is currently occurring,

severe levels of psychological distress when exposed to internal or external reminders of the event, and/or physical reactivity when exposed to such cues.

- C. Persistent avoidance of stimuli associated with the trauma and a numbing response as signified by avoidance of conversation and/or activities associated with trauma, inability to recollect aspects of trauma, decreases interest in significant activities, detachment from others, and loss of future oriented ideation.
- D. Increased arousal as indicated by inability to fall or stay asleep, enhanced irritability, difficulty concentrating, hypervigilance, and/or heightened startle response.

One term that could serve to encompass varying results of working in a professional capacity is professional quality of life (Stamm, 2002). *Professional quality of life* “includes both positive and negative variables at the individual, organizational, and societal levels that influence the well-being and effectiveness of the professional” (Larsen & Stamm, 2008, p. 275). There are five prominent terms used to depict the negative risks therapists face when working with traumatized clientele: compassion fatigue or secondary traumatic stress (STS), burnout, countertransference, and vicarious traumatization.

Compassion fatigue (CF), otherwise known as *secondary traumatic stress* (STS), is frequently referred to as the “cost of caring” and is a general term applied to those that suffer as a result of helping others (Figley, 1995; 2002, p. 1441; Rothchild, 2000). Specifically, CF “is defined as a state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders persistent arousal (e.g. anxiety) associated with the patient. “It is a function of bearing witness to the suffering of others” (Figley, 2002, p. 1435).

According to Pines & Maslach, *burnout* is “a syndrome of physical and emotional exhaustion, involving the development of negative self-concept, negative job attitudes, and loss of

concern and feeling for clients” (1978, p.233). This concept is reserved for those that have developed a negatively skewed professional outlook based on feeling overwhelmed at work (Rothchild, 2000).

Countertransference includes the “affective, ideational, and physical responses a therapist has to her client, his material, transference and reenactments” and “the therapist’s conscious and unconscious defenses against the affects, intrapsychic conflicts, and associations aroused by the former” (Pearlman & Saakvitne, 1995, p. 23). The central component of this concept focuses on the psychotherapist’s reaction to client material which is rooted in his or her own unconscious or unresolved conflicts (Freud, 1910; Hesse, 2002; McCann & Pearlman, 1999)

Vicarious traumatization (VT) applies to mental health professionals impacted by repeatedly empathetically engaging with traumatized clients (Pearlman, 1999). This concept emphasizes how the psychotherapist is transformed and at times, extremely affected by his or her client (Cunningham, 2003; Rothchild, 2000). This is a process of change rooted in exposure to traumatic material shared by clients (Pearlman, 1999).

The literature also reflects positive consequences for working with survivors of trauma. *Compassion satisfaction* (CS) refers to the sense of fulfillment or enjoyment that psychotherapists obtain from doing their work well (Stamm, 2002). This concept has been found to serve as a buffer for both CF and burnout (Sprang, Whitt-Woosley, & Clark, 2007).

Post traumatic growth (PTG) incorporates the perceptions of benefits derived from traumatic experiences (Calhoun & Tedeschi, 1991). In this sense, growth represents cognitive adaptations in beliefs about oneself, others, and the world, thus diffusing the adversity initially experienced when faced with trauma (Karanci & Acarturk, 2003). Posttraumatic growth is

considered “both a process and an outcome” and can occur within the therapeutic exchange (Tedeschi, Park, & Calhoun, 1998; Saakvitne et al., 1998).

Delimitations

There are several specifications that define the scope of this study. The focus of interest was on mental health professionals that were employed by the agencies enlisted to assist with recovery efforts after the Virginia Tech shootings and are currently still employed or are students at Virginia Tech. In addition, those that were directly involved in such efforts who had some exposure to traumatized clients were contacted for participation. Participants were identified via their professional employment with Cook Counseling Center, Psychological Services Center at Virginia Tech, and the New River Valley Community Services Board.

Limitations

The primary limitation of this study is the applicability to a broad audience. The scope of this study is germane to Virginia Tech and surrounding communities as college based shootings and other acts of violence are occurring on a national and global scale. In addition, as this is a qualitative study, there will be a guarded amount of generalizability. As such there was a restricted sample size in which the findings will apply to those within this group who share their experiences. There are a limited number of psychotherapists at Virginia Tech and within the New River Valley; and even less so who worked directly on campus or locally during the time of the shootings. Also, my role as a researcher was sufficiently explored during the data analysis process as I have professionally worked in various clinical capacities during the recovery efforts and have pre-established relationships with some of the potential participants. This limitation was countered by requesting assistance of committee members during the data analysis as this could dilute the bias associated with the interpretation of results.

Summary

The purpose of this chapter was to review the rationales and plan for this study. As traumas continue to unfold in our day to day lives, it is important to consider the professional ramifications for those that assist the traumatized. Addressing the professional quality of life issues that could arise when working with traumatized individuals is critical to enhancing one's self awareness and ability to professionally thrive while engaging in such emotionally involved work. By taking into account the vicarious and mutualistic aspects of this work, I extended the literature to comprehensively represent the costs and rewards for mental health professionals who are directly affected by traumatic events with the professional duty to assist clients exposed to the same event.

A comprehensive review of the literature follows in Chapter two. The information in this chapter emphasizes concepts of professional quality of life such as compassion fatigue, compassion satisfaction, and burnout. In addition, other concepts that influence the role of the psychotherapist such as countertransference, vicarious traumatization, and post traumatic growth will be explored. This literature review supports the rationale for this study via establishing a contextual framework for the methodology illustrated in Chapter three. Chapter three will introduce and review the key components of the methodology for this study including research methods, selection of participants, instrumentation, research questions, data collection and analysis procedures.

CHAPTER TWO

Literature Review

Although psychotherapy is an interactive, engaging process that affects psychotherapists' and clients, early research on the therapeutic process primarily focused on the impact derived from the clients' perspective (Arnold, Calhoun, Tedeschi, & Cann, 2005). Recent research has begun to focus on the impact of providing psychotherapy on the mental health professionals themselves, especially in the field of trauma work (Arnold et al., 2005). This research has evolved over the past several decades in response to the potential negative effects experienced by professionals providing crisis intervention and traumatic stress services to clients (Jacobson, 2006).

Traumatic events invade one's personal and professional life and can foster both "opportunities and dangers" (Carbonell & Figley, 1996, p. 53). Definitions of trauma have been broadened "to include hearing about trauma, direct exposure to the aftereffects of trauma (such as in rescue workers), indirect exposure to the effects of trauma (such as mental health counselors and court workers), and even observation at a safe distance from the trauma (as in the television coverage of the terrorist attacks of September 11) (Dreisbach, 2003; Kroll, 2003, p. 668; North & Pfefferbaum, 2002). In essence the crux of the definition is rooted in the subjective experience of the victim; no longer does one need to be a *direct* victim or witness to be traumatized (McNally, Bryant, & Ehlers, 2003).

Regardless of exposure level, psychological trauma induces individuals to confront their vulnerable existence and others capacity for committing atrocious acts (Lasiuk & Hegadoren, 2006). The normal response to traumatic events includes a set of predictable reactions such as reexperiencing (e.g nightmares), avoidance or emotional numbing, and hyperarousal (e.g. difficulty sleeping, easily startled) (McNally et al., 2003; Rothbaum & Davis, 2003). Most often such

reactions lessen to the point of extinction over time. Those whose symptoms continue and/ or worsen over time would be characterized as having posttraumatic stress disorder (PTSD; American Psychiatric Association [APA], 2000). Evidence reflects that only a small proportion of those exposed to traumatic events develop PTSD (Yehuda, McFarlane, & Shalev, 1998). By definition, PTSD can only be diagnosed following a traumatic event which “results in a threat of death or to physical integrity and is a subjective response of fear, helplessness, or horror” (APA, 2000, p. 463).

Most people recover from acute posttrauma symptoms within three months, with or without mental health treatment (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). This ability to adapt well when faced with trauma is commonly referred to as resiliency in the psychosocial literature (Yehuda & Flory, 2007). There are both sociocultural and psychobiological protective variables that serve to promote resiliency and shield many exposed to traumatic events from developing PTSD (Agaibi & Wilson, 2005). Often, survivors rely on their social support networks to recover from trauma. According to McNally et al. (2003), those directly traumatized by the terrorist attacks that occurred on September 11, 2001 relied more heavily on their family, friends, and church members rather than seeking professional counseling services.

Social support is considered a crucial piece of health and well-being and has been linked to faster and more successful posttraumatic recovery as survivors are given the space to process and verbalize the internal turmoil and stress typically associated with exposure to trauma (Hobfoll, Freedy, Lane, & Gellar, 1990). Secure and healthy attachments to family and friends have been illustrated to increase the survivor’s ability to autonomously address a stressful event (Masten, 1999 as cited in Agaibi & Wilson, 2005). Hardiness has been positively correlated with emotional and influential forms of social support. In their metaanalysis of the trauma literature, Agaibi & Wilson concluded “that hardiness reflects a propensity for active problem solving and capacity to mobilize

resources as needed to achieve desired outcomes” (2005, p. 206). Survivors that recognize and utilize their support systems enhance their ability to positive cope with adverse events.

Individual attributes also have been linked to healthy recovery from traumatic events. Self-esteem and self-efficacy are two protective aspects that serve survivors well in the recovery process (White, 1959 as cited in Agaibi & Wilson, 2005). In addition, “persons with an internal locus of control tend to exhibit less PTSD and psychopathology and have better overall adjustment than persons with an external locus of control” (Agaibi & Wilson, 2005, p. 202). Several other personality factors that have been connected to resiliency include level of autonomy, good temperament, ego defenses, affect regulation and a positive social outlook associated with the ability to deduce constructive meaning from traumatic events. Such factors have been related to recovering after trauma and deferring the development of PTSD symptoms (Agaibi & Wilson, 2005).

In essence posttraumatic responses are intricate in nature and cannot be easily categorized. There are a wide range of subjective responses that could arise in reaction to one objective event (Yehuda & Flory, 2007). Although there are three categories utilized to classify PTSD (re-experiencing, avoidance, and arousal) the long-term consequences of trauma are broad. In order to accurately diagnosis and treat clients with PTSD, the mental health professional must consider the “context in which the trauma occurs, the age and stage of life of the traumatized person, the associated losses of family and cultural coherence, characteristics of the person prior to the trauma, the conditions of the life after the traumatic event, and the symbolic and moral meanings attached to the traumatic events” that affect the range of experiences and responses (Kroll, 2003, p. 669).

There are a multitude of outcomes that summarize working with traumatized clients. The variety of issues that such mental health professionals encounter are multidimensional and include

one's work context, characteristics of his or her client, and psychotherapist variables. Due to such complexity, it is critical to consider the broad ramifications and scope of professional quality of life when addressing the outcomes of trauma work on mental health professionals. Professional quality of life "includes both positive and negative variables at the individual, organizational, and societal levels that influence the well-being and effectiveness of the professional" (Larsen & Stamm, 2008, p. 275). As such it is crucial to consider both the rewarding and detrimental results derived from the impact of such work.

Stamm (1995) published a review of the literature examining the impact on psychotherapists treating traumatized clients. This author highlighted that the issue was not whether such a phenomenon existed but what it would be called. Compassion fatigue (CF) also referred to as Secondary traumatic stress (STS), vicarious traumatization (VT), burnout, countertransference, compassion satisfaction (CS), and post traumatic growth (PTG) are some of the prominent terms used to define the range of outcomes derivative from working with trauma survivors. Regardless of such terms, some of which are used interchangeably, research indicates that working with trauma victims does have an impact on mental health professionals (Figley, 1995; McCann & Pearlman, 1990; Pines & Maslach, 1978). An exploration of the concepts compassion fatigue or secondary traumatic stress, burnout, traumatic countertransference, compassion satisfaction, vicarious traumatization, and post-traumatic growth follows.

Compassion Fatigue

Compassion is an essential element in effective mental health practice. Establishing rapport via empathy and concern are critical components to establishing a healthy therapeutic relationship. "Yet as our hearts go out to our clients through our sustained compassion, our hearts can *give* out from fatigue" (Radey & Figley, 2007, p. 207). Compassion fatigue (CF) or secondary traumatic

stress (STS), are exchangeable terms first utilized when discussing the traumatic work related experiences of nurses (Johnson, 1992; Salston & Figley, 2003). Traumatologist Charles Figley expanded and adapted this concept to describe the stress and emotional duress “resulting from helping or wanting to help a traumatized or suffering person” (Figley, 1993; Figley, 1995, p. 7). He developed this concept after considering the unique work environment of trauma workers and how they seemed to vicariously experience the effects of trauma.

At the root of this response is an empathetic stance the therapist takes towards a traumatized client paired with the secondary exposure of the trauma and desire to relieve the pain of others (Salston & Figley, 2003; Ting et al., 2005). In particular, CF appears to be the consequence of working with traumatized individuals with a strong sense of empathy and was complicated by a lack of support in the workplace and (Adams, Boscarino, & Figley, 2006; Figley, 1995; Radey & Figley, 2007). Currently, this concept is based on the assumption that “empathy and emotional energy are the driving force in effectively working with the suffering in general”; “however being compassionate and empathic involves costs in addition to the energy required to provide those services” (Figley, 2002, p. 1436).

Figley (1995) specified characteristics of compassion fatigue to include the emotional, physical, behavioral, spiritual, interpersonal, and cognitive costs accrued by those who work with the traumatized. It is considered a “natural response or reaction” to working with trauma survivors and can suddenly develop as a result of the combination of exposure to listening to clients’ traumatic stories and the clinician’s professional sense of empathy (Figley, 1995; Jacobson, 2006). The proposed continuum of professionals’ responses ranges from compassion satisfaction to compassion stress, ending with compassion fatigue (Figley, 1995; Sprang, Clark, & Whitt- Woosley, 2007; Stamm, 2002). Five key determinants that account for the development of

compassion fatigue are empathy, exposure, poor self-care, inability or refusal to manage work stressors, and dissatisfaction for clinical work (Figley, 1995; Radey & Figley, 2007). As each component is included within the work of mental health professionals who treat the traumatized, they are naturally more susceptible to developing CF. Infused within these core components are various variables Figley (2002) identified in the development and prediction of CF, including those related to exposure to traumatic material and mental health professionals' capacity for empathetic engagement (Sprang et al., 2007).

Empathy is a significant resource for psychotherapists who assist the traumatized (Figley, 1995; Radey & Figley, 2007). Engaging empathically with clients motivates altruistic behavior of psychotherapists who strive to alleviate the suffering of others (Radey & Figley, 2007). Empathetic ability is defined as the aptitude of the mental health professional for recognizing another's pain. This ability is a double edged sword in the sense that without it there would be minimal compassion stress and fatigue yet it enhances one's ability to provide effective services and makes one more susceptible to developing CF (Figley, 2002). Another factor included in the process of developing CF is empathetic concern; the motivation to respond to clients' in need (Figley, 2002). Associated with this process is the demand to assist the client in resolving or relieving his or her distress. In order to effectively do so, the psychotherapist must embrace the distress in order to more fully appreciate his or her client's experience. Espousing such distress requires the psychotherapist to work within the frame of their client's experiences; "a key factor in the induction of traumatic material from primary to the secondary victim" (Figley, 1995, p. 15).

One must be motivated to help others in order to be empathetic. When motivated, the mental health professional is better able to draw on his or her talents and training in order to provide compassionate treatment. Compassion stress is rooted in the excess of emotional energy

that is required for empathetic response coupled with the constant demand to lessen the suffering of others (Figley, 2002). When combined with other factors, compassion stress can have a negative impact on one's professional quality of life and contribute to CF. Such demand reinforces one's exposure to his or her clients which is another factor to consider when addressing CF. According to Figley (2002), the more direct contact mental health professionals have with their clients, the more likely they are to experience the costs of caring.

Sense of achievement is one variable that can serve to lower or add to compassion stress (Figley, 2002). Mental health professionals that have a heightened sense of achievement about the clinical services they are delivering are more apt to develop stronger boundaries and a rational perspective of their and their clients' responsibilities. The ability to disengage from clients' ongoing misery is indicative of how successful the mental health professional will be in avoiding CF. "Disengagement is the recognition on the part of the psychotherapist for importance of self-care and to carry out a deliberate program of self-care" (Figley, 2002, p. 1438). If not actively addressed, distressed psychotherapists "may dissociate to some degree, distance themselves, question the viability of the story being told, experience somatic responses, and be overwhelmed with feelings of grief or helplessness" (Salston & Figley, 2003, p.170).

If the mental health professional does not monitor his or her self care, inability to disengage and sustain a sense of achievement, he or she is more likely progress on the continuum from compassion stress to compassion fatigue (Figley, 2002; Sprang et al., 2007). As the compassion stress continues to build, the following three factors play a role in enhancing CF. Prolonged exposure is the continued sense of professional responsibility to provide services for the suffering over an extended period of time (Figley, 2002). According to Figley (1995), most mental health professionals who work with trauma survivors have experienced some form of traumatic event in

their own lives. As there are various forms of trauma, most of these professionals will interact with clients with similar traumatic experiences in which they are struggling. This is especially the case for mass violence occurrences in which there is a greater likelihood that a higher proportion of the population will develop a variety of psychiatric symptoms (Murthy, 2007). In addition, there is also a heightened chance that the mental health professional was exposed to or familiar with the same set of circumstances that such clients would be presenting in treatment, thus enhancing the breadth of exposure. Such exposure may trigger unresolved trauma of the worker based on the similarity of traumatic events (Figley, 1995). A break from the role of professional caretaker in which sustained compassion is necessary should be matched with a degree of respite in order to recharge the empathetic battery that fuels one's professional quality of life.

Unfortunately, case loads are expanding thus, expanding the empathetic stretching of therapists. As such, the more empathy psychotherapists expend, the more likely they are to internalize their client's trauma (Conrad & Kellar-Guenther, 2006). Exposure factors such as long work hours or length of assignment and trauma saturated caseloads have been associated with increased cases of CF (Boscarino, Figley, & Adams, 2004; Creamer & Liddle, 2005; Spring et al., 2007). In addition, locale could also enhance exposure as was found in a study of mental health workers in which CF rates were higher for rural providers when compared to their urban equivalents (Meldrum, King, & Spooner, 1999 as cited in Jacobson, 2006; Stamm, Lambert, Piland, & Speck, 2007). Due to the lack of health care resources and client access to fiscal assets, those in rural clinical settings frequently have to work beyond their capacities (Stamm et al., 2007). These exposure factors coupled with lack of self care and time off are a recipe for CF.

Traumatic recollections are another defining contributor to CF. These memories can induce post traumatic stress disorder like symptoms in mental health professionals and are based on

recollections of traumatic stories heard or events that when recalled, cause an emotional reaction (Figley, 2002). This component of CF could be especially pronounced in first responders and those that are involved in disaster relief services (Boscarino et al., 2004). According to Boscarino et al., social workers more involved in counseling victims of the September 11, 2001 attacks were at a greater risk for CF versus those that were not involved in the recovery efforts (2004). Such work can be the basis of memories that can be provoked by certain types of clients and client experiences (Figley, 2002).

The last factor in this model is life disruption. This refers to unexpected personal and professional changes that demand attention and alter one's schedule, routine, and management of life responsibilities. Some degree of change in life style is expected, yet when this occurs in combination of the other aforementioned factors such disruption can increase the likelihood of developing CF. "The risk of CF is believed to increase when professionals experience 'shared trauma' or exposure to both primary and secondary traumatic events" (Jacobson, 2006, p. 135; White, 2001). Given the strategic role mental health professionals play when responding to traumatic events, research suggests that such individuals are "among those likely to suffer adverse psychological consequences" resulting from directly aiding client activities (Boscarino et al., 2004, p. 1; Figley, 2002). For example, Jacobson found that employee assistance professionals who responded to the terrorist attacks in 2001 were also personally affected (2006). Although CF is considered a natural derivative of caring for traumatized people, if symptoms are ignored secondary traumatic stress disorder could develop (STSD; Collins & Long, 2003; Figley, 1995; Salston & Figley, 2003).

The symptoms of STSD are quite similar to those of the diagnosis Post Traumatic Stress Disorder (PTSD) in the *Diagnostic and Statistical Manual of Mental Disorders- Fourth Edition-*

Text Revision; the main difference being that the traumatized person will develop PTSD symptoms and the mental health professional exposed to knowledge about the trauma will develop STSD (DSM-IV-TR; American Psychological Association, 2000; Figley, 1995; Jenkins & Baird, 2002). Figley (1995) described three content domains of symptoms: (1) reexperiencing of the client's traumatic event (recurrent dreams, intrusive thoughts); (2) avoidance of reminders and/or numbing in response to reminders (efforts to avoid trauma-associated thoughts or activities, diminished effect) and (3) persistent arousal (difficulty falling or staying asleep, irritability, hypervigilance). "Such symptoms under one month duration are considered normal, acute, crisis-related reactions. Those not manifesting symptoms until six months or more following the event are delayed STSD" (Figley, 1995, p. 8). The accumulation of the aforementioned symptoms can lead to a "decrease in the level of concern and empathy for clients, decreased positive feelings for clients, physical and emotional exhaustion, increased levels of job dissatisfaction, and feelings of hopelessness related to the job that can overflow into other areas of the professional's life (Figley, 1995, 2002; Jacobson, 2006, p. 135; Pines & Maslach, 1978).

Self-care is a positive coping skill that has the potential to increase professionals' positive affect and utilization of physical, mental, and social resources (Radey & Figley, 2007). The importance of self-care in worker retention and professional wellbeing is often overlooked in the empirical research yet is essential to minimizing the development of CF (Jacobson, 2006). It is logical to consider the importance of helping oneself in order to help others yet if not stressed in the workplace and made a priority this mechanism can be placed on the mental health professionals' personal back burner.

Organizational self-care "includes ways that agencies facilitate self-care, such as limiting case loads or diversifying caseloads, and providing appropriate supervision, adequate benefits, and

staff development opportunities (Hesse, 2002; Radey & Figley, 2007). In addition it is beneficial that agencies promote a welcoming environment in which professionals believe they can depend on their colleagues in times of stress (Radey & Figley, 2007). Being able to care for oneself via exercising, eating well, scheduling vacation or time off, engaging in spiritually oriented activities, checking in with one's internal stress level, and utilizing emotional and instrumental support systems are critical pieces of promoting individual self care (Radey & Figley, 2007; Salston & Figley, 2003). By following through with such efforts, mental health professionals can better manage their work load stressors and enhance their satisfaction at work.

Most agree that working with clients who have been traumatized has inevitable, long-lasting, and often detrimental effects on therapists (Herman, 1992), and that these reactions may occur regardless of race, gender, age, or level of training (Edelwich & Brodsky, 1980).

“Traumatized professionals, who may be suffering from symptoms of compassion fatigue, can be ineffective or even detrimental in their clinical work with traumatized clients due to an inability to effectively attend to the client's traumatic material” (Jacobson, 2006, p.146). A common aspect of mental health professionals role within the therapeutic relationship is promoting self care and positive coping, yet it is not clear if these therapists effectively utilize such feedback and knowledge of dealing with work related stressful situations (Jacobson, 2006).

Burnout

More recently, researchers have noticed that CF and what has been termed burnout overlap in that both signify emotional exhaustion (Figley 1995, 2002; Salston & Figley, 2003; Stamm, 2002). Both burnout and CF can create feelings of helplessness, loneliness, depression, and anxiety

(Conrad & Kellar-Guenther, 2006). According to Pines & Maslach (1978), burnout is “a syndrome of physical and emotional exhaustion, involving the development of negative self-concept, negative job attitudes, and loss of concern and feeling for clients” (p.233). Work related burnout is a multidisciplinary term has been defined as resulting from prolonged emotional and interpersonal stressors at work such as the conflict between individual values and organizational goals and demands, an overload of responsibilities, a sense of loss of community within the workplace, feeling overextended and ineffective, and the perception of inequality or lack of respect (Maslach, Schaufeli, & Leiter, 2001).

It develops gradually, worsens over time and is a consistent consequence when work demands exceed individual resources (Larsen & Stamm, 2008). As its development is a process, its evolution is not significantly correlated with “reactions to traumatic client material but is associated with other workplace characteristics such as caseload size and institutional stress”. Burnout impairs both social and personal functioning and is often greater in human-service professions as the norms of these occupations are to be selfless and putting clients’ needs first (Maslach & Goldberg, 1998; Reid et al., 1999). Pines & Maslach found that burnout developed at higher rates in those whose duration in the field was longer as they reported liking their clients less, low morale, absenteeism, high job turnover, feeling less successful with their clients and having less humanistic attitudes regarding mental illness (1978).

This syndrome is considered to have three components which include emotional exhaustion, depersonalization, and lessening of personal accomplishment. Emotional exhaustion represents the decrease of emotional resources, including an inability to engage in the work or relationships within that setting (Larsen & Stamm, 2008). The predominant sources of exhaustion are occupation overload and personal conflict at work (Maslach & Goldberg, 1998). This form of exhaustion is the

root of experienced stress and leaves psychotherapists feeling drained. Depersonalization refers to a detachment and objectification of clients (i.e referring to clients by their diagnosis). It develops in response to emotional exhaustion and is considered a self protective defense mechanism in which psychotherapists distance themselves in order to cope (Maslach & Goldberg, 1998). This represents the interpersonal portion of burnout and places the professional at risk for dehumanizing his or her interactions.

The third component, decreased personal accomplishment, often encompasses feeling ineffective in creating positive changes with clients or within the work context. Also, being excluded from important organizational decisions and experiencing little control over work environment can heighten feelings of ineffectiveness (Maslach & Goldberg, 1998). The lowered sense of self-efficacy associated with this component has the potential to trigger depression and inability to cope with work demands thus representing the personal-accomplishment facet of burnout. These three aspects of burnout reside under the theme of imbalance between work demands and resources, with the scale always being more heavily weighted with organizational and client demands (Larsen & Stamm, 2008).

The physiological symptoms of burnout include headaches, sleep difficulties, physical exhaustion, and hypertension (Salston & Figley, 2002). Such reactions are easily recognized allowing for more self motivated modifications if the mental health professional is in tune with his or her health. There are also behavioral, emotional, work-related, and interpersonal responses to burnout. Some of the more obvious behavioral indicators include boredom, decrease in job performance, enhanced usage of drugs or alcohol, aggression, and pessimism (Figley, 1995; Kahill, 1988). Those that experience burnout may react via becoming depressed, anxious, develop a sense

of guilt and hopelessness as well as have a heightened sense of irritability with clients and co-workers.

These emotional reactions may be channeled through work-related choices such as not coming to work or quitting, misusing work breaks and showing up late. In addition, while working with clients and interacting with co-workers, burned out mental health professionals may find difficulty communicating and concentrating thus resulting in withdrawing and enhancing the potential of objectifying clients (Figley, 1995; Kahill, 1988).

Highly emotional engagement without sufficient social support or feeling of professionally satisfied may leave the mental health professional vulnerable to burnout. Thus, it has been suggested that job burnout is likely to have a symbiotic relationship with CF (Conrad & Kellar-Guenther, 2006; Larsen & Stamm, 2008).

Difference between compassion fatigue and burnout

Burnout is more common than CF among mental health professionals as it is a result of general psychological stress not specifically related to exposure to traumatic material (Larsen & Stamm, 2008; Trippany, Whit Kress, & Wilcoxon, 2004). Figley (2002) has suggested that CF is not the same as burnout syndrome and that each should be treated as having a unique effect on a professional's well-being. Another distinction is the development of symptoms. In contrast to burnout, which emerges gradually as a result of emotional exhaustion, CF can emerge rapidly with minimal warning (Figley, 1995). Compassion fatigue can occur after exposure to a single traumatic incident, contrasting with the gradual evolution of burnout (Conrad & Kellar-Guenther, 2006). Unfortunately, the concept of burnout is "far too vague" in understanding and helping mental health professionals who work with clients traumatized by violence therefore other concepts such as

countertransference and vicarious traumatization have been developed to describe such exposure (Salston & Figley, 2003).

Countertransference

The concepts transference and countertransference were first contrived as a clinical term in Freud's essays regarding the psychoanalytic technique (1910). Both terms refer to the reciprocal influence exchanged between the client and psychotherapist during therapy (Wilson & Lindy, 1994). Freud identified countertransference as the unconscious feelings that arouse in the physician in reaction to his or her client (Clarkson & Nuttall, 2000). Currently, this definition has evolved and includes "some of the thoughts, feelings, and behaviors that the counselor experiences in relation to client" (Watkins, 1985, p. 356). Countertransference is infused within every therapeutic relationship (Pearlman & Saakvitne, 1995). As such, the inclusion of countertransference contextualizes the view of the therapeutic relationship as it considers the impact such work can have on the mental health professional. "This shift in attention from an exclusive focus on the client to a more complicated view of the client, the therapeutic relationship, and the therapist makes available the fertile, intersubjective field of the therapeutic process" (Pearlman & Saakvitne, 1995, p. 15).

Countertransference includes the "affective, ideational, and physical responses a therapist has to her client, his material, transference and reenactments" and "the therapist's conscious and unconscious defenses against the affects, intrapsychic conflicts, and associations aroused by the former" (Pearlman & Saakvitne, 1995, p. 23). According to Watkins (1985), countertransference stems from the psychotherapist's identification with his or her client. Identification refers to the mental health professionals' ability to recognize or share their clients' experiences. This is a critical component of clinical work and is optimally utilized when the psychotherapist can relate to

and understand his or her client whilst maintaining appropriate clinical boundaries (Watkins, 1985). There are several pathways in which balanced identification is established or impaired and include values, demeanor, language, physical appearance, and expectations.

A major tool utilized in counseling is empathy. Empathy enables psychotherapists to relate to those in their care and put their experiences into perspective via established the interpersonal rapport and emotional conduit (Rothschild, 2006). An empathetic stance enables the mental health professional to assist the client through their traumatic material to the place where they can successfully integrate their traumatic memories into their self-structure (Wilson & Lindy, 1994). Via repeated extension of empathetic support and identification with traumatized clients, the psychotherapist's sources may become depleted. The extent to which the psychotherapist and client share such characteristics speaks to the level of positive, negative, or potential overidentification that could occur on a conscious or unconscious level. Conversely, where there is no optimal identification, the client's stories and affect can stimulate a common range of reactions ranging from avoidance or disidentification to overidentification; enhancing the potential of a compromised therapeutic relationship (Watkins, 1985; Wilson & Lindy, 1994).

Therapists working with traumatized individuals will often experience short term reactions to unexpected or evoked responses to the information provided, behaviors and emotions exhibited by the traumatized client (Salston & Figley, 2003; Wilson & Lindy, 1994). Several researchers have conceptualized psychotherapist identification reactions as existing on a continuum with the polar ends indicating Type I and Type II behaviors (Clarkson & Nuttall, 2000; Shubs, 2008; Watkins, 1985; Wilson & Lindy, 1994). Wilson and Lindy (1994) have proposed that the intensity of clients' affective responses to trauma and the often-horrific nature of their trauma stories tend to elicit negative countertransference reactions. This unfavorable circumstance has been referred to as

empathetic strain and is differentiated into four domains which classify the plausible responses of the psychotherapist due to countertransference (Wilson & Lindy, 1994).

Wilson & Lindy (1994) have identified two categories of countertransference reactions (CTRs), Type I and Type II, which are divided into objective and subjective processes. On one side of the spectrum is the objective or normative CTRs, which comprise the natural emotional and cognitive responses of the mental health professional in reaction to the “personality, behavior, and trauma story of the client” (Wilson & Lindy, 1994, p. 15-16). On the other end of the continuum is the subjective or personalized CTRs which include the personal responses originating from the psychotherapist’s “personal conflicts, idiosyncrasies, or unresolved issues” that have evolved throughout his or her development (Wilson & Lindy, 1994, p. 16). Type I

Countertransference reactions usually include the mental health professionals’ characteristic defensive styles such as denial, minimization, distortion, counterphobic reactions, avoidance, detachment, and withdrawal from his or her ability to take an empathetic clinical approach (Shubs, 2008; Wilson & Lindy, 1994). Contrastingly, Type II CTRs entail aspects of overidentification, overidealization, enmeshment, and extreme advocacy for his or her client (Wilson & Lindy, 1994).

Overidentification indicates the psychotherapist’s actions in which boundaries are missing as he or she becomes enmeshed in the client’s story and cannot effectively disconnect from it. The opposite occurs when the professional experiences disidentification with his or her client based on the emotional distance he or she has created. This could manifest in behaviors such as aloofness, hostility, coldness, and lack of empathy for his or her client (Watkins, 1985). Overidentification and avoidance highlight a rupture of empathy has occurred under the stress of being able to understand the traumatic stories of clients, resulting in the loss of an effective therapeutic role (Shubs, 2008; Wilson & Lindy, 1994).

In the midst of the spectrum between objective and subjective dimensions are four styles of empathic strain; empathic withdrawal, repression, disequilibrium, and enmeshment. Although a psychotherapist may experience one style more so than the others, any or all can be experienced by the same professional during the course of working with a traumatized client (Wilson & Lindy, 1994). The avoidance side of the figure includes empathic withdrawal (objective), in which the “therapist experiences expected affective and cognitive reactions during treatment” and empathic repression (subjective), in which “the transference issues of the patient reactivate conflicts and unresolved personal concern in the therapist’s life” (Wilson & Lindy, 1994, p. 16).

On the contrary, overidentification sides of the quadrant include empathic disequilibrium (objective), which is characterized by “somatic discomfort and feelings of insecurity and uncertainty as to how to deal with the client” (Wilson & Lindy, 1994, p. 17). Some psychotherapists may experience visual images and heightened autonomic nervous system activity which are indicative of the empathic hyper arousal associated with this CTR. A mental health professional would be considered empathetically enmeshed (subjective) with his or her client when he or she “leaves the therapeutic role by becoming overly involved and overly identified with the client,” losing therapeutically appropriate boundaries (Wilson & Lindy, 1994, p. 17). This pattern is particularly prevalent in psychotherapists with similar trauma histories or experiences as their clients. At its peak, enmeshment may lead to “secondary victimization or intensification of transference” as it draws the psychotherapist to shed the empathic stance initially established in order to unconsciously reenact unresolved personal conflicts (Wilson & Lindy, 1994, p. 17).

Such reactions can be positive (e.g. the psychotherapist acts as a ‘fellow survivor’ or supporter) or negative (e.g. the psychotherapist acts as a hostile judge) (Wilson & Lindy, 1994). Countertransference can become therapeutically detrimental when the mental health professional’s

feelings are out of his or her awareness, chronic or repetitive, and distressing. (Clarkson & Nuttall, 2000). Although Wilson and Lindy “do not directly attempt to integrate the concept of vicarious traumatization into their discussion, it would seem that their whole framework is based on a foundation of vicarious traumatization”, as the reactions depicted in their model highlight empathic strain, thus indicating that the therapist has been traumatized (Shubs, 2008, p. 160). Neither countertransference nor burnout comprehensively account for the impact of the traumatic material presented by the client on the mental health professional (Cunningham, 2003). Therefore it is pertinent that vicarious traumatization be extensively examined when considering the impact of providing clinical services to clients who have been exposed to traumatic events (VT; Pearlman & Saakvitne, 1995).

Vicarious Traumatization

Vicarious traumatization (VT) differs significantly from the concepts of countertransference reactions, compassion fatigue, and burnout due to its emphasis on the transformation of the psychotherapist (Cunningham, 2003; Thomas & Wilson, 2004). The concept of VT provides a more complex and developed rationalization of psychotherapists’ reactions to client trauma (Trippany et al., 2004). Vicarious traumatization is a process of change due to empathic engagement with clients who have survived trauma (Pearlman, 1999). This process is considered ineluctable and is the result of the long term, cumulative effects on a psychotherapist which can be understood as relating both to the graphic and painful depiction of traumatic events and to the therapist’s cognitive beliefs, expectations, spirituality, affect tolerance, interpersonal relationships, imagery system of memory and assumptions about self and others (McCann & Pearlman, 1990; Pearlman, 1999; Ting et al., 2005).

According to Pearlman and Saakvitne (1995a), long-term empathic interaction with traumatized clients can alter the psychotherapist's ways of experiencing the self, others, and the world. "Vicarious traumatization, then, implies that basic self-capacities in terms of affect regulation, the structure of the self, and the nature of interpersonal connectedness can be transformed" (Thomas & Wilson, 2004, p. 84). It reflects the cognitive shifts experienced by psychotherapists exposed to their clients' traumatic stories (McCann & Pearlman, 1990). Such disruptions in the cognitive schemas of psychotherapists can detrimentally impact both their professional and personal lives as they become witness to the explicit details of their clients' traumatic realities (Cunningham, 2003; Trippany et al., 2004). These schemas include beliefs, expectations and assumptions about oneself and the world (Hesse, 2002). This transformation of the psychotherapist's inner experience parallel those experienced by trauma survivors and can result from direct exposure of working with traumatized clientele or indirectly via exposure to depictions of violence in other forums such as supervision, readings, or presentations (Rosenbloom, Pratt, & Pearlman, 1999).

There are multiple facets to the development of VT. While a psychotherapist's vulnerabilities and issues do contribute to VT, no one, regardless of their psychological health, can work with traumatized clients and remain unchanged. Experiencing disturbed beliefs and intrusive images associated with trauma focused treatment is both unavoidable and typical (Pearlman & Saakvitne, 1995a). Although most who work with the traumatized have advanced degrees and training, they are not invulnerable to the painful images, feelings, and thoughts associated with being exposed to their clients' graphic memories. Such psychological effects, although a normal consequence of such work, can be disruptive and painful for the psychotherapist, and continue for months or years (McCann & Pearlman, 1990). Neither mental health professional nor client can

engage in an enriching, trauma-focused therapeutic relationship without being deeply transformed (Pearlman & Saakvitne, 1995a). As such it is important to highlight that this theoretical framework does not blame clients for traumatizing their psychotherapists but instead addresses a predictable occupational by-product which can be alleviated (Pearlman & Saakvitne, 1995b; Rosenbloom et al., 1999).

The conceptualization of VT focuses on the various exchanges between clients and psychotherapists, accounting for variables such as the traumatic material presented and the professional's personal characteristics such as current life conditions and personal trauma history (Cunningham, 2003). The concept of VT was created and originally grew from constructivist self development theory (CSDT; McCann & Pearlman, 1990). In their research, McCann and Pearlman (1990) utilized this theory to illustrate the "complex relation among traumatic life events, cognitive schemas about self and world, and psychological adaptation" (p. 136-137). Constructivist self-development theory is an inclusive personality theory that depicts the influence of a traumatic milieu on the development of self (Saakvitne, Tennen, & Affleck, 1998). In addition, CSDT describes the interaction between core self capacities (pertaining to relationships, attachments, and ego resources) and schemas (pertaining to collective occurrences and the meaning associated with such occurrences) which serve as the basis of personality development. In essence, CSDT acknowledges the psychotherapist's adaption to trauma as an interplay between personality, personal history and exposure to the traumatic event within the social, cultural, and organizational contexts of the therapeutic setting (Saakvitne et al., 1998).

This theory postulates that human beings create their own realities that develop into ever-changing and complex schemas (Hesse, 2002). As such there are specified schemas of the professional's life that can be affected by this line of work and include; frame of reference, self

capacities, ego resources, psychological needs and memory system (Rosenbloom et al., 1999). Such developed schemas are rooted on the basis of psychological needs in five areas. The psychological need domains impacted by VT include safety, trust, esteem, intimacy and control (Cunningham, 2003; McCann & Pearlman, 1990). The major hypothesis of CSDT is that “trauma can disrupt these schemas and that the unique way that trauma is experienced depends in part upon which schemas are central or salient for the individual” (McCann & Pearlman, 1990, p. 137).

Frame of reference

Mental health professionals may experience an alteration in their frame of reference as a result of their work with traumatized clients (Rosenbloom et al., 1999). This is the most fundamental disruption those working with survivors of trauma will experience as it includes the psychotherapist’s world view, sense of identity, and spirituality (Pearlman & Saakvitne, 1995b). World view includes one’s “beliefs about the world, including life philosophy, moral principles, causality” and control (Pearlman & Saakvitne, 1995, p.61). These beliefs shape one’s interpretation of interpersonal and life happenings. This view encompasses general assumptions about morality and the predictability of others’ benevolence. The veil of invulnerability is lifted as one hears about the harmful acts of others. No longer can that psychotherapist live in a bubble infused with denial about how he or she is not also susceptible to being inflicted by similar violent acts (Astin, 1997). This could be heightened when working with survivors of mass violence as the psychotherapist could be exposed to a multitude of clients presenting similar traumatic memories. When working with survivors of trauma, this frame of reference can be painfully shifted and psychotherapists who are experiencing VT may begin to question the cruelty of mankind and find themselves losing hope and connection with others.

Identity, one's sense of self across time, situations, and affective states, may also be impacted (Pearlman & Saakvitne, 1995; Rosenbloom et al., 1999). This component of reference reflects one's personal story and "includes but is not limited to racial, maturational, gender, cultural, and vocational identities, as well as the complex internalizations and introjections of, and identifications with, significant others, and roles, projections, and ego ideals experienced within early relationships" (Pearlman & Saakvitne, 1995a, p. 61). Listening to traumatic material whilst empathizing with his or her client may lead the mental health professional suffering from VT to question how much he or she can do in his or her clinical role. Spirituality is considered the "meeting place" linking identity and worldview as it is the springboard for meaning making (Pearlman & Saakvitne, 1995a). Mental health professionals experiencing VT are often confronted with spiritual challenges as they can begin to question their own sense of meaning and hope when facing such traumatic material infused with human cruelty (Brady, Guy, Poelstra, & Brokaw, 1999). Both identity and world view disruptions are evidenced in the realm of spiritual impoverishment as it reflects a "loss of a sense of meaning for one's life, a loss of hope and idealism, a loss of connection with others, and a devaluing of awareness of one's experience" (Pearlman & Saakvitne, 1995b, p.161). These authors postulate that disruption in this component is more detrimental and potentially least explored.

Self Capacities

Self capacities are "inner capabilities that allow the individual to maintain a consistent, coherent sense of identity, connection, and positive self-esteem" (Pearlman & Saakvitne, 1995a, p.64). These self capacities allow the psychotherapist to regulate strong emotions, sustain a sense of interpersonal connections and maintain a positive self-perception. Such securities are rooted in the secure attachments established during early development. Indicators that these abilities may be

disturbed include interpersonal difficulties, overindulging, overextending, or compulsively consuming to manage or avoid the heightened levels of self-criticism. Psychotherapists may also find themselves hypersensitive to traumatic material presented in sessions and exposure to media that addresses the suffering of others (Pearlman & Saakvitne, 1995b). Such difficulties could have prominent implications for mental health professionals attempting to work with survivors of trauma (Trippany et al., 2004), especially in contexts in which on-going media coverage and attention prolong the exposure for such helpers.

Ego resources

The third component of CSDT, ego resources, enables psychotherapists to meet their psychological needs in order to develop and maintain interpersonal relationships and protect themselves (Saakvitne et al., 1998). There are two sets of ego resources that are helpful in the therapeutic process. The first set includes intelligence, willpower, initiative, self awareness of needs, and drive for personal growth. The second set is essential for self preservation and include the ability to consider consequences, establish mature relationships with others, establish boundaries, and make self-protective decisions. Perfectionism and the drive to overextend oneself at work are two key disruptions that could hinder one's ego resources (Pearlman & Saakvitne, 1995a).

The other components of CDST influenced by VT are psychological needs and cognitive schemas. Such needs include safety, trust, esteem, intimacy, and control and manifest both in relation to the self and within others. Cognitive schemas are the unconscious and conscious beliefs and assumptions one has about self and others and are based on these psychological needs. Disrupted schemas highlight generalized negative thoughts about oneself, others, and the ability to have one's psychological needs met. Such disturbance can hinder the psychotherapist's ability to

formulate healthy interpersonal relationships (Pearlman & Saakvitne, 1995a). Psychological needs and attached schemas are discernibly different in each individual based on his or her personal history and “appear to be most sensitive to the effects of psychological trauma” (Pearlman & Saakvitne, 1995a, p.68). As such, it is important to address each psychological need as they could shed light in understanding and potentially preventing VT in psychotherapists (Trippany et al., 2004).

Safety needs

Each psychological need includes two subcategories; the need as it relates to oneself and to one’s experience of others. A sense of personal safety refers to the individual’s need for security and invulnerability to harm while other-safety is the desire to believe that important persons are also safe from harm (Pearlman & Saakvitne, 1995a; Rosenbloom et al., 1998). Psychotherapists with prominent safety needs who are experiencing VT may believe that there is no safe place to protect them from real or imagined threats (Trippany et al., 2003). This is especially triggered with unexpected events, such as natural disasters or mass violence occurrences, in which people are subjected to widespread physical harm. Disruptions in this need could be experienced via a heightened sense of vulnerability and fragility, disproportionate concern about locking one’s house and car, or concern about one’s current living situation (e.g. on the bottom floor which could be more easily accessed). Associated cognitive changes could include not believing that he or she is safe anywhere, even at their place of employment (Rosenbloom et al., 1998).

Trust needs

According to CSDT, trust needs encompass self-trust and other trust. Trust, the second psychological need, represents a healthy form of attachment and reflects a psychotherapist's ability to believe his or her own perceptions as well as trust clients' ability to meet his or her own psychological, emotional, and physical needs (Pearlman & Saakvitne, 1995a; Trippany et al., 2004). Mental health professionals with VT for whom trust is significant can develop disturbed schemas in response to traumatic events linked to betrayal or stemming from errors in judgment (e.g. plane crash). As a result, psychotherapists may begin to question other's motives and become more cynical and distrustful (McCann & Pearlman, 1990). In addition, those with VT could begin to question their own capacity to independently work and no longer feel confidence in their ability to assess other's needs and character accurately (Rosenbloom et al., 1998). Trust disruptions can also evolve via denial and "present as indiscriminate misplaced trust in others, leading to revictimization" (Pearlman & Saakvitne, 1995a, p. 71). This could enhance one's sense of isolation, a crucial piece of developing VT, as he or she does not want to address his or her concerns with others.

Esteem needs

Self-esteem represents the need to feel regard and value for oneself and by others; other-esteem speaks to the need to value others (Pearlman & Saakvitne, 1995a). Psychotherapists with VT may find it challenging to sustain a positive regard for themselves, especially if feeling overwhelmed and/or ineffective. Sentiments of high regard for others may also be compromised as the psychotherapist begins to question the ability for people to be positive and fair when faced with traumatic stories rooted in human cruelty (Trippany et al., 2004). This is especially true for those exposed to "situations of intentional injury, such as assault or murder". Desire to extend one's

social network may be replaced by feeling cynical, doubtful of others, and self-protected (Rosenbloom et al., 2004, p. 73).

Intimacy needs

Self-intimacy is the need to feel meaningfully joined to oneself. If a psychotherapist is distracted in this area, he or she may find it difficult or feel empty when alone and as a result try to fill this void with superficial relationships, self-medicating, and/or compulsive compensatory behaviors such as exercising or excessive working (Rosenbloom et al., 1998). Other-intimacy, the need to interconnect with others, can also be affected by VT. Mental health professionals who work with survivors of trauma may feel alienated as a result of hearing such graphic details which can be compounded by other psychotherapists who view this form of work with condescension or confusion. Just as the survivor often feels stigmatized and judged due to their experiences so too may the therapist also exposed to such information who is legally bound by confidentiality to withhold what has been shared, thus adding to the sense of professional separation (McCann & Pearlman, 1990). Those with VT feeling such separation may be compelled to pull away from colleagues who do not work with trauma survivors or conversely become overly dependent on significant persons in their personal lives (Trippany et al., 2004). Disruptions in other intimacy may leave psychotherapists feeling less available to family and friends, perhaps due to being preoccupied with work or feeling less sympathetic to others' daily difficulties (Rosenbloom et al., 1998).

Control needs

Control, or power, refers to the need to manage one's thoughts, feelings, and actions (Rosenbloom et al., 1998). Exposure to traumatic material in which survivor's have felt helpless or experienced events outside of his or her control could evoke the psychotherapist's concerns

regarding his or her own sense of worth or power in the world. Vicarious traumatization can also influence other-control which is the desire to direct others' behaviors. Mental health workers with VT whose perception of control is challenged may inappropriately advocate for their clients' to take action instead of address the meaning of the traumatic event as well as become more dominant in their professional or personal roles (McCann & Pearlman, 1990).

These five areas reflect both experiential and thought processing modes of organizing experience. In response to a traumatic event or being exposed to traumatic material, the psychotherapist must incorporate the event, its context, and consequences into his or her belief system about self and others. "The intensity of the somatic, affective, and interpersonal components of the experience determines the availability of the event for cognitive processing". The more overwhelming or intolerable the experience given one's self capacities, the greater the likelihood one will experience disruptions in his or her psychological needs (Saakvitne et al., 1998, p. 283).

Memory system

Mental health workers who hear countless accounts of traumatic occurrences run the risk of internalizing such stories thus altering their memory systems (McCann & Pearlman, 1990). This seems particularly likely when such psychotherapists are also exposed to varying stimuli of such events via the media and other forms of communication. These images engrained in the therapists' memory may surface in the form of fragmented images, flashbacks, nightmares, somatically and affectively. In addition, such memories may be triggered by interpersonal exchanges outside of the clinical setting. To counter such experiences, some psychotherapists, "particularly those who are unable to process their emotional reactions, may experience denial or emotional numbing. These

latter reactions may occur when therapists are exposed to traumatic imagery that is too overwhelming, emotionally or cognitively, to integrate” (McCann & Pearlman, 1990, p. 143).

These reactions could be also heightened in mental health professionals who are intimately familiar and/or share similar experiences with the traumatic material being presented by clients. All in all, these memories could be temporary, but psychotherapists with VT run the risk of permanently incorporating such recollections into their memory system, especially if the material is “particularly salient to the therapist, relating closely to his or her psychological needs and life experience, and when the therapist does not have the opportunity to talk about his or her experiences of traumatic material” (McCann & Pearlman, 1990, p. 143). Therefore addressing the contributors to VT is imperative for psychotherapists.

Contributors to vicarious traumatization

As each person’s story is unique, so too is the variance in how psychotherapists are impacted by VT. The degree to which each professional’s psychological need areas are affected depends upon individual contributors such as his or her psychological composition, empathic connections with clients, personal trauma history, perceived coping style and current personal circumstances (Baird & Kracen, 2006; Rosenbloom et al., 1998). As previously mentioned, one of the most valuable tools of psychotherapists is the ability to empathically experience their clients. Yet this tool is double edged in the sense that it also makes professionals in the counseling field more at risk for developing VT. McCann and Pearlman (1990) describe empathy as multi-dimensional with cognitive and affective connection components to the therapeutic relationship. The cognitive form of empathy speaks to the psychotherapist’s comprehension of the sequence of events and the associated meaning for his or her client. Affective empathy refers to the psychotherapist’s ability to feel the associated feelings attached to such traumatic events.

The mental health professional's own trauma history is another potential contributor to VT. Such personal exposure to trauma could influence how the psychotherapist responds to his or her client's recollections of their own traumatic experiences. If there is a similarity amongst traumatic experiences, the psychotherapist may have a deeper understanding and sensitivity to what his or her client is experiencing, enhancing their level of empathic connection. Conversely, this similarity could also hinder the psychotherapist as he or she may be more in tune to their disrupted need areas and more likely to experience flashbacks and other reoccurring images from their own lives (Rosenbloom et al., 1998). If such recollections and needs are not addressed, the mental health professional may unconsciously utilize maladaptive coping skills as a means of blocking his or her own pain. This impairment of coping resources coupled with a heightened lack of self awareness make the psychotherapist more vulnerable to being affected by the client's emotions (Sabin-Farrell & Turpin, 2003).

A psychotherapist's current psychological state and interpersonal circumstances will influence his or her susceptibility to VT. Life stressors such as personal illness, pregnancy and divorce can extract from a psychotherapist's defense against developing VT (Norcross & Prochaska, 1986). Mental health professionals grappling with such struggles can become overwhelmed with the compilation of his or her client's graphic material (Pearlman & Saakvitne, 1995). This is especially pertinent amongst professionals whose personal stressors blend into their clinical work, such as those that live amongst and assist with natural disaster and other massive trauma recovery sites (Eidelson, D'Alessio, & Eidelson, 2003; Gill, 2007; Kamps, 2008).

Eidelson et al. (2003) assessed the impact of the terrorist attacks that occurred September 11, 2001 on the psychologists who responded. At least 50% of respondents indicated an increase in work load stress, slight feelings of being professionally unprepared, some measure of change in

their professional focus. In addition, 82% of these psychologists reporting that their personal lives had also been affected and that they were slightly more fearful since the attacks. One author who's child was at Columbine the day of the deadly shootings reflected, "although my child emerged from the school physically unharmed, we had to reconcile ourselves to a new awareness of vulnerability..." (Mears, 2008, p. 160). Faust, Black, Abrahams, Warner, and Bellando (2008) addressed the impact on psychological practice in New Orleans after Hurricane Katrina. Reflecting upon their professional experiences, all of the authors observed the chronic stress of recovery and therapeutic fatigue from working with their clients. These authors presented the personal impact as "more chronic distress than impairment", adding that concepts such as VT do not alone capture their experience as they too were directly impacted by the storm and its adverse consequences (Faust et al., 2008). Due to this it is imperative to consider the systemic variables of psychotherapists who work with trauma survivors in order to comprehensively conceptualize the multiple aspects of VT.

Organizational, professional, and social aspects of one's work environment have also been found to contribute to VT (McCann & Pearlman, 1990). Concrete aspects such as supervisors, fiscal compensation, policies and procedures have been found to contribute to a psychotherapist's level of professional stress (Norcross & Prochaska, 1986). The clinical setting has also been indicated to contribute to VT in psychotherapists (Moulden & Firestone, 2007). Mental health professionals that work within larger institutions have a stronger likelihood of feeling isolated which could be reinforced by the organizational confines such as having less control over case load, what type of issues clients within their caseload present, and the parameters around treatment length (McCann & Pearlman, 1990). Research has suggested that detrimental reactions in psychotherapists are proportional to the psychotherapists' exposure to traumatized clients (Moulden, 2007). In the victim

therapist literature, it has been indicated that the proportion of trauma clients compared with non-trauma clients may be related to symptoms of VT (Cunningham, 2003; Stamm, 1995).

Several authors have suggested that working with survivors of human-induced trauma may be more difficult for psychotherapists than naturally caused trauma (Cunningham, 2003; Herman, 1992; Pearlman & Saakvitne, 1995a). As such, those that work in areas in which massive trauma or disaster have occurred may encounter a higher volume of interpersonal violence cases which could enhance their likelihood of developing VT. In addition, agencies “can become involved in trauma reenactments, for example by becoming insensitive or abusive to clients or employees, or they may themselves reflect the effects of vicarious traumatization as a result of doing too much trauma work with too little support” (Pearlman & Saakvitne, 1995a, p. 304). Such systemic dynamics can be damaging to both the clients and staff and require an awareness and willingness to address and repair the organizational dysfunction.

“In CDST, growth and pain are not mutually exclusive but rather inextricably linked in recovery from trauma and loss” (Saakvitne et al., p. 1998, p. 295). While the likelihood of experiencing the ‘costs of caring’ such as compassion fatigue, countertransference and VT are greater when working with survivors of trauma, it is crucial to remember that reactions to stress are not always deleterious or pathological (Larsen & Stamm, 2008). In fact, such work can serve as a catalyst for self re-organization and positive change. In order to comprehend the broader picture of professional wellness, it is imperative to consider the “positive payments” such clinical work has to offer. Compassion satisfaction and post-traumatic growth are two aspects of professional trauma work research that explore the rewards psychotherapists working with trauma survivors reap.

Compassion Satisfaction

Compassion satisfaction (CS) refers to the sense of fulfillment or enjoyment that psychotherapists obtain from doing their work well (Stamm, 2002). This satisfaction can be enriched via the professionals' interactions with their colleagues and plays a key role in reducing compassion fatigue and burnout (Conrad & Kellar-Guenther, 2006). As noted earlier, empathy and compassion are critical tools of the psychotherapist hence such personalized engagement makes this satisfaction unique to the mental health professional. This concept is crucial to understanding mental health professionals' quality of life as it is generalizable in the sense that it pertains to all helping roles, not just those that center on trauma (Larsen & Stamm, 2008).

Psychotherapists who focus on the positive outcomes of their work, such as the sense of helping others despite the inherent risks, are more likely to experience CS and successfully cope with the 'costs' of such work (Larsen & Stamm, 2008). Seeing clients heal and transform from victim to survivor can also reinforce the satisfaction deduced from such difficult work (Radey & Figley, 2007). Maintaining hope and positivity when working with graphic stories is a key component to promoting healing in clients (McCann & Pearlman, 1990). Despite the costs associated with trauma work, which can include direct personal exposure and the risk of work-related secondary exposure, it would seem that emotional engagement and professional connectedness can supersede the risks (Collins & Long, 2003; Larsen & Stamm, 2008). According to Larsen and Stamm (2008), CS is the result of "positive feelings arising from helping others, particularly those exposed to traumatic stressors. Posttraumatic growth, on the other hand, occurs as a result of direct or indirect trauma exposure while working with trauma survivors" (p. 283-284). This specification could indicate that post traumatic growth may be more suited to counter the deleterious symptoms of VT.

Post Traumatic Growth

Posttraumatic growth (PTG) is considered “both a process and an outcome” and can occur within the therapeutic exchange (Tedeschi, Park, & Calhoun, 1998; Saakvitne et al., 1998). This process is rooted in the relationship between the understanding of a traumatic event and its meaning (Saakvitne et al., 1998). In essence, PTG is the progression of deriving positive meaning and associated outcomes from a traumatic experience (Tedeschi et al., 1998). In this sense, growth represents cognitive adaptations in beliefs about oneself, others, and the world, thus diffusing the adversity initially experienced when faced with trauma (Karanci & Acarturk, 2003). In their description of the PTG model, Tedeschi and Calhoun (2004) stressed the importance of the initial distress as the impetus for the positive changes that develop as a result of the challenging life circumstances. Major life crises typically produce distressing psychological reactions. This is particularly the case for traumatic events that threaten the person’s physical safety, and depending upon the level of intensity, severity, and frequency of the suffering (either direct or vicarious), the distressed responses can persist for a prolonged period of time. In light of this, PTG can occur concomitantly when one attempts to adapt to such traumatic circumstances, highlighting the dynamic process of recovery. In essence, it is one’s struggle with trauma that is what is critical for PTG. This is evident in the developing literature on PTG which highlights how growth after crises occurs in a wide range of people and significantly outnumbers reports of psychiatric disorders (Tedeschi & Calhoun, 2004).

For those able to reconstruct their lives after experiencing a traumatic event, life is qualitatively different (Davis, Wohl, & Verberg, 2007). “Posttraumatic growth describes the experience of individuals whose development, at least in some areas, has surpassed what was present before the struggle with crises occurred” (Tedeschi & Calhoun, 2004). Within the

literature, this growth manifests in three main areas which parallel the core components of one's frame of reference in the CDST literature; changes in self-perception (identity), changes in interpersonal relationships (worldview), and an altered philosophy of life (worldview and spirituality) (Saakvitne et al., 1998; Tedeschi et al., 1998). "Interestingly, the anecdotal evidence of therapists' perceived growth following vicarious brushes with trauma would seem to reflect gains in these same three categories" (Arnold, Calhoun, & Tedeschi, 2005, p. 243). According to Arnold et al. (2005), the rewards of trauma work seem to involve the same types of schemas about self and the world that have been identified as the prominent components of vicarious traumatization, thus a review of the types of growth outcomes would be beneficial in conceptualizing the fluidity between these two frameworks.

Self-perception

A critical element to PTG is the progression in perception of self from being a "victim" of trauma to a "survivor" of trauma. This shift in terminology is not only less stigmatizing but can serve as a self fulfilling prophecy as the term survivor "subtly introduces people affected by trauma to the idea that they have a special status and strength" (Tedeschi et al., 1998, p. 10). The message in this shift speaks to the redemptive value of suffering that is implicit in many religions and cultural norms (e.g. no pain, no gain) (Janoff-Bulman, 2004). Posttraumatic growth further conceptualizes such sentiments via its concentration of one's sense of strength and self-reliance. Two of the most common reports of PTG includes how survivors perceive that they are stronger and identification of positive coping skills they relied on to get them through their struggles (Tedeschi et al., 1998). A plethora of positive coping skills, such as problem solving, regulating emotions, seeking social support, and relying on religion have been related to PTG (Park, Aldwin, Fenster, & Synder, 2008; Park, Cohen, & Murch, 1996). Over time survivors reestablish more

positive, albeit realistic assumptions about their struggles (Janoff-Bulman, 2004). “Positive coping appears to facilitate the making of meaning necessary for growth by promoting active struggle with the event and awareness of the potential for positive outcomes from it” (Park et al., 2008, p. 301; Park, 2004).

Via the process of recovering from the distress of trauma, survivors not only have a heightened awareness of their strength and self-reliance, but a new found confidence in their recently discovered abilities and competencies (Janoff-Bulman, 2004). This awareness is also important for mental health professionals’ PTG. According to a study assessing VT and CF in Oklahoma City bombings, it was found that psychotherapists’ recovering from associated symptoms of CF needed to adjust their critical self-talk and “shift their motivational styles towards more self-accepting and affirming language and tone” in order to resolve their struggles and enhance their PTG (Gentry, 2002). By shifting their negative self talk, such professionals could embrace the strength they used to assist survivors and themselves in the aftermath of such a traumatic event.

Paradoxically, some who experience PTG also report a deepened sense of vulnerability as they are consciously aware of the fragility of life. Such awareness serves as a catalyst for restructuring priorities and extending more effort to enhance interpersonal relationships and positive experiences (Tedeschi et al., 1998). Self care efforts are one of the most important factors in promoting PTG. Engaging in a personal life choices enriched with healthy habits and fruitful interpersonal relationships promote a balanced quality of life. This was also highlighted according to a study conducted by Eidelson et al. (2003). Psychologists directly impacted and involved in the recovery efforts after the terrorists attacks on September 11, 2001 reported feeling closer to their

families and an increased attentiveness of the need to “adjust priorities, stay connected (or reconnect) to deeper values and relationships” (p. 147).

Interpersonal relationships

Establishing and utilizing one’s social support systems is a critical component to developing PTG. Closer and more meaningful relationships with others provide a pathway in which survivors’ can restructure their personal stories by getting varying feedback and support (Tedeschi & Calhoun, 2004). Interacting with others also bestows the opportunity to self-disclose important information and express feelings more openly. This sense of communal support is vital for psychotherapists’ PTG development. According to Eidelson et al., a critical factor that appeared to mitigate the secondary stress experienced by the psychotherapists working with trauma survivors was the existence of a helpful organizational environment (2003). Other research has indicated that mental health professionals who received empathetic support from others during their work in the aftermath of the Oklahoma City bombing had lower levels of VT and CF (Batten & Orsillo, 2002; Gentry, 2002).

In addition to receiving support from others, it has been found that reciprocating support can also contribute to deriving PTG when working with trauma survivors. Psychologists involved in the recovery efforts of 9/11 reported an increase in their positive feelings about their professional work. These professionals felt more meaning and satisfaction from their work with clients as they believed they were “making real and important contributions to the welfare of individuals” and the healing of a community in a time of great need (Eidelson et al., 2003). Providing help to others after traumatic events can induce additional healing as it enables psychotherapists to recognize how they have grown when faced with those that are still struggling (Tedeschi et al., 1998).

Philosophy of life

When one experiences a traumatic event, a variety of cognitive changes about the fundamental questions regarding life and death can arise. “A commonly reported change is for the individual to value the smaller things in life more and also to consider important changes in the religious, spiritual and existential components of philosophies of life” (Tedeschi & Calhoun, 2004, p. 58). Such development in perspective can fuel PTG as it prevents individuals from dwelling on the inconsequential and negative aspects of life. Growth in the domain of spiritual development reflects the individual’s sense that he or she is connected to something transcendent. Others who consider themselves religious can have a more solidified understanding of their beliefs as well as a strengthened dedication to their chosen religious tradition (Tedeschi et al., 1998). As the gifts of life appear more bountiful, so too is the recognition of what is important, which can often include one’s relationship with God or nature (Janoff-Bulman, 2004).

The process of meaning-making sets the stage for revolutionary changes that have a major impact on survivors’ self-discovery and perspective (Davis, Wohl, & Vernberg, 2007; Tedeschi et al., 1998). Posttraumatic growth enables one to step away from the immediacy of events and consider how his or her life has been enriched by such events. Psychotherapists that have listened to the traumatic narratives of their clients communicate “the highest degree of respect” by encouraging clients “to see the value of their own experience” (Tedeschi & Calhoun, 2004, p.59). Assisting clients in considering new possibilities of what life beholds sets the stage for reciprocal posttraumatic growth and empathic connection. Realizing the possibility of loss encourages a new aspect of meaning making, one that centers upon questions of significance and worth (Janoff-Bulman, 2004).

As conceptualized by Tedeschi & Calhoun, the process of PTG is initiated by a traumatic event that severely challenges the individual's comprehension of previously held assumptions about him or herself and the world (2004). Individual qualities such as extroversion, openness to experience, and optimism promote one's potential to grow after trauma. The individual's social system may also play a significant role in developing PTG; particularly when new perspectives and adjusted schemas that embrace both the detrimental and potential aspects of such events are reinforced by others. This aspect of PTG is critical when socially shared schemas are challenged by collective adversity (Tedeschi & Calhoun, 2004). When disasters such as hurricanes, mass shootings, or terrorist attacks occur, community and societal systems are faced with the challenge of collectively responding to an unanticipated, undeserved event. Mental health professionals are "quickly thrust into urgent and unfamiliar territory called upon to respond to the needs of individuals, families, and organizations in psychological crisis at the very same time that their lives are thrown into upheaval" (Eidelson et al., 2003, p. 144). Such disorder can produce profound changes in the psychotherapist's professional and personal lens. Positive changes can develop out of such events if such professionals envision the experience as a potential turning point.

Arnold et al.'s (2005) work regarding vicarious post traumatic growth explored the positive consequences perceived by clinicians who work with trauma survivors. Participants in their study reported positive adaptations in their levels of "sensitivity, insight, tolerance, and empathy-traits that reflect positive changes in their ability to understand, accept, and connect with others" (p.257). Many reported a heightened sense of vulnerability when working with traumatized clientele which in turn deepened their sense of self-perception and strengthened their appreciation for life (Arnold et al., 2005). Eidelson et al. (2003), found similar results in their study. After investigating the psychological outcomes of the terrorist attacks on psychotherapists, some of the common responses

included an enhancement in personal meaning and satisfaction derived from the sense that these clinicians were making significant contributions to the healing of their clients and in a broader sense the nation in a time of such strife and need. In addition to such adaptations of professional focus, volunteer activities with those directly involved in the disaster also contributed to the positive consequences derived from this sample's work.

Many other authors have chronicled their experiences providing disaster relief services during and after Hurricane Katrina (Akin-Little & Little, 2008; Dass-Brailsford, 2008; Faust, Black, Abrahams, Warner, & Bellando, 2008; Jones, Immel, Moore, & Hadder, 2008; Kamps, 2008; Levy, 2008). A common recommendation derived from this literature included the need for familiarization of disaster relief resources and training for psychologists and other mental health professionals who work with the trauma survivors (Kamps, 2008). Jones et al. (2008) also supported the call for more training and research of mental health disaster recovery efforts. In addition, these authors stressed the importance of engagement in self care techniques and how often these efforts are neglected by psychotherapists, especially those suffering from burn out and vicarious traumatization.

Levy (2008) discussed how this intense event affected him both personally and professionally. This author emphasized how engagement amongst social networks and within the community fostered a sense of volunteerism which promoted inner satisfaction and communal support. He also ascertained the positive, albeit indirect consequence this experience had upon his practice when he claimed that it is "human nature to "forget" things we know. We often need to be re-reminded, and if we are open to learning, certain experiences can sharpen our thinking, shine light on things we already know, and enable us to appreciate things in ways we have not before" (p.32). Faust et al., (2008) provided personal narratives regarding the impact this hurricane had on

their practice as psychologists. These authors identified that “most of the research on compassion fatigue or secondary (vicarious) trauma describes the impact on the psychologist or counselor who regularly provides services to populations who are themselves directly traumatized but with whom the therapist typically does not share the experience” (p. 4).

Summary and research direction

The tragic events reviewed in this chapter are some of the most current to alter national and international history. Research pertaining to the ramifications of such events has centered on how clients are affected and the vicarious effects such work can have. Yet nominal research has addressed mental health professionals’ experiences working with victims of mass shootings. This study was focused on the experiences of selected mental health professionals at Virginia Tech and within the surrounding community who provided clinical services during and after the April 16, 2007 shootings. Participants were asked to describe the meaning derived from personally experiencing a tragic event while providing direct clinical and supervisory support directly following and after the shootings.

CHAPTER THREE

Methodology

This study was designed to describe the experiences of selected mental health professionals at Virginia Tech's Cook Counseling Center, Psychological Services Center, and New River Valley Community Services Board who provided clinical services during and after the Virginia Tech April 16, 2007 shootings. Specifically, what did this experience mean to them, what does it mean to them now, and how has it influenced their professional quality of life.

By exploring this phenomenon in depth, I began to fill the gaps within the literature regarding professional challenges and benefits when working so closely with traumatized clients who share similar exposure to traumatic events. In addition, I identified mitigating clinical and supervisory strategies that could enhance such professionals' quality of life. This chapter includes a description of the methodological components that comprised this study. First, a rationale for the methodology is provided. Ethical considerations follow the rationale and are thoroughly explained as a means of stressing my awareness of the sensitive material that could be shared and enhance the refutability of the subsequent sections (Anfara, Brown, & Mangione, 2002).

Other facets of this chapter include research methods, selection of participants, instrumentation, research questions, data collection, analysis procedures, indicators of quality and rigor, and research reflexivity. Results of this study will be disseminated via scholarly journal article submissions and conference proposals. The ultimate goal of this chapter is to "provide enough description and details to allow validity judgments to be made by the reader" (Anfara et al., 2002, p. 28).

Rationale for qualitative research design

The proposed study was designed to describe the experiences of mental health professionals serving the New River Valley and the meaning derived from their experience providing direct clinical and supervisory services after the campus shootings that occurred at Virginia Tech on April 16th, 2007. The basis of quality research designs seeks to answer who, what, when, how, and why questions (Anfara, Brown, & Mangione, 2002). As such, qualitative research is a pathway for determining such answers and “is a broad umbrella term for research methodologies that describe and explain persons’ experiences, behaviors, interactions and social contexts” (Fossey, Harvey, McDermott, & Davidson, 2002, p. 717). This research paradigm encompasses a personalized nature of fieldwork and was most appropriate for the purposes of this study as the research questions are rooted in human interaction (Patton, 2002).

Phenomenological studies stem from interpretation and investigate individual experiences within a group to determine the common essence of the phenomena. As phenomenology is based on interpretation, an individual’s social, cultural, and historical context are considered critical additives to his or her perspective (Fossey et al., 2002). The focus of phenomenological research is on exploring how individuals make sense of a particular experience and transform the experience into consciousness, both individually and as a collective meaning (Patton, 2002). This research paradigm is rooted in two key assumptions. The first assumption is that people’s experience and their interpretation of that experience and the world is what is important. In addition, qualitative methods “extend and magnify our view of studied life” and enable the researcher to get an extensive and more internal view of the participants’ lives (Charmaz, 2006, p. 14). This is a crucial component to empathetically and empirically describing mental health professionals’ quality of life and relationships with their clients (Patton, 2002).

The second assumption is methodologically based and assumes that the “only way for us to really know what another person experiences is to experience the phenomenon as directly as possible for ourselves” (Patton, 2002, p. 106). A qualitative research method seemed most appropriate as it is the primary approach to investigate and comprehend the subjective experience of the mental health professionals directly involved in the recovery efforts following the shootings (Seidman, 2006). This inference was particularly pertinent and underlines the justification for the data collection process of in-depth interviewing.

Two years ago I interned at Cook Counseling Center and worked at the New River Valley Community Services Board, both agencies that employ psychotherapists who have experienced the phenomena in question. In this way, I could “work much more from the participants’ specific statements and experiences”, thus reinforcing my efforts to bracket or counter previous knowledge and assumptions about the topic of study (Creswell, Hanson, Plano Clark & Morales, 2007, p. 252). As a result, I had access to help participants to explore the phenomenon, and enough distance to try to maintain objectivity. I was reflexive regarding my professional role that could influence my line of questioning and overall analysis.

The supposition of phenomenological inquiry is to ascertain the individual and collective essences of the participants’ experiences. “These essences are the core meanings mutually understood through a phenomenon commonly experienced. The experiences of different people are bracketed, analyzed, and compared to identify the essences of the phenomenon” (Patton, 2002, p. 107). In order to conduct a phenomenological study in which the focus was on the essence of the shared experience to which I am closely familiar with, a plethora of ethical considerations and safeguards must be considered.

Ethical considerations

Phenomenological studies are rooted in intentionality, caring and interpretation (Patton, 2002). Due to the sensitivity of this area of study, it was necessary to inform and seek verbal and written approval of the directors of all three counseling centers. This was ethically important and also a requirement for the Institutional Review Board (IRB) and Committee for Assessment and Research after the Tragedy (CART). The key component was to consider safeguards for participants. As this topic could invoke emotional reactions, a list of support services was given to participating mental health professionals. Resources were derived from the Roanoke area as the New River Valley is a smaller community so there was potential for many of the psychotherapists know one another. At the end of each interview, I provided a list of clinical resources to each interviewee in the event that he or she experienced more than minimal distress in which counseling was desired. The referral listing included resources as designated by his or her employee assistance program.

Confidentiality.

Confidentiality was a critical component that will be stressed throughout this study. The data collection procedures was managed in accordance with the American Counseling Association (ACA) guidelines for conducting research. Virginia Polytechnic Institute and State University's IRB and the Committee on Assessment and Research after the Tragedy (CART) approval was sought for the commencement of the study and content of the consent form. Prior to solicitation of participants, the directors of Cook Counseling Center, Psychological Services Center, and the New River Valley Community Services Board were consulted to gain approval to approach their staff and inform them of the purposes of this study. To stress the importance of confidentiality, I offered to meet the participants wherever was most comfortable to them. Also, I had planned to provide, if

requested, a variety of options regarding the interview process in order to preserve confidentiality and remind the participants that any and all participation was completely voluntary. To reinforce this, I kept the identity of the respondents protected from their place of employment so that they do not feel pressured to continue to participate or alter their responses due to the fact that the director of their place of employment is aware of the study.

Once data collection had begun, the participants' identity was maintained via the use of pseudonyms and only portions of the gathered demographic information was displayed in the disseminated results. The data, comprised of interview transcripts and audio recordings, was stored in a secured location only known to me. All source data will be destroyed by the primary researcher once all data analysis, result dissemination and presentation of findings via oral and written forums are complete.

Informed consent.

To respect the ethics of caring (Rossman & Rallis, 2003), the participants were informed that their participation was completely voluntary, as indicated in the informed consent, and verified my cognizance of the sensitivity of the subject matter. The ethical principles that guide informed consent included, "participants are as fully informed as possible about the study's purpose and audience, they understand what their agreement to participate entails, they give their consent willingly and they understand that they may withdraw from the study at any time without prejudice" (Rossman & Rallis, 2003, p. 75). Another component of the informed consent that was highlighted was the nature of the relationship between me and interviewee. As I had pre-existing relationships with the majority of potential participants, my role as a researcher was defined to clarify research objectives and reduce the likelihood of socially desirable responses produced by interviewees.

Risks.

The potential risks in this study may be heightened due to the sensitive nature of the topic. As I was referencing a traumatic event during the interviews, there was a possibility that certain memories were evoked. Participation in this study could have resulted in recollecting difficult experiences with clients and/or supervisees that occurred during the aftermath of the campus shootings. To counter this, questions addressed professional aspects affiliated with this traumatic event. Every effort was made to mask identifying information via the use of pseudonyms and depiction of selected demographic information. All questions were asked in an open-ended, nonjudgmental style to encourage honest communication and appropriate pace with each participant. Lastly, I “must take care to promote non-manipulative research relationships and make sound judgments concerning what is to be reported in the dissemination process” (Clarke, 2006, p. 13). In addition to the aforementioned risks, there were various benefits that could also have been accrued from participating in this study.

Benefits.

As post traumatic growth was one of the fundamental components of the theoretical framework of this study, individual and collective benefits could have been gained. Participants were encouraged to consider how they have developed professionally in light of the clinical and supervisory work they had done regarding trauma survivors. In addition, each mental health professional was given a venue in which they can reflect on their personal and organizational successes during the recovery efforts. This could have been especially uplifting given the ample amount of media and litigious attention that ensued following the Virginia Tech tragedy. In addition, the results of this study will add to the body of literature regarding the potential for professional growth accrued during traumatic events. Lastly, by focusing on the mental health

professionals, implications for research, supervision, and training were concentrated on improving the professional quality of life and preparation of current and future psychotherapists.

Research methods

Based on the call for more in depth research in the trauma literature, a phenomenological research paradigm was chosen for the purposes of this study (Pearlman & Saakvitne, 1995a; Figley, 1995, Trippany et al., 2004). A series of two interviews were conducted with each participant. The research questions that guided the interviews include:

- 1) How did mental health professionals' experiences of the tragedy on the Virginia Tech campus and providing direct clinical and/or supervisory services immediately after the shootings and over time inform their work with those they serve?
- 2) How did the experience affect the mental health professionals' professional quality of life immediately and over time?
- 3) How did this experience influence mental health professionals' understanding of their clinical role and work?

As I have completed a yearlong clinical internship at Cook Counseling Center two years ago as well as worked for two years as an emergency services clinician at New River Valley Community Services Board, I planned to conduct two interviews focusing on the participants past and current experiences. The interviews totaled approximately two hours in length.

Participants

In order to comprehensively gather data, I considered the unique characteristics of research participants within the context of their environments. To holistically conceptualize the phenomenon of interest, I developed a comprehensive sampling frame, which would include criteria for selecting subjects capable of answering the research question(s), identifying such participants, and securing

their participation in the study (Devers & Frankel, 2000). The selection process was streamlined via purposeful sampling. This strategy was designed to enhance understandings of selected individuals or groups' experience(s) or for developing concepts and themes. Researchers seek to accomplish this goal by selecting information rich cases, with the anticipated aim that chosen participants provide the greatest insight into the research questions (Devers & Frankel, 2000; Pembridge et al., under review).

Based on this specified interest, purposeful sampling was used in which pre-selected participants from the New River Valley were contacted. In addition to being purposeful, this group represented an intensity sampling as I contacted those most directly linked to the recovery efforts based on the assumption that those selected have the propensity to provide rich depictions of their experiences (Patton, 2002). I selected a professionally homogenous group of participants. This group represented those within both clinical and supervisory professional capacities in various work settings to ascertain a broad range of perspectives (e.g. administrators, supervisors, clinicians, interns). Due to the sensitivity of subject matter and small number of participants, only select demographic information regarding professional background, gender, race, and years of experience was the represented in this study in order to protect the participants' identity to the fullest extent possible.

Data Collection

Interview structure.

The purpose of interviewing is to explore a person's perspective which is assumed to be meaningful and knowledgeable (Patton, 2002). As such, a combined interview approach was the chosen data collection method for this study. The interview included a fused strategy, combining a standardized interview guide approach and more informal, conversational follow up questioning

technique (Patton, 2002). It was necessary to have a structured interview format to ensure consistency and rigor across interviews. Also, as there was great potential of individuation among interviews, the flexibility of delving deeper regarding certain responses enriched the data collection process. This required asking questions created in the moment based on the feedback of the interviewee. This allowed elasticity in determining when it was appropriate to explore certain subject areas in greater depth (Patton, 2002). In addition, as I had pre-existing relationships with the majority of participants, using an open ended questioning format did “minimize the imposition of predetermined responses when gathering data” (Patton, 2002, p. 353).

Phenomenological research is emergent in nature therefore the following questions may evolve as the interviews progress (Patton, 2002). The overall goal of the interview process was to have each participant reconstruct his or her experience working within their professional role during and after the aforementioned traumatic event (Seidman, 2006). The backbone of the questions was based on the literature regarding professional quality of life, vicarious traumatization and post traumatic growth. These questions did “provide the scaffolding for the investigation and the cornerstone for the analysis of the data” and are based on “what truly needs to be known” (Anfara et al., 2002, p. 31). (See appendices E, G, and H, for the structured portion of the interview protocol and demographic survey).

Interview method.

The purpose of interviewing is to allow researchers to enter the participant’s perspective since they cannot observe participants’ feelings, thoughts, and intentions (Patton, 2002). Data was collected via in depth interviewing as a means of gathering information about participants’ professional experiences working with clients after the shootings and the meanings attached to such experiences. The interviews were scheduled at a time mutually acceptable to the participants and

researcher. The location of each interview was an area that was quiet and comfortable to the participant. The participants were informed in the initial contact that the first interview could last approximately 90 minutes, with the potential for an hour follow up interview. The first interview addressed the past experiences of the participants. Prior to the second interview, the first interviews were transcribed and sent to the participants for review. In the second interview I focused on the current experiences of the participants and allowed for clarification or expansion about points made in the first interview.

Demographic questionnaire.

A demographic questionnaire was sent to each participant prior to the beginning of the first interview. This questionnaire gathered basic information such as gender, race, and age. In addition, questions pertaining to years of experience, current clinical role, previous clinical experience working with trauma survivors, and current work setting were included. As this is a sensitive topic, I did my best to ensure only certain demographic information will be included in the dissemination process. Although all information was considered during data analysis, only demographic information that enriched the results and findings were represented in the dissemination of results as a means of masking identifying information (See Appendix J for demographic results).

Field notes.

Field notes were also taken during the interview process as a means of enriching the interview data and enhancing reflexivity. The purpose of field notes was to gather “insights, interpretations, beginning analyses, and working hypotheses about what is happening in the setting and what it means” (Patton, 2002, p. 304). This was a reflexive process as I had to “undertake an ongoing examination of what I know and how I know it” and assisted in the externalization of

assumptions and personal biases that I may hold (Patton, 2002, p. 64). In addition, writing in the first person prompted me to connect with and own my subjective experience in addition to my participants; enriching the authenticity of the data. In addition, an audit trail, or depiction of research activities and decisions made throughout the data collection process is included in Appendix M.

Data Analysis

“The function of analysis is to bring meaning, structure, and order to data” (Anfara, et al., 2002, p. 31). It is an eclectic endeavor in which the goal is to present the essences streamlined from the prominent themes and recurring language, and “patterns of belief linking people and settings together” (Anfara et al., 2002, p. 31; Creswell, 2002). The analytic process for this study was based on active immersion in the data and repeated coding, documenting, and comparing concepts as a means of deriving themes (Morrow & Smith, 1995). Once the data was gathered, analysis commenced. As a clinician who has assisted with the recovery efforts at Virginia Tech, I am intimately familiar with the content of this study, and was intentional about bracketing interpretations of the material while gathering the data.

Credibility and rigor.

Rossmann & Rallis (2003) suggest several strategies such as using a community of practice, member check, and a peer debriefer as means of ensuring the credibility and rigorousness of qualitative research. It was crucial that assumptions and biases regarding what may unfold in the data analysis were monitored and acknowledged. I worked closely with a community of practice comprised of dissertation committee members in order to ascertain continual feedback regarding interpretations made. This system strengthened the rigor and refutability of this process; ultimately enhancing the depth and breadth of the analysis. A member check system was utilized in which the

participants read, corrected, and added to the data collected in the interviews. The goal of this system was to provide opportunities in which the participants could reflect on their words and emerging findings, thus verifying the accuracy of the data collection (Rossman & Rallis, 2003).

Qualitative analysis is an inductive method in which themes emerge from the data (Patton, 2002). The data is broadly analyzed and conceptualized within each interview. As the researcher delves deeper into the analysis, the data begins to merge and funnel into more concise concepts and categories evidenced throughout experiences until the essence of the phenomena emerges (Patton, 2002). The first stage of analysis is transcribing the interviews and field notes (Rossman & Rallis, 2003). This would entail transcribing all of the audio recorded interviews. Once this process is complete, open codes are identified from the transcriptions. Open codes are descriptive indicators of observable behaviors that occur throughout the interviews.

Once the open codes were identified throughout the interview, I re-read all of the interviews several times to channel the open coding into more detailed, abstract focused coding. Focused coding centralizes the descriptive data, combining it with more abstract interpretations of the data. After the focused codes were created, categories emerged which fused the focused codes with interpretation connected to what is currently in the literature.

Once I designated categories which are consistently evident throughout the interviews, I funneled the categories into themes. Themes are rooted in the interpretation and abstractions of the researcher (Patton, 2002). Themes move beyond the lived experience of the particular individuals and represent the essence of the particular phenomena being studied. Themes are abstract representations of the meaning underlining the phenomena. In order to root the themes, I verified some general themes derived from the first interviews with the interviewees to ensure accuracy and depth of the analytic process (See Appendix K Data Analysis Chart for more details).

Quality assurance.

Several steps were taken during the data analysis process to ensure the quality and integrity of the research process. As previously mentioned, I made every effort to “bracket” presuppositions in order to “identify the data in pure form, uncontaminated by extraneous intrusions” rooted in past experience working amongst several of the participants in the study (Patton, 2002, p. 485). A peer debriefing system was also be used during data analysis. Peer debriefing “is the review of the data and research process by someone who is familiar with the research or the phenomenon being explored” (Creswell & Miller, 2000, p. 129). I utilized an auditing system in which I coded the first transcript for concepts and themes that arose during analysis and sent this work to one of my advisors for feedback and approval. This additional review assessed the overall quality of data collection and analysis (Patton, 2002). The goal of this process was to decipher the “structural synthesis” or deeper meaning of the participants, fusing the essence of their experiences (Patton, 2002).

Summary

“Sound research requires a systemic and rigorous approach to the design and implementation of the study, the collection and analysis of data, and the interpretation and reporting of findings” (Fossey et al., 2002, p. 720). The goal of Chapter three was to address the various facets of the methodology that will be used to complete this study. Included was the rationale for the chosen methodology. Ethical considerations were also explored to account for the sensitive phenomenon that will be examined. Other facets of this chapter include research methods, selection of participants, instrumentation, research questions, data collection and analysis procedures. The goal of the outlined steps and the purpose of this chapter was to substantiate the depiction of the essence of the experiences of the participants.

CHAPTER FOUR: ARTICLE ONE

Shared Traumatic Exposure:

Implications for Preparing and Supporting Clinicians

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Abstract

This researcher explores current research regarding the challenges and benefits of trauma work. Based on research following the 2007 tragic shootings at Virginia Tech, this author proposes a new concept, shared traumatic exposure, as a means of strengthening current trauma literature. Results from this qualitative study highlight the multidimensional effects of such work on mental health providers. Implications for practice and supervision are included. Recommendations for research regarding shared traumatic exposure are examined.

Shared Traumatic Exposure:

Implications for Preparing and Supporting Clinicians

“The lifetime prevalence of major stressful events is high” (Calhoun & Tedeschi, 1998). According to Broman-Fulks et al. (2006), current epidemiological studies estimate that between 50% and 70% of individuals in the United States have experienced some form of interpersonal violence during their lifetime. Based on this increase it can be assumed that most clinicians will either be effected by and/or work with survivors of trauma in some capacity. *Trauma* is generally defined as exposure to an event in which a person is confronted with actual or threatened death or serious injury, or a threat to self or others’ physical well-being. (American Psychiatric Association [APA], 2000). Definitions of trauma have been broadened to include hearing about trauma, direct exposure to the aftereffects of trauma (such as in rescue workers), indirect exposure to the effects of trauma (such as mental health counselors and court workers), and even observation at a safe distance from the trauma (as in the television coverage of the terrorist attacks of September 11) (Dreisbach, 2003; Kroll, 2003; North & Pfefferbaum, 2002). In essence, no longer does one need to be a *direct* victim or witness to be traumatized (McNally, Bryant, & Ehlers, 2003). The expansion of this definition encompasses those who provide recovery assistance after traumatic events.

Review of the Literature

The impact of traumatic experiences is multidimensional and influences emotions, cognitions, and behaviors (Pat-Horenczyk & Brom, 2007). The occurrence of “traumatic incidents may create powerful affective responses in those who rescue, care for, and counsel the individuals directly affected” (Wilson & Lindy, 1994, p. 333). Emotive responses are prevalent among first responders that work with survivors of violent traumatic events (McCann & Pearlman, 1990). This

is especially the case for those that assist in the recovery efforts after mass community catastrophes. In such instances, the impact of mass violence extends beyond the individual victims and survivors to include the local and national communities (Norris, 2007). As this form of crisis impacts the entire community, this work can heighten the psychological stress of mental health professionals as they are working within the environment of the trauma while also personally impacted.

The extensiveness of community based crises is continuously growing. Events, such as mass shootings, shock the community's response capability as human maliciousness and suffering are so evident (Wilson & Lindy, 1994). As such, it is conceivable that mental health professionals working with survivors of interpersonal violence have a higher likelihood of experiencing professional stress and growth (Calhoun & Tedeschi, 1991; Cunningham, 2003). While there is a variety of research regarding the psychological wellbeing following traumatic events for survivors, less is known about the lasting emotional and mental costs for practitioners who are also exposed to the same traumatic events as their survivor clients (McCann & Pearlman, 1990).

Vicarious traumatization.

Currently the literature advances vicarious traumatization (VT) and post traumatic growth (PTG) as two potential outcomes for counselors who do trauma work. Vicarious traumatization, a term developed by McCann and Pearlman (1990), is a process of change on behalf of the mental health provider due to the empathic connection with trauma survivors (Pearlman, 1999). These authors consider VT an unavoidable consequence of trauma work based on the long term, cumulative effects of the exposure to the graphic and painful depiction of traumatic events (McCann & Pearlman, 1990; Pearlman, 1999; Ting et al., 2005).

According to Pearlman and Saakvitne (1995a), long-term empathic interaction with traumatized clients can change clinicians' worldviews. Such disruptions in the cognitive processing

of practitioners can impact both their professional and personal lives as they become witness to the explicit details of their clients' traumatic realities (Cunningham, 2003; Trippany et al., 2004). This transformation of the clinician's inner experience can parallel those of trauma survivors and can be the result of working directly with traumatized clientele or indirectly via exposure to depictions of violence in other forums such as supervision, readings, or presentations (Rosenbloom, Pratt, & Pearlman, 1999). Such psychological effects, although a normal consequence of such work, can be disruptive for the clinician, and continue for months or years (McCann & Pearlman, 1990). Several authors have suggested that working with survivors of human-induced trauma may be more difficult for practitioners than naturally caused trauma (Cunningham, 2003; Herman, 1992; Pearlman & Saakvitne, 1995a). As such, counselors who work in areas in which massive trauma or disaster have occurred may deal with a great deal of interpersonal violence cases which could enhance their likelihood of developing vicarious traumatization.

While the likelihood of experiencing the costs of caring such as VT is greater when working with survivors of trauma, it is crucial to remember that such reactions to stress are not always harmful or pathological (Larsen & Stamm, 2008). In fact, such work can serve as a catalyst for self re-organization and positive change. In order to envision the broader picture of professional resiliency, it is imperative to consider the rewards such clinical work has to offer. Post-traumatic growth is one aspect of professional trauma work research that explores the benefits of working with trauma survivors.

Posttraumatic growth.

Posttraumatic growth (PTG) is considered both a process and a result and can occur within the therapeutic exchange (Tedeschi, Park, & Calhoun, 1998; Saakvitne et al., 1998). "Posttraumatic growth describes the experience of individuals whose development, at least in some areas, has

surpassed what was present before the struggle with crises occurred” (Tedeschi & Calhoun, 2004). In essence, PTG is the process of deriving positive meaning and associated results from a traumatic experience (Tedeschi et al., 1998).

In their description of the PTG model, Tedeschi and Calhoun (2004) stressed the importance of the initial crisis as the medium for the positive changes that develop as a result of such challenging circumstances. Major life crises typically produce distressing psychological reactions. This is particularly the case for traumatic events that threaten the person’s physical safety, and depending upon the level of intensity, severity, and frequency of the suffering (either direct or vicarious), the distressed responses can persist for a prolonged period of time. In light of this, PTG can occur when one attempts to adapt to such traumatic circumstances, illustrating the dynamic process of recovery. Essentially, it is the struggle with trauma that is critical for PTG.

Although there is a plethora of evidence illustrating the effects of vicarious traumatization and the potential for growth, there is little research reflecting personalized accounts of clinicians who experienced the same trauma as their clients. Community based traumas are on the rise, but there is a lack of research regarding the professional and personal ramifications of the mental health practitioner who is simultaneously affected by the same trauma as his or her client (Piercy et al., 2008).

Shared Traumatic Exposure

The shootings that took place on the Virginia Tech campus on April 16th, 2007, constituted a mass casualty disaster, drew national and international attention, and affected the campus and local community without discrimination. “Questions immediately arose about what the psychological impacts of the shootings would be on the survivors, witnesses, their families, first responders, and the entire Virginia Tech community” (Norris, 2007, p. 1). Given the breadth of

trauma the Virginia Tech shootings had on the local and professional communities, this author explored the experiences of the mental health professionals who provided clinical and supervisory services following the shootings as it seems a tragic certainty that this form of violence will continue to occur (Gore-Felton, Gill, Koopman, & Spiegel, 1999).

This study was designed to describe the experiences of select mental health professionals who provided clinical services during and after the April 16, 2007 shootings. The purpose of this study was to fill the gaps in the existing literature regarding professional challenges and benefits when working so closely with traumatized clients who share similar exposure to traumatic events. Mitigating clinical and supervisory strategies that could enhance such professionals' capacity to intervene during times of crisis were also addressed. The research questions included: How did mental health professionals' experiences of the tragedy on the Virginia Tech campus and providing direct clinical and/or supervisory services immediately after the shootings and over time inform their work with those they serve? How did the experience affect the mental health professionals' professional quality of life immediately and over time? How did this experience influence mental health professionals' understanding of their clinical role and work?

Methodology

The purpose of this study was to describe the experiences of selected mental health professionals at Virginia Tech's Cook Counseling Center, Psychological Services Center, and New River Valley Community Services Board who provided clinical services during and after the Virginia Tech April 16, 2007 shootings. Specifically, what did this experience mean to them then, what does it mean to them now, and how has it influenced their professional quality of life. As such, a phenomenological framework was deemed most suitable for the purposes of this study.

The present study was conducted with eight participants consisting of four men and four women (social workers, licensed psychologists, master level psychologist interns) who provided direct clinical and/or supervisory services in response to the April 16th shootings. These individuals practiced either on campus or within the local community during the time of the tragedy. All still practiced and/or provided supervision currently in the same settings when interviewed. This study was approved by the Institutional Review Board (IRB) of Virginia Tech and the Committee for Assessment and Research after the Tragedy (CART). This author followed the American Psychological (APA) and American Counseling Association (ACA) ethics of study guidelines.

The interviews included a fused strategy, combining a standardized interview guide approach and more informal, conversational follow up questioning technique (Patton, 2002). It was deemed necessary to have a structured interview format to ensure consistency and rigor across interviews. In addition, this author used an open-ended questioning format which allowed her the flexibility of delving deeper regarding certain responses for the purposes of enriching the data collection process. This study included two audio recorded interviews averaging 120 minutes in length. The overall goal of the interview process was to have each participant reconstruct his or her experience working within their professional role during and after the aforementioned traumatic event (Seidman, 2006). A demographic questionnaire was sent to each participant gathering general information and clinical experience. Field notes and an audit trail were recorded throughout this process as a means of strengthening the interview data and enhancing reflexivity.

This author was familiar with the phenomena in question as she had served in a clinical capacity in two out of the three agencies. As the professional climate was somewhat overcast with litigious issues making this study somewhat controversial, this author argues that the data collected was enhanced as she was able to quickly develop or strengthen rapport with interviewees. Analytic

memos were infused within the field notes which enabled this author to “work much more from the participants’ specific statements and experiences”, thus reinforcing this author’s efforts to bracket or counter previous knowledge and assumptions about the topic of study (Creswell, Hanson, Plano Clark & Morales, 2007, p. 252). As a result, this researcher had access to help participants to explore the phenomenon, and enough distance to try to maintain objectivity. This author was reflexive regarding her professional role to minimize influence over the data collection and analysis.

Qualitative analysis is an inductive method in which themes emerge from the data (Patton, 2002). The first stage of analysis used in this study was transcribing the audio recorded interviews and field notes (Rossman & Rallis, 2003). Once this process was complete, open codes, descriptive indicators based on the words and actions of the interviewee, were identified from the transcriptions. Once the open codes were identified this author re-read all of the interviews several times to channel the open coding into more detailed, abstract focused coding. Focused coding centralizes the descriptive data, combining it with more abstract interpretations of the data. This author also utilized a member check system in which her advisor reviewed her coding schemes to ensure rigor and refutability. After the focused codes were created, four categories emerged which fused the focused codes with interpretation connected to what is currently in the literature. The categories were then funneled into themes which are rooted in the interpretation and abstractions of the researcher (Patton, 2002). Themes move beyond the lived experience of the particular individuals and represent the essence of the particular phenomena being studied. Copies of both transcripts were sent to participants to provide opportunities in which they could reflect on their words and emerging findings, thus verifying the accuracy of the data collection as suggested by Rossman & Rallis (2003).

Results

Changed perception of those who have experienced shared traumatic exposure.

There were two themes that arose from the data analysis process. One of the themes found was the changed perception of the clinicians due to the comprehensive effects of their shared exposure to trauma. Unlike vicarious trauma, this shared traumatic exposure is compounded in the sense that those providing mental health services are directly impacted by the same trauma as their clients at the same time. In addition, the percentage of time spent with traumatized clients and other members of the community is heightened as these professionals are working and living within the context of the violence while it is occurring. Although the intensity and level of direct exposure varies, the reactions among the clinicians interviewed seemed comparable. As Sam aptly surmised,

...I think that is what made that whole experience different - counseling people who were traumatized by that event-, made it different than some other trauma they might have experienced because we shared the same experience so it's kind of like we started on the same page, you know we didn't have to explain it, it's like you just knew.

In addition, shared traumatic exposure is comprehensive in scope as this form of trauma infiltrates the provider's professional *and* personal life as he or she is a member of the community impacted by the traumatic event. As these clinicians were immersed in the context of the tragedy both professionally and personally, it became apparent that managing emotional reactivity of the work and the overall event and leaving thoughts of the job *at* the job was not feasible immediately following the shootings. Bill recognized that,

The shootings have impacted everyone, that was powerful to see and in some ways made it more difficult because normally my strategy to leave work at the office didn't work because

you go out into the community and are reminded of the same things you are trying to get away from....

Media coverage also adds another layer of exposure, especially when that coverage is interpreted as misrepresentative and in a sense harmful. Jane addressed her distaste for the media stating,

I figured out I don't like dealing with the media, because I felt like they were in it for their own thing...and that in the process of doing that they were hurting students, they weren't always real nice to other people, so I figured out I didn't want to deal with the media anymore...I gave that up completely....

One of the prominent commonalities highlighted by the practitioners included experiencing difficulty separating their own experience and subsequent feelings from their clients due to their shared past and familiarity with the pain expressed by others. As one clinician described,

I was more knowledgeable of the people that were involved—but I think it made it a little more difficult to separate from the client and to just kind of be there with them and probably feel a lot of the same things they were feeling.

Boundaries were challenged and stretched to accommodate the influx of clients' impacted by the shootings. According to Sam,

It was very difficult to draw the line between being the kind of therapist and being kind of removed in just feeling what they are feeling and forget the boundary thing...I cried more with my clients, I hugged more clients....

Some clinicians actively attempted to avoid reminders of the shootings within their professional and personal contexts. John described his effort to “stay away from clients who were involved in 4/16” given his in depth involvement in the immediate aftermath of the shootings.

Linda reported,

I was not able to leave it at the door initially just because it took up so much of my time, I didn't talk to my family about it, I didn't watch news, I probably haven't watched more than two hours of coverage on Tech nor do I tend to watch any kind of horrific thing, there is enough of it going on day to day.

Several participants claimed that they avoided watching the coverage of the tragedy and/or questioned sources much more than they had prior to the shootings. Many found conversing with those outside of the Virginia Tech community to be daunting and tended to avoid such conversations concerning to their work environment. One clinician reported,

I just didn't talk about it and I didn't like talking about it outside of here but as soon as people kind of found out where you work they always had questions and I just gave a cursory answer and I just moved on.

As immediate response was needed and expected by local mental health systems, inadvertent avoidance of personal processing was another component of this shared exposure that arose among the clinicians. As Jane explained, "I think we were and me personally were so involved in what we were doing at the time that I didn't have time to think about my own response". It seems that many, albeit temporarily, disregarded their own processing of the trauma as a means of being able to best meet the needs of their clients.

Yet this intimate experience with trauma can also increase the depth of connection with clients and overall awareness of trauma and subsequent scope of impact. So ultimately, clinicians with shared traumatic exposure have a unique experience as multiple facets of their lives are touched by the trauma and thus there is a higher likelihood that they would derive the professional costs and benefits of such exposure.

Derived Benefits and Costs accrued due to Shared Exposure to Trauma

As previously mentioned, clinicians with shared traumatic exposure have a unique perspective when working with their clients. Suitably, Deion noted that "...as mental health professionals we're really one of the only groups of people that get a more comprehensive sense of the tragedy...you have got a whole picture which I think can be very overwhelming to deal with at times...". It seems having such a holistic vantage point can have challenges as clinicians are inundated with others' stories regarding the trauma which can produce some strong reactions as highlighted by the following quote, "...that's not an image I want or that's not an image that is going to help me sleep at night...I definitely would have been sleeping better tonight not hearing that...".

Emotional and even physiological states are impacted. Deion indicated a "very strong visceral reaction to some of the things..." which he concluded, "hearing that [client's stories] certainly had an impact on me and how I was doing". In order to counter this reactivity and feel effective, some of the participants spoke of having to distance themselves from their own emotions in order to be more present with their clients. Others reported that it was expected of them to provide continual support for others with little regard and consideration for their personal state of healing thus extending the costs of the shared traumatic exposure.

In addition to the challenges that arose from hearing multiple people's perspectives pertaining to trauma, there were benefits deduced from such exposure. Having a shared traumatic experience seemed to enrich the clinical work of those in this study. Some clinicians derived a sense of clinical confidence after they were exposed to trauma and felt more comfort and awareness addressing this tragedy and trauma in general with their clients. Linda noted,

I am definitely more able to just talk about what the trauma is, I don't shy away from that conversation whereas in some of my earlier clinical practices it was so horrible that it was hard for me to talk about because putting it into words for me made it very real for me to discuss their situation with them and I don't think there is any conversation around a trauma that I would shy away from now.

All participants spoke of a heightened sense of awareness of trauma which influenced their assessment and therapeutic techniques. In addition, having a communal experience with their clients enhanced already existing relationships with clients and their ability to develop rapport with new traumatized and non-traumatized clients. Bill reported that, "I think that I'm more interpersonal in general with the things that I do... I see it as more of a change in me and the way that I relate to people since then [the shootings]".

This sense of collectivity extended beyond the therapeutic relationship. Respect and appreciation for the community that arose immediately following the shootings was very evident. As Deion put it,

Nothing happens in a vacuum so everything we do happens in this social context...problems happen in a social context why don't the solutions happen that way too so I think that idea got even strengthened for me by seeing the power that society, community could have coming together.

Communal support was also apparent in the workplace. Many participants spoke of putting differences aside during the immediate aftermath in order to best meet the needs of their clients and the community. In addition, there appeared to be a "band of brothers" mentality in which these professionals initially relied on one another for support and consultation as the work demand and intensity increased. When referencing his relationship with a supervisee one clinician reported,

“...I think we got closer we were dealing with these really important issues, difficult issues with clients and it made us more connected to each other, I think that was a good experience”.

Another benefit noted in this study was the importance of self care. Several clinicians noticed how their desire to improve their self care increased after they went through this experience and discussed how they had to care for their clients immediately following the shootings and had little time to tend to their own needs. In the aftermath of the tragedy, one clinician noted that the intensity of need was still high so as a means of surviving he began to set limits. Another clinician noted, I am “trying to do more self care, trying to stay more connected with colleagues, friends, family, getting more time away, being able to sort of recharge I think has been very important”. Overall the practice of self care was deemed important by most clinicians in this study especially in the aftermath of trauma as the concentration of client needs continued to increase.

The results of this study reflect the comprehensive scope of impact shared traumatic exposure has on mental health clinicians. The ramifications of this tragedy extend beyond the clinical scope as various facets of professional and personal life are affected. Relationships with clients, colleagues, supervisors, family, and community members were influenced by this event. In addition, the work demand, needs and expectations of others intensified and may continue to do so as crises continue to arise throughout the country hence it is critical to consider the implications for supporting and preparing current and future clinicians (Kaminski, Koons-Witt, Thompson, & Weiss, 2010).

Implications for Preparing and Supporting Clinicians

One of the most prominent components of personal growth that the clinicians in this study referenced was self awareness. This was evidenced by accounts of their personal experience and that of their clients processing trauma. According to one participant,

I think that is one of the things that all of us and certainly myself become more aware of is seeing those connections, working with those connections, helping clients figure out that it may be related to trauma—seeing how the trauma might be playing in and using that as part of the treatment.

Being able to identify trauma within their work and utilize this recognition is beneficial to enhancing one's clinical scope of practice. Without such recognition, clinicians are more likely to overlook personal and clinical blind spots that could hinder treatment.

Assessment and knowledge of suicidality and homicidality was also linked to awareness of trauma. In this study, all participants referenced an increased attentiveness to and practice of assessing for risk. Awareness and usage of this skill grounded many of the participants comfort working with their traumatized clients. Risk assessment is and should be an essential element clinicians incorporate into their work with all of their clients as various events, even those that seem mundane to practitioners, can trigger strong reactions from clients. Not overlooking this piece of assessment is critical in all work. Asking the difficult questions in a personalized manner will add to the thoroughness and validity of the clinical work and enhance clinicians' ability to normalize the experience of the individual.

Another component of self awareness identified in this study that could impact clinical work is the understanding of what self and others are capable of doing. This is a confounded notion as it is important to conceptualize how clients are capable of thriving from trauma and also knowing that people are capable of committing reprehensible acts. This awareness can prompt more proactive and thorough actions of the mental health professional. It may also increase acceptance of their clients' actions and reduce the likelihood of blaming themselves for others' behavior. Several participants noted that consulting with others on a continual basis was helpful in feeling proactive

and clinically efficient. According to participants in this study, consulting with supervisors also enhanced their confidence and comfort working with traumatized clients.

Social support is considered a crucial piece of health and well-being and has been linked to faster and more successful posttraumatic recovery as survivors and workers simultaneously traumatized are given the space to process and verbalize the internal turmoil and stress typically associated with exposure to trauma (Hobfoll, Freedy, Lane, & Gellar, 1990). Secure and healthy attachments to family and friends have been illustrated to increase the ability to autonomously address a stressful event (Masten, 1999 as cited in Agaibi & Wilson, 2005). As such, developing professional support networks for consultation and collaboration, being able to debrief with others, and implement a team approach are important strategies to combat the costs of providing trauma focused treatment (Bober et al., 2005; Iliffe & Steed, 2000).

Consultation can spark introspection which is another component of self awareness. Knowing one's professional strengths as well as limitations is a crucial characteristic to accurately assessing clients and targeting blind spots accordingly. Once such growth areas and blind spots are identified, clinicians can begin to develop coping and self care skills that will enhance their professional and personal lives. This is a critical component to combating secondary traumatic exposure. One of the most important and potentially influential forms of consultation is supervision. The supervisory relationship can not only serve to guide supervisees clinically but can also be cathartic for supervisees working with traumatized individuals and even more so if they were traumatized themselves.

Several participants in this study addressed how their relationship with their supervisor strengthened after the shootings as they both had experienced a similar event. In addition, supervisors' expectations regarding crisis assessment and intervention rose aiding supervisees in

being more proactive and mindful of their interactions with their clients. As there is potential for supervisors to play a critical role in providing support and guidance for their supervisees, which can directly impact interventions with clients, it is important to consider the implications of shared traumatic exposure on the supervisory role.

The process of supervision is multifaceted and unique to each supervisory relationship. Some of the goals of supervision should include providing support and reflective feedback for supervisees' professional and personal development (Hallam-Jones & Ridley, 2008). In order to provide appropriate guidance, supervisors first must get to know their supervisees in order to recognize their strengths as well as growth areas. By personalizing the supervision process, supervisors not only can become more familiar with their supervisees clinical styles but also identify signs of shared traumatic exposure. As supervisees' susceptibility to vicarious processing of issues, such as anxiety and grief increases due to shared exposure to trauma, supervisors must be aware of such vulnerability in order to provide the appropriate support. By identifying matters that supervisees are struggling with, supervisors can assist their staff in strengthening their self awareness which could be extended to the therapeutic relationship. This enlightenment could be the catalyst to ensuring and/or improving supervisees' utilization of self care measures.

In addition, supervisors who have also been exposed to the same trauma can assist supervisees in being more attuned to recognizing underlying issues associated with trauma in treatment. One participant in this study reported that,

I think to always be aware of how trauma affects people and I notice even in my supervisory role I will go back and look at interns notes and I will see they had some kind of trauma when they were younger, and then they are dealing with anxiety issues now and they don't always put it together whereas I am, I think I am just more aware to do that now. I will

point that out in my supervisory role, ‘you may want to look at that because that is probably significant’ so I think that affected me more.

Also, having provided front line crisis intervention services, supervisors can define for themselves and model self regulating skill sets that could assist supervisees in ‘weathering the storm’. Linda reported that, “probably the biggest thing that I try to give staff is you can be calm in the middle of any chaos and I think seeing that is probably something they may have taken with them...”. “Exposure to mass trauma often results in marked increases in emotionality at the initial stages” (Hoboll et al., 2007, p. 289). During unforeseen events that produce strong emotional reactions from both clients and supervisees, it is critical that supervisors set a calm example as a means of increasing the likelihood that supervisees will respond supportively to their clients as well as themselves.

In a time of crisis, it is understandable that displacing one’s own needs is necessary to aid clients immediately following the tragedy, yet the personal toll of negating one’s own emotional reactions can be detrimental if not addressed after the immediate response is over. Such results highlight how easy it is for clinicians’ to put their own needs last as they are busy tending to their clients. Due to this it is crucial that clinicians stay connected to their own emotional processing even when attempting to meet the needs of others in order to reduce the negative costs of shared traumatic exposure and promote healthy self care efforts. This would also enable clinicians to model self awareness and accurately pinpoint their clients’ blind spots as they are more in tune with their own.

Mary stressed that their agency’s team work approach when working with clients was “really making a huge difference because we have to take care of the people that work with folks, as much as the folks we work with. It doesn’t make sense not to do both”. Yet results from this

study found a variance in perceived support from supervisors. Those that did not feel as supported in this study reported more costs accrued within the workplace such as decreased social cohesion and increased stressors associated with caseloads. This variance in met professional needs highlights the importance of supporting clinicians' during times of community based crisis. As Deion indicated,

The sense of comradery we had as a unit during that time and a few months after and the comradery with the community it seemed like we were all just one, it was like we knew what happened and no one else could understand that outside of here.

Being directly impacted and involved in the immediate response can naturally separate such workers from those not involved in the response so it is critical to protect such staff from the evolving demands of the community as well as promote networking within the work environment.

Using a team based approach is one such way to promote healthy interaction among co-workers. Working on teams and/or implementing group supervision are two ways this could be accomplished. Several participants in this study depicted how their agencies began infusing more intra-agency collaboration after the tragedy. When describing the changes made after the shootings, Mary spoke positively about working in groups as they,

Allow us to disperse some of that ownership as well as some of that feel of responsibility and you get multidisciplinary feedback; you have people coming from different areas that have different input and I think that has been helpful, coming in feeling like you are part of a bigger dynamic that is making a difference.

Another clinician addressed how her agency "spread out the response [to crises] among folks. She continued to describe how responding to the Virginia Tech crisis "certainly had me

restructure how our agency did it and pay much more attention to the emotional energy it takes to do this work”. Staff who participate in collective case conceptualizations and consultations may feel more supported and comfortable in their decision-making as they have received feedback from various sources.

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) guidelines highlight the importance of supervision and crisis intervention for counselor educators (CACREP, 2009). It is critical that future counselors are exposed to this information so that, when in the field, they are comfortable asking the tough questions. Having this skill set is a significant component to becoming a competent professional counselor which should be developed and stressed during the supervision process.

Being well versed in crisis management will promote the ethically sound practice of counselor educators. Preparing students via course work and on site field experience will enhance the quality and depth of skills sets needed for crisis intervention. It will also aid future counselors in making appropriate ethical *and* legal decisions. The mental health climate is shaded by a perpetual litigious cloud so it is important that students are aware of and properly prepared to work in this type of environment. Practitioners in this study addressed their heightened awareness of the potential for legality related to their work with clients following the shootings thus reinforcing their desire to work proactively and thoroughly in regards to documentation and consultation.

Counseling can be rewarding and draining work so it is critical that practitioners take the necessary steps to being well balanced in their practice. This is especially true when clinicians have shared exposure to trauma as crises can leave practitioners feeling out of control, which does not dissolve due to client need (Fein & Isaacson, 2009). Establishing social rituals within the

workplace could benefit staff and demonstrate that being connected with others and spending time with colleagues is a healthy outlet in which to recharge one's sense of normalcy.

Practitioners in this study noted a decrease in the time and energy designated to structured social outings with colleagues which reinforced the isolative nature of their work environment. In addition to working collaboratively, it could benefit clinicians to encourage and organize social outings as a means of strengthening the professional cohesion needed when working through crisis. These efforts could provide “opportunities for a range of social support activities, including practical problem solving, emotional understanding and acceptance, sharing of traumatic experiences, normalization of reactions and experiences, and mutual instruction about coping” (Hobfoll et al., 2007, p. 296).

Future Recommendations for research

There are several recommendations that can be deduced from this study and current trauma literature. There needs to be an increase in evidence based research regarding shared traumatic exposure in different workplace settings. It is an unfortunate certainty that interpersonal and community based trauma is increasing (Broman-Fulks et al., 2006). As such it is imperative that the ripple effects that impact mental health providers and the community at large be studied on a greater scale in order to reduce the negative impact of such crises. Clinicians and other first responders can set the stage for healing so it would benefit researchers in the mental health field to highlight how such responders can professionally and personally thrive in such circumstances.

Another area of research that could be extended is mass trauma intervention. According to Hobfoll et al. (2007), there is little empirical evidence on how to transfer establishing social support networks and other psychosocial interventions constructs to applicable steps. This author also found that participants and to a degree the agencies they are employed with in this study had never

dealt with a community based trauma of this magnitude. Due to this they accrued challenging deficits, such as turnover and burnout, due to lack of information regarding crisis management and community recovery efficiency. Clinicians, supervisors and counselor educators could all benefit from more knowledge pertaining to effective psychosocial and work environment recovery interventions in the wake of tragedy.

According to Fein and Isaacson (2009), the crisis management literature assumes that “leader rationality is a given” yet in the midst of mass trauma, this researcher found that leadership is at times discernable due to the multitude of agencies and systems that respond to mass traumas (p.1328). Those that are the front line of defense so to speak can be pushed to work harder with less time and resources to meet the needs of the community. Such expectations can create emotional, physiological, mental and work related tolls. This impact on the first responder should be further studied as such reactions can have a multitude of implications for not only the mental health providers but the community members they serve.

It is an unfortunate reality that communities are continuously inflicted with tragedies (Satcher, Friel, & Bell, 2007). In response, clinicians are directly involved in the front line recovery work after crises occur. Shared traumatic exposure is a potential derivative of participating in first responder work. As this study indicates, there are a multitude of benefits and challenges derived from shared traumatic exposure. In the midst of community based crises, clinicians and supervisors run the risk of being simultaneously exposed therefore it is critical that they are aware of and equipped with the skill sets necessary to counter the costs accrued from first responder work. This development could be enhanced within the work place and within the school settings. Administrators need to promote collaboration and individual’s self care in order to deflect

against the natural consequences of such work and produce well rounded clinicians ready to battle the challenges of shared traumatic exposure.

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ARTICLE TWO

Personal and Professional Experiences of Clinicians who Experience Shared Traumatic Exposure:

A Humanistic Perspective

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Abstract

The purpose of this article is to review clinical benefits of trauma work from a humanistic perspective. Results of this author's study regarding the shootings on the Virginia Tech campus highlighted the personal and professional benefits gained. A new concept, Shared Traumatic Exposure, is included to expand upon advantages of trauma work. Professional implications for clinicians and supervisors included.

Personal and Professional Experiences of Clinicians who Experience Shared Traumatic Exposure: A Humanistic perspective

The range of human suffering is ever expanding (Broman-Fulks, Ruggiero, Green, Kilpatrick, Danielson, Resnick, et al. 2006). When traumatic events occur mental health providers are available to assist survivors in addressing the challenges of trauma. Yet survivors are not the only ones affected by such events. Mental health providers are not immune to the range of responses when immersed in the trauma response and recovery process (Sommer & Cox, 2005). The occurrence of “traumatic incidents may create powerful affective responses in those who rescue, care for, and counsel the individuals directly affected” (Wilson & Lindy, 1994, p. 333). Clinicians can be affected positively and negatively, by their traumatic experiences. Such experiences may bring out or enhance the use of humanistic characteristics such as developing genuine therapeutic relationships, unconditional positive regard and empathy, among clinicians who were affected. These same characteristics can also influence the self-care counselors require following traumatic events.

There is a range of both positive and negative reactions to trauma work. One of the costs accrued is compassion or empathy fatigue which is the result of “emotional, mental, physical, and occupational exhaustion that occurs as the counselors’ own wounds are continually revisited by their clients’ life stories” (Stebnicki, 2007). Compassion fatigue, otherwise known as *secondary traumatic stress* (STS), is frequently referred to as another “cost of caring” and is a general term applied to those that suffer as a result of helping others (Figley, 1995; 2002, p. 1441; Rothchild, 2000). Specifically, compassion fatigue is defined as a condition of tension and preoccupation with traumatized clients by re-experiencing the traumatic events, avoidance/numbing of reminders, and persistent arousal (e.g. anxiety) associated with the client.

There are also beneficial responses which counter such fatigue from secondary exposure. Compassion satisfaction and post traumatic growth have been well established in the literature, and are described as the positive outcomes of trauma work. Compassion satisfaction refers to the feelings of accomplishment when clinicians believe they are helping others (Stamm, 2002). Post traumatic growth is the process of deriving positive meaning and associated outcomes from a traumatic experience (Tedeschi et al., 1998).

This author conducted a qualitative study assessing clinicians' experiences after responding to the April 16th shootings that occurred on the campus of Virginia Tech. In addition to the potential positive outcomes noted above, Day (2010) found that clinicians experienced Shared Traumatic Exposure, a comprehensive reaction to trauma in which the experience infiltrates the provider's professional *and* personal life as he or she is simultaneously impacted by the same trauma as their clients. These clinicians had a heightened level of clinical and/or supervisory benefits accrued from their clinical efforts. The catalyst for such professional and personal gains was self-awareness. It is notable how many of the multitude of implications from this research highlight the strength or characteristics identified in the humanistic approaches, for both clinicians and supervisors. The purpose of this article was to reference some of the current literature regarding the positive results of trauma work. In addition, this author's recent findings of Shared Traumatic Exposure are explored as a means of addressing the uniqueness of providing clinical services in the midst of a community based tragedy. Implications for counselors and supervisors regarding the potential clinical benefits gained from trauma work are provided, and the specific contribution of a humanistic stance during and following trauma work is highlighted.

Compassion Satisfaction

Compassion satisfaction refers to the sense of fulfillment or enjoyment that mental health professionals obtain from doing their work well (Stamm, Lambert, Piland, & Speck, 2007). This satisfaction can be enhanced through the professionals' interactions with their colleagues and plays a key role in reducing the negative aspects of such work (Conrad & Kellar-Guenther, 2006). Clinicians who focus on the positive outcomes of their work are more likely to successfully address the challenges of working with traumatized individuals (Larsen & Stamm, 2008). Those that derive satisfaction from their work have a higher likelihood of maintaining hope and positivity when hearing graphic stories, which is a key component to promoting healing in clients (McCann & Pearlman, 1990).

Post Traumatic Growth

Even though there are inherent costs associated with trauma work it seems that therapeutic engagement with clients can supersede such consequences (Collins & Long, 2003; Larsen & Stamm, 2008). According to Larsen and Stamm, "compassion satisfaction is the result of positive feelings that arise from helping others, especially those exposed to traumatic stressors. Posttraumatic growth (PTG), on the other hand, occurs as a result of indirect or direct trauma exposure while working with trauma survivors" (p. 283-284). PTG is considered "both a process and an outcome" and can occur within the therapeutic exchange (Tedeschi, Park, & Calhoun, 1998; Saakvitne et al., 1998). This process is based on the relationship between the understanding of a traumatic event and establishment of a meaning (Saakvitne et al., 1998). PTG highlights the journey one has from deriving positive meaning gained from a traumatic experience (Tedeschi et al., 1998). The specification of indirect *or* direct could indicate that PTG may be more suited to

counter the deleterious consequences of Shared Traumatic Exposure due to its comprehensive effect drawn from trauma work.

In their description of the PTG model, Tedeschi and Calhoun (2004) stressed the importance of the initial crisis as the catalyst for discovering positive changes from difficult life events such as community based traumas. This is a dynamic process as PTG can occur even while those exposed to trauma are grappling with the natural distress responses triggered by conflict. This is particularly the case for traumatic events that threaten the person's physical safety. Depending upon the level of intensity, severity, and frequency of the suffering (either direct or vicarious), the distressed responses can persist for a prolonged period of time. In essence, it is one's struggle with trauma that is critical for PTG.

This process can be very helpful for clinicians as they gain a sense of confidence in their ability to manage stressful situations. In Day (2010), several clinicians spoke about their self awareness that they were able to stay calm during the midst of their service, following a crisis on campus. According to one clinician, the biggest gift she tries to give staff is "that you can be calm in the middle of any chaos...we can be calm in the storm" (L, 9). This attentiveness is an important component for mental health professionals' PTG. Another clinician noted that assisting during the recovery efforts "helps you manage and quickly organize and compartmentalize and focus" (M, 6). By acknowledging their ability to manage crises, such professionals could embrace the strength they used to assist survivors and themselves in the aftermath of such a traumatic event. In addition, providing help to others after traumatic events can produce additional healing as it empowers clinicians to recognize how they have grown when working with those that are still struggling (Tedeschi et al., 1998).

Based on this author's research, she argues that mental health professionals who have experienced Shared Traumatic Exposure have a heightened aptitude for developing PTG and experiencing other positive professional benefits, which bolsters their professional wellness. As this form of exposure is holistic in scope, the clinicians' professional and personal lenses are impacted as these providers are not only providing services to clients but living within the community that was influenced by the trauma. Although the intensity and level of direct exposure can vary, the reactions among the clinicians interviewed in the study were similar. As Sam astutely assessed,

...I think that is what made that whole experience different, counseling people who were traumatized by that event, made it different than some other trauma they might have experienced because we shared the same experience so it's kind of like we started on the same page, you know we didn't have to explain it, it's like you just knew.

Experiences of Clinicians who have encountered Shared Traumatic Exposure

There are numerous potential outcomes from working with traumatized clients when clinicians themselves are also exposed to the same trauma at the same time. The variety of issues that such mental health professionals encounter is multidimensional and can influence one's professional worldview. Although the negative toll has been well established, it is critical to consider the broad ramifications and scope of how trauma may also promote a healthy work outlook and environment. This author found that enhanced self-awareness served as a channel for participants' enhancement and practice of humanistic counseling approaches in their work and personal wellness. This enhancement served to enrich their professional interpersonal exchanges with clients and co-workers and derived compassion satisfaction.

Self awareness.

Humanistic professional and personal variables can be enriched as a result of trauma work. According to Day (2010), the primary medium found for personal and professional enrichment is self-awareness. “Nurturing wellness and preventing impairment require that counselors take an honest appraisal of their health, balance, and self care” (Venhart, Vassos, & Pitcher-Heft, 2007, p. 50). Self awareness was a major attribute that shifted for the majority of the clinicians in this study. Most noted that their self awareness regarding their interpersonal experience with their clients and awareness of trauma in general was enhanced. As one clinician in this study reported, he developed a “new awareness [that] anything can be traumatizing to somebody”. Another clinician noted,

I think it makes me aware of my own personal reactions, my own ways of coping, so obviously I am a big believer of self awareness for myself that translates to the work I can do with clients, that I can be aware of what that experience was like for me so that can help me connect or understand what a client might be going through as well as talking with a client about what they are going through and what their experience has been.

“When counselors are self-aware, they are better able to identify their feelings and needs, regulate their reactions and consider where a client’s issues end and theirs begin. Reflecting on the work and being aware of one’s reactions to it also assists counselors in maintaining wellness and identifying the early warning signs of personal distress” (Venhart, Vassos, & Pitcher-Heft, 2007, p. 54). Mary, who was directly involved in the recovery efforts claimed that,

...you can’t *not* be affected, you just can’t not be affected by [the trauma] and hopefully you are affected in a way that you’re empathetic, you’re sympathetic, and then professionally you become more aware you become more aware of who you are and how to, how to prepare yourself. If you are not emotionally prepared to support others emotionally while

they are in trauma you are ineffective because one, you either transfer or, when you are done, you project it everywhere else so I think that's the biggest part for providers in general, is while you are in that moment you recognize that there's going to be parts of that will stay with you and there's going to be stories that stay with you and are going to move you....

Self-awareness can positively influence the development of essential humanistic principles; genuine relationships, unconditional positive regard, and empathy. This progression has the potential to be heightened for those that have experienced STE as clinicians have a holistic perspective about their client's struggles and strengths. Self awareness coupled with shared traumatic exposure has the potential for rewarding clinical and personal benefits. Mental health professionals are attuned not only to their clients but themselves, widening their therapeutic lens. This insight lends nicely to the therapeutic relationship, enrichment of empathy and unconditional positive regard. As these aspects are critical to humanist counseling, a review of how self awareness enhances each concept will follow.

Genuineness in relationships.

The therapeutic relationship has been found to be a key contributor to client success. Day (2010) found that clinicians who have experienced STE are more attuned to themselves when working with clients and have the potential to provide more effective treatment. When coupled with an enhanced self awareness, the therapeutic relationship represents a genuine exchange of thoughts, feelings, and experiences. According to Bill, "I think that I'm more interpersonal in general with the things that I do...". Another clinician reported that, "I also think that I am more aware of the value of the therapeutic relationship with trauma especially when you think about trauma in terms of that loss piece...".

There are also clinical benefits gained from shared traumatic exposure that positively influence rapport building. According to several clinicians in this study, their ability to develop rapport with certain clients was enhanced after having experiencing the tragedy on campus. Deion noted that,

I do think there was that idea of knowing that my clients knowing that I was here, that I was a part of the community, that I was here before that, that I experienced that, that helped them feel more connected more trusting maybe of that experience, able to buy in a little better help with the rapport a little bit.

In addition to establishing a strong sense of joining and empathizing with their clients, providers who have experienced shared traumatic exposure have the predisposition to develop a strong therapeutic relationship due to the commonality of experience they share. One clinician noted that,

I think whether it [the shared experience] was even at times where it wouldn't be openly stated or acknowledged I think it was something in the room I mean for the students who were here during the shootings whether that really was part of the presenting issue or if it was really clearly was not a big piece it was still a factor, still a piece of their history, our history being part of this community.

Another clinician noted that “I cried more with my clients, I think I hugged more clients and I generally I was not opposed to doing that anyway but I think I did it more freely kind of right after the shootings”. Being authentic to one’s own experience sets the stage for normalizing other’s struggles. Awareness of a shared past of pain and loss could initiate the healing process for clients as they can truly feel heard and supported. Day (2010) found that genuine encounters can extend beyond the therapeutic relationship. According to Sam,

I think we as a staff...were really nice to each other and it's like the community pulled together and it meant something when somebody asked so how are you doing? And you really meant that and if they said 'getting by' that meant something, even the regular 'oh ok' meant something.

Mental health professionals who are immersed in community based tragedies have the opportunity to re-evaluate their clinical approach and utilize their unique perspective when working with traumatized clients. According to Bill, his clinical view had a "different emphasis" on the therapeutic relationship in which he had "more patience and more interpersonal related types of interventions...working on the relationship more". Another clinician was reminded to view each client as an individual to avoid clustering symptoms and seeing clients through their presenting problems. Mary observed that,

If you consistently are dealing for long periods of time with folks with different experiences you hear so much stuff, you have to make sure that each person is individualized and you are not just hearing it because you have heard it so much. Yes these bad things have happened...you have to continually make sure that you know that you are not becoming desensitized.

The integrity of relationships seems strengthened after tragedy as the emotional toll of such experiences sparks communal support and empathetic concern.

Unconditional positive regard.

Clinicians who experienced STE also have an enriched view of the trauma and thus are better equipped to see client's strengths and potential for resiliency (Day, 2010). According to Linda,

...it was almost in the air it is really hard to describe but having experienced [this tragedy] I think it gave me some truer sense of what that really feels like because you were so totally immersed in such emotions over there.... so I think in that way I have a greater understanding of what that really, of how overwhelming that can be and yet while in the midst of that, how people can still rise above that and go forward.

When exposed to tragedy, clinicians are given opportunities to see their client's in different contexts. Two clinicians in this study noted their gratitude for their clients that gave up their regularly scheduled appointments for those in crisis who might need to be seen. One clinician highlighted that this selflessness gave him the opportunity to see his client in a different light which was helpful to the therapeutic process. He reported that,

Clients would even call in, and just say 'hey I just wanted to see if you are alright just wanted to let you know I have that appointment next week but I am doing relatively ok and I know you guys are really busy, I just want you to know if someone else needs that time please let someone else take that time'. The amount of empathy that my clients were demonstrating not just to myself but also to their other peers in the community...I was able to use that highlighting 'that [concern] meant a lot to me' and you get kind of interpersonal when you share that and so you know so you get to use all of that in some sense.

Exposure to trauma also provides the chance for clients to demonstrate their strengths (Day, 2010). Another clinician commented that the overall community response was enlightening to see and attuned them to others' desire to survive which extended to their clients. Mary noted it was "cathartic" to process how those impacted wanted to thrive. She stated "I think it went across the masses of survival, that survival thing, the coping, the insight, the understanding that transcended all of that [trauma]". It seemed that in a broader sense these participants were more equipped to see

not only their clients' strengths, but the strengths of their colleagues and those within their community as well.

Empathy.

Clinicians who have experienced STE not only have knowledge about their experience with the trauma but hear the perspectives of others and thus have a more developed bag of tools at their disposal to assist their clients in healing (Day, 2010). As one clinician astutely surmised,

...so I think again one of the positives of [the tragedy] is it gave me that experience which I certainly had not had. In anything like that it adds to your clinical skills, and empathy or knowledge. So I think in that way it probably made me a better clinician.

One of the most essential tools for clinicians is empathy. Empathy is a significant resource for therapists who assist the traumatized (Figley, 1995; Radey & Figley, 2007). Empathetic ability is defined as the aptitude of the mental health professional for recognizing another's pain. Engaging empathically with clients motivates altruistic behavior of providers who strive to alleviate the suffering of others (Radey & Figley, 2007). According to Rogers (1975), "a high degree of empathy in a relationship is possibly the most potent and certainly one of the most potent factors in bringing about change and learning" (p.2). This ability is a double edged sword in the sense that without it there would be minimal compassion stress and fatigue yet it enhances one's ability to provide effective services and makes one more susceptible to the emotional toll of such work (Figley, 2002).

Being exposed to tragedy presents the chance to re-arrange personal and professional priorities. Clinicians who have been directly or indirectly impacted by trauma have a heightened awareness of the support that traumatized individuals need therefore they may rely heavily on humanistic client-centered counseling principles. As previously mentioned, several clinicians in

this study found that they reverted to a more interpersonal approach with their clients as a means of connecting and supporting them. Being in the moment and sensitive to the “changing felt meanings” of clients’ perceptions enables clinicians to accurately perceive and assess what their clients’ are experiencing (Rogers, 1975, p. 3). In times of crisis where circumstances can be uncertain, attentively listening to clients can be very helpful (1975). In addition to listening to clients, practitioners also need to listen to and recognize *their* struggles and feelings. “The better integrated the therapist is within himself, the higher the degree of empathy he exhibits” (Rogers, 1975, p. 5). In order to do this, clinicians need to be connected to their intra and interpersonal relationships. Participating in self care and utilizing social supports are two avenues in which clinicians can care for themselves as a means of providing better care for others.

Contributors to Counselors’ Wellness

Self care.

Self-care was one factor that several clinicians addressed as a prominent attribute warranting more of their attention after being exposed to the campus trauma at Virginia Tech, and serving clients who had been exposed as well. This concept is a positive coping skill that has the potential to increase professionals’ positive affect and application of physical, mental, and social resources as well as reduce the deleterious consequences of trauma work (Radey & Figley, 2007). This resource “provides the foundation” for good clinical work (Venhart, Vassos, & Pitcher-Heft, 2007, p. 50). Being able to care for oneself via exercising, eating well, scheduling time off, and utilizing emotional and instrumental support systems are essential components of promoting individual self-care (Radey & Figley, 2007; Salston & Figley, 2003). By following through with such efforts, mental health professionals can better manage their work load stressors and enhance their satisfaction at work. As Deion noted,

I am well aware that you can be helpful in the moment and have long term benefits but at the same time I think most of us, and certainly myself included, are far from a finished product. I am still very aware of some of those reactions some of those feelings that can come up in ways that wouldn't have before April 16th. I am trying to do more self care, trying to stay more connected with colleagues, friends, family, getting more time away, being able to sort of recharge I think has been very important.

Ultimately, “when counselors take better care of themselves, there is a positive effect on their ability to meet the needs of their clients” (Lawson, 2007, p. 20). In times of crisis, self care can be placed on the back burner so it is crucial that practitioners remember to sustain wellness efforts throughout their practice so, if and when in times of crisis or dealing with those in crisis, they have healthy coping skills to revert to when stressed.

Social support.

The relationships between clinicians and their work environment can also influence professional and personal wellness therefore it is important to consider the contextual variables which could impact this relationship. According to Myers and Sweeney, “a complete understanding of the individual cannot be made without incorporating a concern for environmental factors, which always can operate for better or for worse in relation to individual wellness” (2005, p. 275). Social support is one of the primary sources of resiliency in the work place. Social support is considered a crucial piece of health and well-being and has been linked to faster and more successful posttraumatic recovery as individuals are given the space to process and verbalize the internal turmoil and stress typically associated with exposure to trauma (Hobfoll, Freedy, Lane, & Gellar, 1990). “The ability to talk with other counselors about the work is essential in reducing

feelings of isolation, broadening one's perspective on possible options for intervention, and providing a safety net when one faces difficult and ethically complex situations" (Venart et al., 2007, p. 60).

Work place collaboration is especially critical during times of crisis response. Clinicians in this study highlighted their ability to put differences aside so they could align and meet the needs of their clients. This alliance should be extended to the systemic workings of the environment. Several practitioners in this study addressed how their agency created a team approach to managing client needs after the crisis which seemed mutually beneficial for staff and clients. One clinician spoke highly of the team approach embraced by their agency stating,

...all of these teams that allow us to disperse some of that ownership as well as some of that feel of responsibility and you have people coming from different areas with different input and I think that has been helpful, coming in feeling like you are part of a bigger dynamic that is making a difference.

This confidence in decision making could enhance the clinician's sense of accomplishment and their desire to collaborate and share with others. An extension of one's social network is an essential component to bolstering one's professional resiliency as the provider can be assured that colleagues are aware of his or her case load and can offer additional informed support and knowledge when needed. Bill reported,

I think I am more apt to rely on my colleagues here. It used to be that I would do my own thing in my personal life...this situation and just all of the pressure and stress and everything made that much more difficult and so I think what happened is the people on whom I rely got broader...to include some of the people that are here.

In essence, “Developing interpersonal wellness includes seeking support for one’s professional work and nurturing relationships that promote life balance” (Venart et al., 2007, p. 58)

Clinical implications for Counselors

When lacking clinical self awareness, one is predisposed to experience more of the negative consequences of trauma work (Stebnicki, 2007; Venhart et al., 2007). “The experience of empathy fatigue hinders counselors’ opportunities for personal growth, professional development, and overall mental, physical, and spiritual well-being” (Stebnicki, 2007, p. 319). As such it is critical that counselors’ be mindful of the potential negative personal ramifications that such professional work can have, and practice coping strategies they have previously found useful. As previously mentioned there are a multitude of methods in which counselors can promote their professional wellness. Self-care and the utilization of social supports fueled by self-awareness are several ways practitioners’ in this study found helpful in recovering and growing from the tragedy that occurred at Virginia Tech on April 16th, 2007. There are several clinical implications that can be deduced from these results. Self-care cannot be initiated without a certain level of self awareness. Tending to one’s wellness requires that “counselors take an honest appraisal of their health, balance and self-care” (Venhart et al., 2007, p. 50).

Primarily, mental health providers need to tend to their own needs as well as their clients. This could serve not only as a modeling tool for counselors but could also promote their longevity in the field and professional vitality. Self-care is the foundation for work with clients and should be a continual piece of professional and personal development *especially* utilized during times of crisis (Venhart et al., 2007). This author found the opposite, as several clinicians in this study were so focused on tending to their clients’ needs that they neglected their own. Only later once the crisis response had subsided did they consider the toll this crisis work had taken.

In addition to being attuned to others, most participants also became more aware of their presence and personal experience with their clients. “Facilitating empathetic approaches in the counseling relationship requires that we unfold the layers of their stress, grief, and loss, or traumatic experiences” by allowing them to shared their stories (Stebnicki, 2007, p. 329). The essence of this sharing is finding the meaning behind the experience which may add to the counselor’s emotional fatigue and acute awareness of the therapeutic relationship as such exchanges can be emotionally charged and at times draining (Stebnicki, 2007). In the current study, three clinicians’ spoke about their heightened focus on their interpersonal exchanges with clients and conscious intention to view them as individuals to avoid pathologizing and generalizing their responses. By being more aware of these exchanges, these clinicians were more in tune with their emotional reactivity which enabled them to better manage their response to such emotions and reduce their likelihood of accruing the costs of such work.

Utilizing ones’ social supports was another implication found in this study. The majority of clinicians in this study addressed their reliance on co-workers whom a couple referred to as “their band of brothers”. This reference highlighted the unique experience that these clinicians shared with one another which gave them the distinctive perspective to provide that much needed and in a sense specified support during the time immediately following the shootings. Yet this support should not only be applied during times of crisis. Clinicians should strive to support one another continually and request a team based approach in their work setting.

This request could weave the support network so heavily relied upon during times of crisis.

Providing the space to hear one another’s clinical trials and tribulations can enhance the opportunity to gain a balanced perspective as well as derived meaning from hardship. It could also reduce the possibility of isolation in the workplace as clinicians have preemptively established

stronger relationships with one another which could be harder to neglect after crisis occurs. As such it is critical that clinicians strive to establish strong lines of communication with their co-workers and supervisors initially so that if and when a crisis occurs a unified response system is already established.

Supervisory implications

Self awareness, self care, and group collaboration are three components that can and should be developed in the supervisory relationship. It is crucial that clinicians who have experienced shared traumatic exposure are also able to share their stories as a means of relinquishing some of the pain derived from trauma work. Supervisors should strive to empathize and join with their supervisees as a means of prompting such discussions. Without encouragement, supervisees may not think to speak of their own experience as, as this author found, may be too consumed with meeting their clients' needs. These discussions could enrich supervisees' perspectives as potential blindspots could be addressed and accurate support can be given.

The potential for parallel processing, the unconscious reenactment of the counseling relationship within supervision, could be greater during exchanges in which the supervisor also focuses on his or her own interpersonal exchanges with supervisees, enriching the clinical benefits gained when processed in the moment (DeLucia, Bowman & Bowman, 1989; Morrissey & Tribe, 2001). It is crucial that supervisor's be privy to how their relationship could replicate their supervisee's relationship with his or her client. This is especially important when the clinician has experienced shared traumatic exposure as this replication could be harder to see due to the avoidance coping skill that is so often evident in those that have been exposed to trauma. In order to ensure that this discussion is fruitful, supervisors should be mindful of their own personal processing of the supervisory relationship in order to model appropriate self awareness and self-

care which in turn could enhance the authenticity of the supervisory bond (Wells, Trad, & Alves, 2003). This bond is the glue that could serve to mold the clinicians' wellness. In essence supervisors willing to explore and understand their own reactions can "help a therapist-trainee process his/her reactions in a productive and empowering way" (Wells et al., 2003, p. 25).

Based on the results of this author's study, self-awareness is a critical element to effectively managing professional and personal wellness. Developing genuine relationships, unconditional positive regard and empathy are three humanistic elements found fundamental to meaningful trauma work, regardless of clinical background. On a personal level, self-care and social support could arguably apply to and bolster the work of all mental health clinicians and supervisors as they are centered on individual wellness and clinical prosperity. Clinicians who focus on themselves as well as their clients during times of crisis are more likely to derive the benefits of such work as well as enhance their professional vitality. Self care also extends to the supervisory relationship. Supervisors who are more mindful of how their supervisees' exposure to trauma influences their exchanges with others are more likely to provide comprehensive, humanistic guiding.

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ARTICLE THREE

Consequences of Working with Traumatized Clients During and Following Crisis:

Implications for Practice

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Abstract

There is a range of consequences for mental health providers working with traumatized clients. These positive and negative consequences could be heightened when such providers are simultaneously exposed to the same trauma as their clients. This article reviews two widely researched concepts in the trauma literature; vicarious traumatization (VT) and post traumatic growth (PTG). Shared traumatic exposure (STE), a new concept addressing mental health providers' simultaneous experience with the same trauma as their clients, was explored.

Consequences of Working with Traumatized Clients During and Following Crisis: Implications for Practice

“Counselors in virtually all settings work with clients who are survivors of trauma” (Trippany, White Kress, & Wilcoxon, 2004, p.31). Because many of these traumatic experiences are large scale and effect whole communities (e.g. natural disasters, school/work shootings), more and more clinicians are being exposed to the same trauma as their clients at the same time. There are various reactions to trauma work that counselors can experience. Vicarious traumatization and post traumatic growth are two of the most researched concepts in the trauma literature that address the range of reactions to trauma work. An extension of these terms which conceptualizes how mental health providers who are simultaneously impacted by the same event as their clients is called shared traumatic exposure. The purpose of this article is to review the current literature regarding some of the positive and negative consequences of working with traumatized clientele. Personal reflections of clinicians impacted by various natural and human made traumas will highlight the influence such experiences can have on one professionally and personally. In addition, this author will address how these post-traumatic reactions could be amplified to shared traumatic exposure during situations in which clinicians are simultaneously impacted by the same trauma as their clients. Implications for practice will be reviewed as a means of stressing the need for current and future clinicians to be prepared for the potential impact of trauma.

Professional and Personal Consequences of Trauma Work

Vicarious Traumatization

Vicarious traumatization (VT) is a process of change due to empathic engagement with clients who have survived trauma (Pearlman, 1999). This process is considered unavoidable and is the long term, cumulative effect of trauma work on a mental health provider. VT emphasizes the

transformation of the clinician in reaction to hearing client's traumatic experiences (Cunningham, 2003; Thomas & Wilson, 2004). According to Pearlman and Saakvitne (1995a), long-term empathic interaction with traumatized clients can alter the therapist's ways of experiencing the self, others, and the world. "Vicarious traumatization, then, implies that basic self-capacities in terms of affect regulation, the structure of the self, and the nature of interpersonal connectedness can be transformed" (Thomas & Wilson, 2004, p. 84). These distorted perceptions can detrimentally impact mental health providers' professional and personal lives as they become witness to the explicit details of their clients' traumatic realities (Cunningham, 2003; Trippany et al., 2004).

There are multiple aspects to the development of VT. While a clinician's vulnerabilities and personal conditions do contribute to VT, it is reasonable to assume that no one is immune to the effects of working with traumatized clients. Neither mental health professional nor client can engage in an enriching, trauma-focused therapeutic relationship without being deeply transformed (Pearlman & Saakvitne, 1995a). As such it is important to highlight that this theory does not blame clients for traumatizing their counselors but instead addresses a predictable occupational side-effect which can be alleviated (Pearlman & Saakvitne, 1995b; Rosenbloom et al., 1999).

The term vicarious traumatization was created and originally grew from constructivist self development theory (CSDT; McCann & Pearlman, 1990). In their research, McCann and Pearlman (1990) utilized this theory to illustrate the "complex relation among traumatic life events, cognitive schemas about self and world, and psychological adaptation" (p. 136-137). CSDT is a personality theory that addresses the influence of a traumatic environment on the development of self (Saakvitne, Tennen, & Affleck, 1998). In essence, CSDT recognizes the clinician's adaptation to trauma as an interaction between personality, personal history and exposure to the traumatic event

within the social, cultural, and organizational contexts of the therapeutic setting (Saakvitne et al., 1998).

This theory hypothesizes that human beings create their own realities that develop into ever-changing and complex mental patterns (Hesse, 2002). As such there are specified schemas of the professional's life that can be affected by this line of work and include; frame of reference, self capacities, ego resources, psychological needs and memory system (Rosenbloom et al., 1999). The major hypothesis of CSDT is that "trauma can disrupt these schemas and that the unique way that trauma is experienced depends in part upon which schemas are central or salient for the individual" (McCann & Pearlman, 1990, p. 137).

Frame of reference.

Mental health professionals may experience an alteration in their frame of reference as a result of their work with traumatized clients (Rosenbloom et al., 1999). This is the most fundamental disruption those working with survivors of trauma will experience as it includes the clinician's world view, sense of identity, and spirituality (Pearlman & Saakvitne, 1995b). World view includes one's "beliefs about the world, including life philosophy, moral principles, causality" and control (Pearlman & Saakvitne, 1995, p.61). These beliefs shape one's interpretation of interpersonal and life happenings. If this worldview is skewed negatively, this frame of reference can be painfully shifted and professionals who are experiencing VT may begin to question the malice of humankind and find they lose hope and connection with others. Both identity and world view disruptions are evidenced in the realm of spiritual impoverishment as it reflects a "loss of a sense of meaning for one's life, a loss of hope and idealism, a loss of connection with others, and a devaluing of awareness of one's experience" (Pearlman & Saakvitne, 1995b, p.161).

Self capacities.

Self capacities are “inner capabilities that allow the individual to maintain a consistent, coherent sense of identity, connection, and positive self-esteem” (Pearlman & Saakvitne, 1995a, p.64). Such capacities allow the clinician to regulate strong emotions, sustain a sense of interpersonal connections and maintain a positive self-perception. Indicators that these competencies may be impacted by VT include interpersonal difficulties, overindulging, overextending, or compulsively consuming to manage or avoid the heightened levels of self-criticism. Mental health professionals may also be hypersensitive to traumatic stories they hear directly from clients and also indirectly through venues such as the media (Pearlman & Saakvitne, 1995b). Such difficulties could extend the breadth of traumatic impact (Trippany et al., 2004), especially in contexts in which on-going media coverage and attention prolong the exposure for such helpers.

Ego resources.

The third component of CSDT, ego resources, allows clinicians to meet personal mental health needs so that they can develop and maintain interpersonal relationships (Saakvitne et al., 1998). There are two sets of ego resources that are helpful in the therapeutic process. The first set includes intelligence, willpower, initiative, self awareness of needs, and drive for personal growth. The second set is essential for self preservation and include the ability to consider consequences, establish mature relationships with others, establish boundaries, and make self-protective decisions. Perfectionism and the drive to overextend oneself at work are two key disruptions that could hinder one’s ego resources (Pearlman & Saakvitne, 1995a).

Contributors to vicarious traumatization.

As each person's story is unique, so too is the variance in how clinicians are impacted by vicarious traumatization. The degree to which each professional's psychological need areas are affected depends upon individual contributors such as his or her psychological composition, empathic connections with clients, personal trauma history, perceived coping style and current personal circumstances (Baird & Kracen, 2006; Rosenbloom et al., 1998). One of the most valuable tools of counselors is the ability to empathically connect with their clients' experiences. Yet this tool can also make professionals more susceptible to developing VT.

The mental health professional's own trauma history is another potential contributor to VT. Personal experience with trauma could influence how the clinician reacts to his or her client's trauma stories. If the professional has experienced a similar trauma he or she may have a deeper understanding and sensitivity to what his or her client is experiencing, enhancing their level of empathic connection. Conversely, the clinician may also be more likely to experience flashbacks and other reoccurring images from their own lives (Rosenbloom et al., 1998). If the mental health professional does not deal with these memories he or she may rely on maladaptive coping skills which could reinforce avoidance of difficult emotions. This impairment of coping resources coupled with a heightened lack of self awareness may make the counselor more vulnerable to being affected by the client's emotions (Sabin-Farrell & Turpin, 2003).

A clinician's current psychological state and interpersonal situation will influence his or her susceptibility to VT. Life stressors such as personal illness, pregnancy and divorce can decrease a therapist's defense against developing VT (Norcross & Prochaska, 1986). Mental health professionals grappling with their own struggles can become overwhelmed when processing their clients' traumas (Pearlman & Saakvitne, 1995). This is especially the case for clinicians who are

impacted by the same event as their clients, such as during natural disasters or massive trauma events. Those clinicians are especially prone to developing VT as they live within the context of the tragedy (Eidelson, D'Alessio, & Eidelson, 2003; Gill, 2007; Kamps, 2008).

Organizational, professional, and social aspects of one's work environment have also been found to contribute to VT (McCann & Pearlman, 1990). Contributors such as supervisors, earnings, policies and procedures have been found to contribute to a counselor's level of professional stress (Norcross & Prochaska, 1986). The clinical setting has also been indicated to contribute to VT (Moulden & Firestone, 2007). Those that work in larger settings are more likely to feel on their own with less control over their caseload (McCann & Pearlman, 1990). In addition, clinicians with more traumatized clientele or those that have been exposed to man-made traumas are more likely to develop symptoms of VT than those with a higher ratio of non-traumatized (Cunningham, 2003; Stamm, 1995).

“In CDST, growth and pain are not mutually exclusive but rather inextricably linked in recovery from trauma and loss” (Saakvitne et al., p. 1998, p. 295). While the likelihood of experiencing the consequences of VT is greater when working with survivors of trauma, it is important to recognize that reactions to stress are not always deleterious (Larsen & Stamm, 2008). In fact, such work can serve as a catalyst for self re-organization and positive change. In order to comprehend the broader picture of professional wellness, it is imperative to consider the rewards such clinical work has to offer. Post-traumatic growth is one concept in the trauma literature that reflects the gains that clinicians working with trauma survivors attain.

Post Traumatic Growth

Posttraumatic growth (PTG) is considered “both a process and an outcome” and can occur within the therapeutic exchange (Tedeschi, Park, & Calhoun, 1998; Saakvitne et al., 1998). This

process is based on the relationship between one's comprehension of the traumatic event and its meaning (Saakvitne et al., 1998). Essentially, PTG is the development of positive meaning gained from a traumatic experience (Tedeschi et al., 1998). In this sense, growth represents changes in beliefs about oneself, others, and worldview, countering the adverse reactions initially experienced when faced with tragedy (Karanci & Acarturk, 2003). Major life crises can produce distressing cognitive, emotional, and physiological reactions. According to the model, these crises serve as the catalyst for positive change.

PTG can occur at the same time one is grappling with the distress, highlighting how this is a dynamic process of recovery. In essence, it is one's struggle with trauma that is critical for PTG (Tedeschi & Calhoun, 2004). "Posttraumatic growth describes the experience of individuals whose development, at least in some areas, has surpassed what was present before the struggle with crises occurred" (Tedeschi & Calhoun, 2004). Within the literature, this growth manifests in three main areas which parallel the core components of one's frame of reference in the CDST literature; changes in self-perception (identity), changes in interpersonal relationships (worldview), and an altered philosophy of life (worldview and spirituality) (Saakvitne et al., 1998; Tedeschi et al., 1998). "Interestingly, the anecdotal evidence of therapists' perceived growth following vicarious brushes with trauma would seem to reflect gains in these same three categories" (Arnold, Calhoun, & Tedeschi, 2005, p. 243). According to Arnold et al. (2005), the positive consequences of trauma work involve the same conceptualizations about self and the world that have been identified within the vicarious traumatization literature. Therefore it is important to consider that different types of growth outcomes would be beneficial as a means of identifying the fluidity between these two frameworks.

Self-perception.

A critical element to PTG is the progression in perception of self from being a “victim” of trauma to a “survivor” of trauma. This cognitive shift could serve to lessen the self-stigma that survivors may feel and “subtly introduces people affected by trauma to the idea that they have a special status and strength” (Tedeschi et al., 1998, p. 10). Posttraumatic growth further extends the personal consequences gained from trauma via focusing on one’s sense of strength and self-reliance. Two of the most common reports of PTG include how survivors perceive that they are stronger and identification of positive coping skills they relied on to get them through their struggles (Tedeschi et al., 1998). Examples of positive coping skills learned include problem solving, enhanced regulation of emotions, strengthened social support, and utilization of religion (Park, Aldwin, Fenster, & Synder, 2008; Park, Cohen, & Murch, 1996). “Positive coping appears to facilitate the making of meaning necessary for growth by promoting active struggle with the event and awareness of the potential for positive outcomes from it” (Park et al., 2008, p. 301).

In addition to feeling stronger and self-reliant, survivors also have new found confidence as they have had to recognize and connect with abilities and competencies (Janoff-Bulman, 2004). They have had to rely on such strengths as a means of thriving through adversity. Paradoxically, some who experience PTG also report a deepened sense of vulnerability as they are consciously aware of the fragility of life. Clinicians that are consistently exposed to traumatic stories possibly become more aware of the unpredictability of life. Such awareness serves as a catalyst for restructuring priorities and extending more effort to enhance interpersonal relationships and positive experiences (Tedeschi et al., 1998).

Interpersonal relationships.

Establishing and utilizing one's social support systems is a critical component to developing PTG. Closer and more meaningful relationships with others provide a pathway in which survivors' can restructure their personal stories by getting varying feedback and support (Tedeschi & Calhoun, 2004). This was evidenced by a study conducted by Eidelson et al. (2003). Psychologists who were directly impacted by the terrorists attacks on September 11, 2001, and involved in the recovery efforts, reported feeling closer to their families and an increased attentiveness of the need to "adjust priorities, stay connected (or reconnect) to deeper values and relationships" (p. 147).

Interacting with others also bestows the opportunity for self-disclosure. Being able to share with colleagues in a supportive work environment can assist in mitigating the secondary stress experienced by therapists (Eidelson et al., 2003). Research has indicated that mental health professionals who received empathetic support from others during their work in the aftermath of the Oklahoma City bombing had lower levels of VT (Batten & Orsillo, 2002; Gentry, 2002).

In the PTG process it is critical that clinicians provide as well as receive support. Being able to reciprocate support can enhance one's feelings of contribution and strength. Psychologists involved in the recovery efforts of 9/11 reported an increase in their positive feelings about their professional work during the recovery efforts. These professionals felt more meaning and satisfaction from their work with clients as they believed they were "making real and important contributions to the welfare of individuals" and the healing of a community in a time of great need (Eidelson et al., 2003). Providing help to others after traumatic events can induce additional healing as it provides the therapists with opportunities to appreciate how they have grown when faced with those that are still struggling (Tedeschi et al., 1998).

Philosophy of life.

When one faces tragedy, experiential questions and thoughts regarding life and death can arise. “A commonly reported change is for the individual to value the smaller things in life more and also to consider important changes in the religious, spiritual and existential components of philosophies of life” (Tedeschi & Calhoun, 2004, p. 58). These thoughts can promote the development of PTG as it prevents individuals from dwelling on the inconsequential and negative aspects of life. As the gifts of life appear more bountiful, so too is the recognition of what is important, which can often include one’s relationship with God or nature (Janoff-Bulman, 2004). This growth can reflect the domain of spiritual development common among survivors as their beliefs about a higher power are solidified (Tedeschi et al., 1998).

When natural and human made disasters strike, community and societal systems are faced with the challenge of collectively responding to an unanticipated event. Mental health professionals are “quickly thrust into urgent and unfamiliar territory called upon en masse to respond to the needs of individuals, families, and organizations in psychological crisis at the very same time that their lives are thrown into upheaval” (Eidelson et al., 2003, p. 144). Such chaos can produce profound changes in the therapist’s professional and personal lens. Positive changes can develop out of such events if professionals envision the experience as a potential turning point. This aspect of PTG is critical when socially shared schemas are challenged by collective adversity (Tedeschi & Calhoun, 2004). It is especially important for clinicians facing mass traumas to envision the positive changes as they are working and living within the context of the trauma. This dynamic could present a unique challenge for clinicians as both their professional and personal lives are impacted. Due to the simultaneous nature of this work, professionals may present with more intensified symptoms than vicarious traumatization and post traumatic growth. As such, a

review of personal stories from clinicians who were personally and professionally touched by tragedy follows to illustrate the variance in impact.

Personal Experiences of Clinicians Exposed to Trauma

Although the literature is growing, minimal attention has been given to the professional and personal ramifications of clinicians simultaneously affected by the same trauma as their client.

Faust, Black, Abrahams, Warner, and Bellando (2008) provided personal narratives regarding the impact Hurricane Katrina had on the practice of psychologists. These authors identified that “most of the research on compassion fatigue or secondary (vicarious) trauma describes the impact on the psychologist or counselor who regularly provides services to populations who are themselves directly traumatized but with whom the therapist typically does not share the experience” (Faust et al., 2008, p. 4). Reflecting on their professional experiences, all of the authors observed the chronic stress of recovery and therapeutic fatigue from working with their clients. These authors presented the personal impact as “more chronic distress than impairment”, adding that concepts such as VT alone do not capture their experience as they too were directly impacted by the storm and its adverse consequences (Faust et al., 2008, p.4).

Arnold et al.’s (2005) work regarding post traumatic growth explored the positive consequences perceived by clinicians who work with trauma survivors. Participants in their study reported positive adaptations in their levels of “sensitivity, insight, tolerance, and empathy-traits that reflect positive changes in their ability to understand, accept, and connect with others” (p.257). Many reported a deeper sense of vulnerability when working with traumatized clientele which in turn strengthened their self awareness and enhanced their appreciation for life (Arnold et al., 2005). Eidelson et al. (2003), found similar results in their study pertaining to psychologists who worked during the September 11, 2001 attacks. After investigating the psychological outcomes of the 9/11

terrorist attacks on therapists, many felt an enhancement in personal meaning and satisfaction derived from the sense that they were contributing to their country by attending to those in need.

As these reports indicate, clinicians are not immune to the profound influence mass traumas can produce. According to one clinician impacted by the Virginia Tech shootings, “one cannot truly be prepared for a traumatic event of this magnitude” (Piercy et al., 2008, p. 215). Since such tragedy is comprehensive in scope, so are the resulting symptoms. As previously noted by Faust et al. (2008), most of the current trauma literature does not reflect this holistic impact on the clinician simultaneously impacted by the same trauma as his or her client. Day (2010) conducted a qualitative study which consisted of 16 interviews with clinicians who lived in the community and provided clinical services following the April 16th, 2007 Virginia Tech shootings. One prominent theme was the concept of shared traumatic exposure. Day found that this theory was a comprehensive extension of VT and PTG as it represented the personal and professional experiences of the mental health professionals directly involved in the recovery efforts during the tragedy (2010).

Shared Traumatic Exposure

Shared traumatic exposure (STE) pertains to mental health professionals directly impacted by the same traumatic event at the same time as their clients that they treating. The amount of time that these providers spend with traumatized clients and other members of the community is heightened as these professionals are working and living within the context of the crisis while it is occurring. This exposure differs from VT as it is comprehensive in scope because this experience infiltrates the provider’s professional *and* personal life as he or she is a member of the community impacted by the traumatic event. Clinicians who have experienced STE are immersed in the context

of the tragedy both professionally and personally, it may be more difficult for those exposed to leave their thoughts of their job *at* the job.

For example, Day (2010) found that one of the prominent commonalities highlighted by those that have experienced STE includes encountering difficulty separating their own experience and subsequent feelings, from their clients due to their shared past and familiarity with the pain expressed by others. Professional boundaries can be challenged and stretched to accommodate the increase in traumatized clientele. Another possible reaction to STE is avoidance. As a means of coping, clinicians may attempt to avoid reminders of the crisis within their professional and personal contexts (Day, 2010). These efforts could extend to not watching media coverage of the tragedy and/or questioning the information presented in the news. Conversations outside of the community may also be avoided as a means of reducing the discomfort about conversing about the incident. One of the most prominent forms of avoidance found by Day (2010) regarded the mental health professionals personal processing. As an immediate response was needed and expected by local mental health systems, inadvertent avoidance of personal processing occurred as staff was consumed with assisting clients and those in the community. It seems that many, albeit temporarily, of those who experience STE may disregard their own processing of the trauma as a means of being able to best meet the needs of their clients.

This intimate experience with trauma can also increase the depth of connection with clients and overall awareness of trauma and subsequent scope of impact (Day, 2010). The ability to build a deeper level of rapport could be easier to achieve as the clinicians have a personalized conception of what their clients are going through. In addition, working with traumatized clients could assist providers in deriving meaning and appreciation from the event as they are gaining perspective about their healing and progress. Ultimately, clinicians who experience STE have a unique outlook

as multiple facets of their lives are touched by the trauma. As such, there is a higher likelihood that they would derive the professional costs and benefits of such exposure (Day, 2010). As there is a strong potential for professional and personal change, it is important to consider the lessons learned from mental health professionals that have lived and worked through tragedy.

Lessons Learned: Implications for Practice

There were a multitude of lessons learned from the literature regarding clinicians who were directly impacted by natural and human made traumas. Preparation was a key element learned after Hurricane Katrina. Clinicians need to prepare themselves internally when providing response services to traumatic events. According to Levy (2008), therapists may be the only ones available during a catastrophic disaster to provide objective, reflective listening therefore it is critical that such providers be in tune with their own reactions to the trauma prior to assisting others. This would allow them to hear other people's stories and not let their own experiences "color what the other person is saying," as they could "miss the mark" leaving the person to feel "not understood and known" (Levy, 2008, p. 32).

Self awareness

One reflection highlighted by Faust et al. (2008), was the need for clinicians to establish balance between concerns for themselves, their families and their clients. This balance is a critical element to ensuring that therapists' are truly hearing their clients stories. After Hurricane Katrina these counselors were pulled in multiple directions trying to meet their own physical and emotional needs as well as ensuring the emotional stability of their clients. As they were exposed to the same trauma as their clients, they also experienced "therapeutic fatigue associated with the provision of professional services to a devastated population" (Faust et al., 2008, p.4). As such, these therapists attempted to monitor their own struggles and coping to ensure that their experience did not bleed

over into their work with their clients. These efforts can serve to preserve the clinician's personal identity and personal tolerance level for clients (Trippany, White Kress, & Wilcoxon, 2004).

In order to self-monitor successfully, thus protecting his or her own self identity, one must be self aware. According to Day (2010), self awareness is one of the most prominent contributors to personal growth for clinicians' who provide crisis response services. This was evidenced by accounts of the participants' personal experience and that of their clients processing trauma. Being able to identify one's own traumatic reaction is beneficial to enhancing one's clinical scope of practice. Without such recognition, clinicians are more likely to overlook personal and clinical blind spots that could hinder treatment.

Social support

“Connection to and being embedded within a support system in one's community has been demonstrated to be an enormous value for mental health and overall quality of life” (Levy, 2008, p. 34). Social support is considered a crucial piece of psychological well-being and has been linked to faster and more successful posttraumatic recovery for workers who experience simultaneous trauma are given the space to process and verbalize the internal struggle and stress which is usually associated with exposure to trauma (Hobfoll, Freedy, Lane, & Gellar, 1990). Secure and healthy attachments to family and friends have been illustrated to increase the ability to autonomously address a stressful event (Masten, 1999 as cited in Agaibi & Wilson, 2005).

It is important that mental health professionals appreciate their professional and personal networks as this community provides both “instrumental and emotional support” (Levy, 2008, p. 34). According to Haskett, Scott, Nears, and Grimmett (2008), relationships counselors developed with their peers while assisting with the response efforts during Hurricane Katrina “affirmed and sustained the efforts and energy necessary to provide mental health services for clients as well as

staff” (p. 97). According to Day (2010), a team based approach has been found to be helpful during the aftermath of crisis response. Clinicians who perceive support via feedback from their colleagues felt less isolation, more comfortable in their decision making, and joint accountability for their clients.

Consultation with peers was another practice of social workers who responded after the September 11, 2001 terrorist attacks. According to Pulido (2007), several clinicians in her study “found it very helpful to meet with peers and colleagues to discuss cases” and to help them deal with the secondary traumatic stress they were experiencing (p. 280). Knowing one’s professional strengths as well as limitations is an essential characteristic to accurately assessing clients’ needs and targeting blind spots. Once blind spots are identified, clinicians can begin to address such growth areas and develop coping and self care skills that will enhance their professional lens. This is a critical component to combating secondary traumatic exposure.

Developing professional support networks for consultation and collaboration, being able to debrief with others, and using a team approach are important strategies to mitigate the costs of providing trauma focused treatment (Bober et al., 2005; Iliffe & Steed, 2000). According to Day (2010), it is important for practitioners to sustain their professional social networks. Without such efforts, the isolative nature of crisis response could be reinforced and heighten the costs of such work. In addition to working collaboratively, it could benefit clinicians to organize social outings as a means of strengthening the professional cohesion and support system outside of their professional setting. These efforts could provide “opportunities for a range of social support activities, including practical problem solving, emotional understanding and acceptance, sharing of traumatic experiences, normalization of reactions and experiences, and mutual instruction about coping” (Hobfoll et al., 2007, p. 296).

Supervision

A common recommendation in the trauma literature regarding post trauma recovery for mental health practitioners is receiving supportive supervision. The supervisory relationship can not only serve to guide supervisees clinically but can also be cathartic for supervisees working with traumatized individuals and even more so if they were traumatized themselves. Day (2010) found that clinicians who experienced STE and who perceived less support from their supervisors experienced more costs within the workplace such as decreased social cohesion and increased stressors associated with caseloads. The consequences of failing to meet professional needs illustrates the importance of supervisors providing support when providers are working through times of community tragedy. Being directly impacted and involved in the immediate response to trauma can separate some workers from those not involved in the response so it is critical to protect such staff from being continually drawn into the evolving demands of the community as well as promote networking within the work environment (Day, 2010).

The supervisory relationship, although not therapy, can be a strong contributor to clinicians' recovery process as guidance and support can be ascertained which can improve stress symptoms (Pulido, 2007). Additionally, supervisors' expectations regarding how to assess and intervene following a crisis can be instructive and aid supervisees in being more proactive and mindful of their interactions with their clients (Day, 2010). Supervisors can play a critical role in providing support and guidance for their supervisees, that will ultimately extend to and impact interventions with clients, so it is important for this relationship to be a priority for all involved.

Self care

In a time of crisis, it is understandable that clinicians responding to community traumas would displace their own emotions and needs in order to meet the needs of clients. Yet the personal

toll of setting aside their emotional reactions can be detrimental if not addressed after the immediate response is over (Day, 2010). It is crucial that clinicians stay connected to their own emotional processing even when attempting to meet the needs of others, in order to establish balance in their life and reduce the costs of VT and STE as well as promote healthy self care efforts (Faust et al., 2008; Schechter, 2008). One psychologist who assisted with both the 9/11 and Katrina response efforts recalled how critical it was for her to maintain her self-care during the recovery efforts. She reported that “this strategy was very effective for keeping myself emotionally fueled and better able to help in the face of the pain and suffering of the survivors” (Schechter, 2008, p. 45).

Setting boundaries within the work place is another lesson learned from post trauma work. Diversifying case loads to reduce the amount of traumatized clientele is an important effort that, if possible, clinicians should make in order to reduce the likelihood of experiencing therapeutic fatigue (Cunningham, 1999; Pulido, 2007; Trippany, White Kress & Wilcoxon, 2004). In addition, clinicians have the “professional and ethical obligation to critically self-examine their capacity for the provision of service during both the acute and the chronic phase of recovery” (Faust, Abrahams, Black, Warner, & Bellando, 2008, p. 5). If clinicians do not believe that they are ready to provide support to others and they feel impaired from their own processing, then they are ethically bound to cease providing services until stable enough to do so.

Appropriate follow up care was another recommendation for responders who are directly impacted by traumatic events (Pulido, 2007). Debriefings and other professional consultation should be offered as a means of recognizing the inherent costs of such work (Pearlman & Mac Ian, 1995). Such interventions should promote resiliency and coping skills as well as aid recovery and professional, personal and organizational growth (Faust et al, 2008; Pulido, 2007). One of the most prominent recommendations within the trauma literature is that clinicians be familiar with disaster

relief resources. It has been recommended that training be provided for mental health professionals who work with trauma survivors (Akin-Little & Little, 2008; Dass-Brailsford, 2008; Faust, Black, Abrahams, Warner, & Bellando, 2008; Jones, Immel, Moore, & Hadder, 2008; Kamps, 2008; Levy, 2008). Professional trainings focused on post traumatic stress, typical responses to trauma, clinical interventions and referral sources could be provided as a supportive response to crisis work (Pulido, 2007; Trippany et al., 2004). This form of training could be used as a means of empowering clinicians with knowledge so that they are more comfortable treating traumatized clientele and also as a means of reducing their own responses to the stress of such experiences.

According to Trippany et al., counselors who derive a sense of meaning and purpose from trauma are less likely to experience vicarious traumatization (2004). This is in conjunction with the post traumatic growth literature which links exposure to trauma with the potential for personal and in this case professional development. According to Osofsky, Hurricane Katrina was a “life transforming event” full of positive lessons. This author reported she and her colleagues grew from this tragedy and found internal strength that they were not connected with prior to the hurricane (2008). This author also described new friendships and connections that were formed in response to the tragedy that continue to be defined. In addition “opportunity to rebuild and to help others in establishing a sound new future” continues to arise providing the sense of fulfillment many mental health practitioners get from assisting others in need (Osofsky, 2008, p.17). Ultimately the rewards gained far outweigh the costs of working with traumatized clientele but those gains can only be realized when clinicians balance caring for others and themselves (Salston & Figley, 2003).

Conclusion

There are both costs and benefits accrued when mental health providers work with traumatized clientele. Such consequences are amplified when clinicians are simultaneously exposed to the same trauma as their clients. Community based traumas can impact clinicians' professional and personal lives so it is important to be prepared for the ramifications of providing aid during times of crisis. Vicarious traumatization, post traumatic growth, and shared traumatic exposure are three possible outcomes for clinicians working with traumatized clientele. Through the reliance on personal and professional support systems, the supervisory relationship, self care efforts, and knowledge gained through trainings, mental health professionals can better deter the deleterious effects of trauma work and unearth the meaning derived from such events.

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CHAPTER FIVE

Conclusion

The purpose of this study was to analyze, through qualitative methodology, the experiences of mental health professionals directly involved in the recovery efforts after the campus shootings that occurred at Virginia Tech on April 16th, 2007. I sought to examine the ramifications of vicarious exposure and growth potential involved in this work. Participants were asked to describe the meaning derived from personally experiencing a tragic event while providing direct clinical and supervisory support directly following and after the shootings.

In chapter one, the rationales and plan for this study were addressed. By discussing the vicarious and beneficial aspects of this work through my research, I can extend the literature to comprehensively represent the costs and rewards for mental health professionals who are directly affected by traumatic events with the professional duty to assist clients exposed to the same event. Chapter two was the literature review and explored some of the most prominent concepts within the trauma literature. Compassion fatigue, burnout, countertransference, vicarious traumatization, compassion satisfaction, and post traumatic growth were extensively addressed to highlight the consequences of providing mental health trauma focused services.

Chapter three addressed the various facets of the methodology that were used to complete this study. Included was the rationale for the chosen methodology. A phenomenological research design was used to gather information regarding the experiences and perceptions of various mental health professionals. Ethical considerations were also explored to account for the sensitive phenomenon examined. Other facets of this chapter included research methods, selection of participants, instrumentation, research questions, data collection and analysis procedures. The goal

of the outlined steps and the purpose of this chapter was to substantiate the description of the essence of the experiences of the participants.

Three articles were prepared in order to represent the results and discussion of the aforementioned research. The first article entitled, *Shared Traumatic Exposure: Implications for Preparing and Supporting Clinicians*. This article addressed current literature pertaining to the challenges and benefits of trauma work derived by mental health professionals. Based on research following the 2007 tragic shootings on the campus of Virginia Tech I proposed a new concept, shared traumatic exposure, as a means of strengthening existing trauma research. Results of this study were explored to highlight the multidimensionality of this study. Article one concluded with implications for practice and supervision, for clinicians and supervisors who have experienced share traumatic exposure. Recommendations for research into shared traumatic exposure are examined.

The second article, *Personal and Professional Experiences of Clinicians who experience Shared Traumatic Exposure from a Humanistic perspective*, explored the benefits of trauma work. The purpose of this article was to review professional and personal benefits of trauma work from a humanistic perspective. Results of this study were discussed illustrating the potential positive aspects of providing direct mental health services when tragic events occur. Professional implications for clinicians and supervisors were included. The third article, *Consequences of Working with Traumatized Clients During and Following Crisis: Implications for Practice*, addressed the range of consequences for mental health providers working with traumatized clients. It explored the positive and negative consequences that could be heightened when such providers are simultaneously exposed to the same trauma as their clients. This article focused on vicarious traumatization and post traumatic growth; two widely researched concepts in the trauma literature.

The results of the research highlight the implications of trauma work. In addition, self awareness was found to be a crucial component to improving self care and providing enriched therapeutic services. This research supported and added to the current research regarding the professional and personal consequences and benefits of being directly and indirectly exposed to trauma.

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APPENDICES

Appendix A

Request Letter to Directors

Dear (Director),

Greetings! My name is Kristen Day and I am a doctoral candidate in the Counselor Education program at Virginia Tech in Blacksburg. I am interested in conducting research regarding psychotherapists' perceptions and experiences providing clinical and supervisory services following the April 16, 2007 campus shootings. I am seeking volunteers to interview about their experiences. Today I am writing you to seek permission in speaking to some of your staff and/or interns. I will be requesting to speak to those that were directly involved in the recovery efforts on April 16th and thereafter. In addition, my preference is to speak with those that are still practicing as I am interested in the long term professional ramifications of such an experience.

Involvement in this study will include two one-on-one, face-to-face interviews with the researcher. The first interview will be an in-depth interview about their perceptions and experiences immediately following the shootings up through last year. Upon the completion of this interview, a second interview will be scheduled. Prior to the second interview, a transcript of the first interview will be completed and mailed to the participant to check for accuracy. The second interview will allow time to discuss any changes to the initial interview transcript and ask follow-up questions regarding their current clinical and supervisory experiences.

I have included a copy of the abstract and the informed consent to provide more information about the study. I will touch base with you by email in a week to discuss any questions and/or concerns you may have about the psychotherapists' participation in the study. Please feel free to contact me by phone or email with any questions you may have prior to our discussion.

Sincerely,

Kristen Day, LPC

Doctoral Candidate, Virginia Tech

Email: daykw@vt.edu

Cell Phone: 843-513-7705

Appendix B

Follow up Email – Directors

Good morning (insert name)! My name is Kristen Day and I am a doctoral student in Counselor Education at Virginia Tech. I contacted you last week in reference to the research I am conducting on the perceptions and experiences of psychotherapists' providing clinical and supervisory services following the April 16, 2007 campus shootings. Approximately a week ago, I included information on a study that I am conducting as part of my doctoral program. I wanted to touch base with you to make sure you received the information and to answer any questions you may have about the study.

An initial one-on-one interview will be scheduled with the participants at a convenient location for them. Upon completion of the interview, I will transcribe the interview and forward a copy to the counselor by mail. A second interview will be scheduled to discuss follow up questions and/or concerns they may have about the initial interview. In addition I will ask them to reflect on their current professional experiences.

I am aware of the sensitive nature of this topic and want to stress the importance I place on confidentiality as it is crucial to the success of this study. Although I will be taking multiple steps to avoid any identifying characteristics of participants, there is always a possibility that someone may be able to deduce the identity of a participant in the final documents. Pseudonyms will be used for participants in all research documents and only I will know the identity of the participants and have access to these documents containing identifying information.

I would like to thank you for your time and appreciate your assistance in my research study. I plan to begin interviewing within the next month. If you have any questions or concerns regarding this please do not hesitate to contact me now or anytime in the future.

Thanks again,

Kristen Day, LPC

Doctoral Candidate, Virginia Tech

Appendix C

Email/Phone Call Script – Interview Participants

Hello (insert name)! My name is Kristen Day and I am a doctoral student in Counselor Education at Virginia Tech. I am conducting research on the psychotherapists' perceptions and experiences providing clinical and supervisory services following the April 16, 2007 campus shootings. I hope to understand mental health professionals' perspectives regarding the professional ramifications of being so intimately involved in the recovery efforts and how this exposure impacted their professional role and professional quality of life.

The purpose of this study is to explore, through qualitative methodology, the professional quality of life of mental health professionals directly involved in the recovery efforts after the campus shootings. I am interested in exploring the unique aspects of growth and professional challenges that arose for you as you assisted clients in healing whilst you were also recovering from the tragic events that occurred. Involvement in this study will include two face-to-face interviews with the researcher. The first interview will be an in-depth interview about your perception and experience immediately following the shootings up through last year.

Upon the completion of this interview, a second interview will be scheduled. Prior to the second interview, a transcript of the first interview will be completed and mailed to you to check for accuracy. A second interview will be scheduled to discuss any changes to the initial interview transcript, address any questions or concerns you may have and ask follow-up questions regarding your current clinical and supervisory experiences. This is also a time for you to add to or change any inaccuracies with the original transcript.

I know this could be a sensitive topic to discuss and I will make every effort to protect your privacy and provide confidentiality. Although I will be taking numerous steps to avoid any

identifying characteristics of participants, there is always a possibility that someone may be able to deduce the identity of a participant in the final write up. Pseudonyms will be used for participants in all research documents. I will be the only one with access to these documents.

If you are interested, I would like to set a date for our initial interview and discussion. Is there a particular day and time that would work best for you? I am available to talk in the evening or on the weekend if that would be more convenient. In the meantime, I will mail you a copy of the abstract, the informed consent and a short demographic survey to be completed during the first interview. If you would be so kind as to confirm your participation via either phone or replying to this email I would greatly appreciate it. Please do not hesitate to contact me if you have any questions. Thank you for your time!

Sincerely,

Kristen Day, LPC

Doctoral Candidate, Virginia Tech

Cell Phone: 843-513-7705

Email: daykw@vt.edu

Appendix D

Informed Consent Form

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Informed Consent for Participants in Research Projects Involving Human Subjects

Title of Project: The Perceptions and Experiences of Mental Health Professionals' Involved in the Response and Recovery following the April 16, 2007 campus shootings at Virginia Tech

Investigator(s): Kristen W. Day

Advisor: Dr. Gerard Lawson

I. Purpose of this Research Paper

The purpose of this study is to explore, through qualitative methodology, the professional experiences and perceptions of mental health professionals directly involved in the recovery efforts after the campus shootings that occurred at Virginia Tech on April 16, 2007.

II. Procedures

The researcher will conduct two one-on-one, in-depth, face-to-face interviews with psychotherapists' in the New River Valley. The interviews will take place at a site of your choice and last for approximately 60-90 minutes. The interviews will be audio recorded and written notes will be taken during the interview. All data will be used for research purposes only.

During the interview, you will be asked to be open and honest about your past and current experiences working with traumatized clients. The information collected will allow the researcher to investigate the collective experience perceived by mental health professionals providing clinical services following the campus shootings.

At the end of the first interview, a second interview will be scheduled for approximately two to four weeks. A transcript of the audio recording from the first interview will be completed and mailed to you to check for accuracy and for you to add any additional comments. The second interview will allow you time to reflect on your current experiences and add information pertaining to the first interview. You will also have the opportunity to read the second if so requested to clarify any information.

After you have reviewed this entire informed consent form, you will have the opportunity to ask any questions. The researcher will provide you with a copy of the signed documents and the researcher will also retain a copy.

III. Risks

There are minimal risks associated with participation in this study. Participation in this study may result in recollecting difficult experiences with clients and/or supervisees that occurred during the aftermath of the campus shootings, or the tragedy itself. To counter this, you are allowed to state that you do not wish to continue the interview or specific line of questioning at any time if it causes you any discomfort.

IV. Benefits

The possible benefits of participating in this study are the ability to review and process experiences that you have had working with traumatized clients. You will be given a venue in which you can reflect of your personal and organizational successes during the recovery efforts. There is no promise made to participants that you will receive any benefits. It is the hope of the researcher that elementary mental health professionals and educators will benefit from the results and implications of the study.

V. Extent of Anonymity and Confidentiality

Every effort will be made to protect your identity during the course of this research. Only the researcher will know the identity of the interview participant. Pseudonyms will be used and every effort will be made not to reveal any identifying characteristics in this study. You may select your pseudonym if you choose.

As you may have a pre-existing professional relationship with the with the researcher, she will define her role as a researcher to clarify research objectives.

Audio recordings of interviews, transcription of interviews, field notes and audit trail will be stored in a secure location by the researcher. Only the researcher will have access to the tapes and transcribed interviews. All tapes will be destroyed upon completion of the study and its results.

VI. Compensation

There will be no monetary compensation given for participating in this study. A small token of appreciation will be provided to each participant upon completion of the second interview.

VII. Freedom to Withdraw

Participants have the freedom to withdraw from the study at any time with no penalty. Participants have the right to refuse to answer any question during the interview. The researcher has the right to also stop the interview if it is deemed beneficial to the participant.

VIII. Subject's Permission

I have read the Informed Consent Form and details about this project. I confirm that I meet the criteria for participating in this study. I have had all of my questions answered. I hereby acknowledge the above and give my voluntary consent:

Participant Signature

Date

Should you have any questions about this research or its conduct, you may contact:

Kristen W. Day kwday@vt.edu 843-513-7705

Faculty Advisor E-mail/Telephone:

Dr. Gerard Lawson glawson@vt.edu 540-231-9103

Department Head E-mail/Telephone:

M. David Alexander mdavid@vt.edu 540-231-9723

Chair, IRB E-mail/Telephone:

Dr. David M. Moore moored@vt.edu 540-231-4991

(Note: Subjects must be given a complete copy (or duplicate original) of the signed Informed Consent Form)

Appendix E

Demographic Survey

1. What is your age? _____

2. Gender: M _____ F _____

3. Ethnic Background: _____

4. How many years experience do you have providing clinical services?

5. What is your current professional and/or student role and affiliated duties?

6. What is your current work setting?

7. What if any, relevant professional or volunteer experiences do you have assisting traumatized clientele?

Appendix F

Cover Letter for Transcript and Member Check

Dear (Participant's Name),

Included is the transcript from your initial interview. Please review this transcript and note any changes that you believe need to be made, and include any comments you wish to add to your initial feedback. You may write directly on the transcript for organizational purposes. I will contact you within a week of receiving the revised transcript to facilitate the progress of the study by confirming the date of the second interview. I sincerely appreciate your participation in this study.

Sincerely,

Kristen W. Day

Doctoral Candidate, Virginia Tech

Cell Phone: 843-513-7705

Email: kwday@vt.edu

Appendix G – Interview One Protocol

As a reminder...

The purpose of this interview is to reflect on and describe your perceptions and experiences providing clinical and/or supervisory services following the shootings that occurred on campus April 16, 2007.

Your feedback is very valuable so please be as candid as possible. Please note that I am no longer providing any type of clinical services in the New River Valley and my role here today is strictly as a researcher conducting this interview.

Any questions before we proceed?

- 1) How did your experience of being part of this community when the shootings occurred inform your clinical work with traumatized clients after the shootings?
 - a. Non-traumatized clients?
 - b. Enhance work?
 - c. Limit work?
- 2) Before this work would have considered yourself a specialist in treating trauma survivors?
- 3) How did that experience affect aspects of your professional worldview?
 - a. Were you more hopeful?
 - i. Pragmatic?
 - ii. Guarded?
 - iii. Optimistic?
 - b. What was it like providing clinical services to traumatized clients?
 - i. Clients in general?

- ii. Prior to this experience had you received any training in providing trauma focused treatment?
- 4) When did you feel successful in your clinical role?
 - a. Are you satisfied with your clinical work?
- 5) Some literature suggests that individuals who counsel traumatized clients may experience changes in their professional role. Can you tell me if and how your perception of your role has changed since the shootings?
 - b. Can you tell me to what extent you have experienced feeling energized?
 - i. Effective?
 - ii. Exhausted?
 - iii. Trapped?
 - iv. Depressed?
 - v. Overloaded by caseload?
 - vi. Do you see more professional opportunities?
 - b. Is your professional world blending into your personal life?
 - c. Did your professional relationships change?
 - i. Coworkers?
 - ii. Supervisors?
 - iii. Supervisees?
- 6) Having shared a similar experience with your clients, do you think your clients have or might experience you differently?
- 7) Has this shared experience affected...
 - a. The rapport you have built?

- b. The relationships you have sustained with current clients?
 - c. Challenge any relationships with clients?
 - d. Display of empathy?
 - e. How you identify with trauma clients?
 - f. Did you feel more connected?
 - g. Guarded?
 - i. How?
 - h. How did you maintain professional boundaries?
 - i. Did you ever feel like you were reliving the trauma?
 - i. Did you believe disclose more?
 - j. Since this experience, how has your compassion for others changed?
 - k. Have you felt more preoccupied with clients?
 - i. Think about them outside of work?
 - ii. Sleep affected?
 - iii. Intrusive thoughts?
- 8) What was it like working with clients presenting with issues related to the shootings?
- a. How has that affected your own processing of the tragedy?
 - b. Have you had any personal traumatic experiences prior to the shootings that might have affected your processing of the shootings?
 - c. Were unresolved feelings brought up?
 - i. If so how did you address this?
 - ii. How did you cope during this time?
- 9) After having this experience, what is different about your professional environment?

- a. Difference in interacting with coworkers?
- b. Supervisors?
- c. Expectations?

Additional questions may be explored based on individual responses.

I want to thank you again for your participation in this study. I will be mailing you a copy of the transcript from today's interview and please make comments and/or corrections directly on the transcript and return in the envelope provided. If I do not hear from you within two weeks after I have mailed you the transcript, I will assume you did not desire any alterations.

Appendix H

Interview Two Protocol

Hello (participant's name) and thank you again for participating in this research addressing psychotherapists' perceptions and experiences following the April 16th shootings. Today, I would like to provide you a chance to ask any questions or share any concerns from our first interview. In addition, I would like to talk a bit more about your current experiences and perceptions. First, you were provided a copy of the transcript from the first interview.

What questions, if any, do you have from the first interview?

What concerns, if any, do you have from the first interview?

Are there any additional comments you would like to make based on our conversation from the first interview?

Now that we have addressed all feedback about the first interview, I would like to ask you several follow up questions regarding your current experience during this school year.

- 1) Now that it has been over 2.5 years since the campus shootings, what is your perception of your clinical role now?
 - a. Has it changed?
 - i. Priorities?
 - ii. Explore issues that you might not have before this experience (such as spirituality)?
- 2) In what ways have your feelings of effectiveness in your clinical role been changed by your experiences over the past 2.5 years?
- 3) Can you describe for me, your clinical approach to working with traumatized clients now, having been through this experience and the events of the last 2.5 years?

- 4) What are the especially powerful or meaningful memories from your professional experiences associated with the shootings that affect you now?
- 5) What professional coping skills have you developed that helps you now?
- 6) How might this experience change your clinical approach in the future?

Additional questions may be developed by the researcher based on initial interview responses.

These questions would be used to clarify any initial responses from the participant and to elicit additional information as needed.

I want to thank you again for your participation in this study. As an expression of my appreciation, here is a parting gift. I will be mailing you a copy of the transcript from today's interview and please make comments and/or corrections as you did for the first interview. If I do not hear from you with two weeks after I have mailed you the transcript, I will assume you did not desire any alterations.

Appendix I

IRB Acceptance Letter



MEMORANDUM

DATE: October 20, 2010

TO: Gerard F. Lawson, Kristen Day

FROM: Virginia Tech Institutional Review Board (FWA00000572, expires June 13, 2011)

PROTOCOL TITLE: The Perceptions and Experiences of Mental Health Professionals Involved in the Response and Recovery Following the April 16th, 2007 Campus Shootings at Virginia Tech

IRB NUMBER: 09-882

Effective November 17, 2010, the Virginia Tech IRB Chair, Dr. David M. Moore, approved the new protocol for the above-mentioned research protocol.

This approval provides permission to begin the human subject activities outlined in the IRB-approved protocol and supporting documents.

Plans to deviate from the approved protocol and/or supporting documents must be submitted to the IRB as an amendment request and approved by the IRB prior to the implementation of any changes, regardless of how minor, except where necessary to eliminate apparent immediate hazards to the subjects. Report promptly to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.

All investigators (listed above) are required to comply with the researcher requirements outlined at <http://www.irb.vt.edu/pages/responsibilities.htm> (please review before the commencement of your_research).

PROTOCOL INFORMATION:

Approved as: **Expedited, under 45 CFR 46.110 category(ies) 6, 7**

Protocol Approval Date: **11/17/2010 (protocol's initial approval date: 11/17/2009)**

Protocol Expiration Date: **11/16/2011**

Continuing Review Due Date*: **11/2/2011**

*Date a Continuing Review application is due to the IRB office if human subject activities covered under this protocol, including data analysis, are to continue beyond the Protocol Expiration Date.

FEDERALLY FUNDED RESEARCH REQUIREMENTS:

Per federal regulations, 45 CFR 46.103(f), the IRB is required to compare all federally funded grant proposals / work statements to the IRB protocol(s) which cover the human research activities

included in the proposal / work statement before funds are released. Note that this requirement does not apply to Exempt and Interim IRB protocols, or grants for which VT is not the primary awardee.

The table on the following page indicates whether grant proposals are related to this IRB protocol, and which of the listed proposals, if any, have been compared to this IRB protocol, if required.

Appendix J

Demographic Survey Results

Pseudonym	Age	Gender	Years experience
Bill	35	Male	5-10
Jane	52	Female	20-25
Anne	27	Female	5-10
Deion	33	Male	5-10
Sam	48	Male	20-25
John	27	Male	< 5
Linda	52	Female	30-35
Mary	40	Female	10-15

Appendix K

Data Analysis Chart

Theme:	<i>Changed perception due to shared exposure to trauma</i>		<i>Derived benefits and costs accrued due to shared exposure to trauma</i>	
Category:	<u>Shared traumatic exposure</u>	<u>Potential clinical and professional benefits</u>	<u>Possible ramifications within work environment after community based trauma</u>	<u>Adaptation of perspective regarding trauma and professional worldview</u>
Focused codes:	More difficult to separate from client—feeling a lot of the same thing	Increased ability to relate to others, bond, build rapport	Change in work demand: intensity of work, focus on work, increased referrals/requests	Increased risk assessment
	Direct impact	Unique perspective	Response of staff: immediate and delayed	More sensitive to trauma
	Enhanced awareness regarding lack of control over other people/situations	Resilience witnessed; saw what other professionals, clients, community members and self are capable of managing/doing	Increased reliance on co-workers/colleagues	New understanding of trauma
	Avoidance: personal reactions managed through avoidance in order to professionally survive	Professional satisfaction: felt satisfied with work, derived rewards and positive impact on clinical work	Variance in perceived administrative support	Awareness of personal and client processing of trauma
	Personal wellness impacted: draining to hear painful stories,	Professional and personal purpose	Enhanced intra-agency relationships, collaboration	Recognition of scope of those impacted by trauma

	memories			
	Personal processing: denied/ignored	Exposure: increased comfort with high risk clients, decreased anxiety, and increased sense of effectiveness	Team versus isolative perception/clinical approach	Awareness of what self and others are capable of doing (both positive and negative)
	Familiarity with pain	Perception of client comfort increased client (shared past)	Greater workload, responsibilities, expectations of others	Appreciation of multi-dimensional impact of trauma
	Shared experience/past: (can't get away from trauma reminders, with clients, family, community)	Enhanced appreciation of clients	Change in implementation of concerns for clients; increased gatekeeping	
	Interpersonal relationships (with children, partners, socializing) outside professional life influenced	Self awareness, sense of preparedness enhanced (checking in with self and clients)	Internal and external expectations of clinical role	
	More intense work demand	Enhanced personalization of work due to personal experience with trauma		
	Sense of community (communal response professionally, personally, within community, society)	Altered clinical approach: slower pace, more gentle, deliberate		
		More appreciation for therapeutic and		

		personal relationships		
Initial (in vivo) codes:	I think we were and me personally were so involved in what we were doing at the time that I didn't have time to think about my own response.	I think it was helpful kind of going through it to experience it firsthand what it is like. I feel like I can relate to people who also went through it.	There was a point where we could put differences aside to work with, for the common good, uh with the staff and I think just in general.	I think that is one of the things that all of us and certainly myself become more aware of is seeing those connections, working with those connections, helping clients figure out is that maybe related—seeing how the trauma might be playing in and using that as part of the treatment.
	I was more knowledgeable of the people that were involved—but I think it made it a little more difficult to separate from the client and to you know just kind of be there with them and probably feel a lot of the same things they were feeling.	...as well this idea of there are often times in our lives that we would never ever want, that weren't something we would invite weren't something that we liked but we grew from them in ways that were impossible otherwise...	I think lots of people myself included were more tired than they'd like to be more burned out more just kind of at wits end without a lot of chance for our own self care...	I think it makes me more sensitive to traumatic events not just on a microlevel...now I take a much broader view in that I can see the effects of the trauma in the moment at the microlevel but I can also see it impacting someone's long term views on things and the impact of the community.
	I have actually tried to stay away from	I think it really has shown me the resilience	...responsibilities are now even higher than they	I am more sensitive to risk assessment than I

	clients who were involved in 4/16 given my involvement.	that people have that has been very encouraging.	were before so I am expected to see more people than I was before expected to do more outreach, the workload on everyone has increased which means the workload on my supervisee has increased which means then that my workload as a supervisor increases...	was before so any suicidality or homicidality that's more of a concern and also the effects of trauma on clients, seeing if it's still affecting people who were here.
	I think it was very difficult to draw the line between being the kind of therapist and being kind of removed in just feeling what they are feeling and forget the boundary thing...I cried more with my clients, I hugged more clients...	...knowing that I was here that I was part of the community that I was here before that I experienced that you know that helped them feel more connected more trusting maybe.	...there were plenty of times where I wanted to be here I wanted to be here not just doing the work but in some sense just being with my colleagues, the people that were kind of the band of brothers idea that people that I know have been through the fire with me that we're all working on the same cause that have that understanding that shared connection...	...going in with the understanding that people want to survive, make it through, it's helping them figure out how to do it...
	...I think that is what made that whole experience different	...while doing it (recovery) I tried to just take in what was occurring and	...we found ourselves being asked to do things outside of the counseling center	It's kind of given me more of an appreciation for the experience that people, that

	<p>counseling people who were traumatized by that event made it different than some other trauma they might have experienced cause we shared the same experience so it's kind of like we started on the same page, you know we didn't have to explain it, it's like you just knew.</p>	<p>taking in information you can't not be affected, hopefully you are affected in a way, I mean you are empathetic, you are sympathetic, and professionally you become more aware of who you are and how to prepare yourself.</p>	<p>that we had never done before...</p>	<p>trauma has on my clients.</p>
	<p>...as mental health professionals we're really one of the only groups of people that get a more comprehensive sense of the tragedy...you have got a whole picture which I think can be very overwhelming to deal with at times...</p>	<p>I think more patience, more interpersonal related types of interventions and working on the relationship; a different emphasis on the relationship maybe...</p>	<p>...it was almost like my tolerance went up because I was able to say this was an emergency and I just got to do what I got to do...since then there is not been very much positive in terms of the professional environment.</p>	<p>I am always under the impression that if a person wants to do something like a person is suicidal and they want to go do something they are going to do it...but it does I think I try to be more sensitive to what might be under there, if anything is bubbling under the surface that could result in something like that. I think we all are a little more sensitive to stuff like that.</p>
	<p>...recognition that the</p>	<p>I think I appreciate my</p>	<p>...there has been much more</p>	<p>I think it makes me aware of my</p>

	<p>shootings have impacted everyone, that was powerful to see and in some ways made it more difficult because normally my strategy to leave work at the office didn't work but when you go out into the community and are reminded of the same things you are trying to get away from...</p>	<p>interaction with my children everyday differently...I never leave my children without saying I love them, I have always done that but I have reason behind it now.</p>	<p>burnout, there has been an extreme stress response, in general the way in which we communicate with one another has gotten worse, turn over has increased, morale wasn't great but in retrospect it was a lot higher than it is now so morale has really really taken a hit since that time.</p>	<p>own personal reactions, my own ways of coping, I am a big believer in self awareness which translates into the work I do with clients, that can help me connect or understand what a client might be going through as well as talking with a client about what they are going through and what their experience has been so I think that has ramifications for my future work with clients.</p>
	<p>...that's not an image I want or that's not an image that is going to help me sleep at night...I definitely would have been sleeping better tonight not hearing that...very strong visceral reaction to some of the things...hearing that certainly had an impact on me and how I was doing.</p>	<p>I am more able to talk about the trauma, I don't think there is any conversation around a trauma that I would shy away from now; I am not intimidated by that conversation at all anymore.</p>	<p>...some people have changed...felt like it had an affect on specific staff member in not such a nice way; I think they became more anxious, I want to say vigilant about worrying they missed something; taking that out on other people kind of thing.</p>	<p>...makes me aware that that's a unique aspect of treatment that needs to be addressed that it can kind of proliferate other areas of a case conceptualization but you know trauma itself deserves its own form of treatment.</p>

	<p>Nothing happens in a vacuum so everything we do happens in this social context...the problems happen in a social context why don't the solutions happen that way too so I think that idea got even strengthened for me by seeing the power that society, community could have coming together.</p>			
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Appendix L

Audit Trail

10/15/09 Begin IRB application
11/9/09 Prospectus defense/approval
11/ 10/09 Finalize and submit IRB application
11/17/09: IRB application conditionally approved pending CART approval
11/18/09: Contact CART committee member Robert Walters for clarification regarding applications requirements.
11/24/09: Contacted by Jack Finney, chair of CART, with request for IRB materials.
11/24/09: Sent application materials in electronic format to Dr. Finney.
12/02/09: Contact Dr. Finney to confirm receipt of materials and request timeline of when CART would contact me. He replies that I should hear by that Friday.
12/04/09: CART committee sends letter approving study
12/08/09: IRB emails expedited approval letter
12/09/09: Send request letter by email to directors of Cook Counseling Center, New River Valley Community Services Board and Psychological Services Center.
12/09/09: Dr. Barker replies to email request informing me he has passed on the request to staff.
12/10/09: Dr. Cooper confirms request and recommends that I contact Dr. Winett to have request posted on listserv. I reply that there were some participants that we had previously discussed in our first informal meeting last spring that I would contact first and then contact Dr. Winett as needed.
12/10/09: Contact possible participant to assess her interest in participation and ask her for last name of mutual colleague.
12/14/09: Send follow up letter to all three directors.
12/14/09: I realize I did not ask for specific follow up from the directors and ask Dr. Lawson if it is ok to proceed with contacting participants which he confirms.
12/14/09: Send out request email to all participants that I previously had in mind. I also contact Dr. Barker to see what supervisors I could contact for possible staff participation.
12/14/09: Contacted PSC student that I briefly met with last year to see if he still is in Blacksburg and providing clinical services.
12/14/09: Dr. Barker provides names of three individuals I should contact who could put me in contact with other participants or participate.
12/16/09: I hear back from one of the APS supervisors from the CSB who agrees to forward my request to her staff. I reply and thank her.
12/16/09: I hear back from PSC student who asks for more information regarding my study and I send a reply email providing more information.
12/16/09: I hear back from one participant at the CCC who agrees to participate and I inform him I will email him with possible meeting times once I have heard from more people.
12/16/09: I hear back from a possible participant at the CSB who agrees to meet but cannot meet until February. I do not want to lose this participant although this could push back my timeline but agree that this will be fine and plan to contact her around that time.
12/16/09: I heard back from another PSC participant who reports that she is not providing any direct clinical services this semester but is still open to meeting. I am not sure if I should still include her in the study so I contact Dr. Lawson for guidance.

12/17/09: Dr. Lawson replies that I should still meet with this participant as having more is better. I ask him about recording equipment and arrangements for pick up.

12/17/09: I begin setting up meeting times for first interview. As I am out of town I am trying to fit in multiple interviews in one trip.

12/17/09: I hear back from PSC participant who does not believe he would be a good fit for my study. I then contact other possible participant that was suggested by colleague at the PSC. I decide that my first round of interviews should be before students return and decide on 1/6-1/7 based on work schedule and email these possible dates to confirmed participants.

12/22/09: I hear back from supervisor at CSB letting me know that she is waiting for response from her staff before she provides their names. I reply and thank her for this. She later responds with a staff member who may be interested in participating. I decide to wait until after the holidays to send a request to this staff member.

12/31/09: I send a request email to CSB participant. She replies with a confirmation of her desire to participant. I send her the upcoming dates that I plan to come.

1/3/10: I send a reminder email to four confirmed participants that I have scheduled on 1/6. I decide to email demographic questionnaire and informed consent and request that these be completed prior to interview.

1/3/10: I email Dr. Lawson to confirm location where he plans to leave recording equipment.

1/4/10: I hear back from CSB participant and she can only meet on 1/6 during already scheduled time slots. She also replies that she can meet on 1/7 in the afternoon.

1/5/10: I decide that I do not think I should stay in town another night for one interview so I request to reschedule interview by email and phone call with CSB participant which she confirms by email is ok.

1/5/10: I drive to Blacksburg in the evening after work as I want to give myself plenty of time in the morning to get set up for my interviews.

1/6/10: I conduct four interviews with CCC participants (see field notes 1-4 and transcripts for more information regarding time/content of interviews). I drive back to Richmond after I complete my last interview. In between interviews, I write field notes.

1/7/10: I send an email to Dr. Lawson to let him know this first set of interviews went well.

1/7/10: I send another PSC student recruitment letter. I remember him from our brief contact last year at CCC and he was also recommended by my colleague at PSC.

1/9/10: I begin transcribing first set of interviews.

1/11/10: I determine that I will return to conduct more interviews 2/8-2/9 as this is the best time I can take off my work schedule. I contact confirmed PSC participant to set up meeting time for our first interview. I contact another PSC student whom I have been conversing with regarding plausible meetings times as well.

1/11/10: I contact CCC participants to see if they are able to meet for our second interview between 2/8-2/9. I also confirm I will have their transcripts to them by the end of the week.

1/11/10: I continue to work on transcribing.

1/12/10, 1/14/10: I confirm meeting times and locations with some participants for 2/8 and 2/9.

1/18/10: Confirmed PSC participant and set up meeting time for first interview. Contact the third PSC participant to schedule first meeting time.

1/18/10: Follow up with last CCC participant whom I have not heard from yet.

1/20/10: Schedule with remainder of participants except PSC participant, plan to meet with nine participants over two days.

1/25/10: Finish transcription of first four interviews. Email Dr. Lawson to see if it is ok to email and mail transcriptions as I want to make sure they have two weeks to review transcripts.

1/26/10: Get ok from Dr. Lawson to email transcripts. Email transcripts to four CCC participants.

1/28/10: Finalize meeting place and time with PSC participant.

1/30/10: Send email to Dr. Lawson asking preliminary coding questions and request meeting. Start open coding first transcript.

1/31/10: Continue open coding interviews two and three.

2/1/10: Open code interview four.

2/3/10: I send an email to all of my participants to warn them I may have to postpone the interviews depending upon the weather prediction. I struggle with sending this email out as I really do not want to reschedule. I request that they check their emails later in the week as I will be emailing them with my decision.

2/4/10: I send an email to Dr. Lawson asking advice regarding postponing my trip since he is local and has a better idea about the weather.

2/4/10: I am still not clear about what I will do so I email all participants and let them know that I plan to email them on Sunday with my decision and ask for additional contact information if they are unable to check their email.

2/5/10: All participants respond letting me know I can email them on Sunday.

2/7/10: I decide to travel to Blacksburg and email all of the participants. I confirm my meeting in the afternoon with PSC participant that I am interviewing today.

2/7/10: I conduct interview five with PSC participant (see Field note 5 for interview time and content).

2/8/10: I meet with Dr. Lawson to review first coded transcript and the data analysis process. I give him one of the coded transcripts and he plans to review my coding and give me feedback.

2/8/10: I conduct interviews 6-9 (see Field notes 6-9 for interview times and content). I decide to ask permission from participants about emailing transcript in addition to mailing hard copy to which all agree.

2/8/10: I watch the local news and determine that I need to cancel my interviews for 2/9 and email the remaining four participants with the plan to reschedule for a later date. I decide to get up very early the following morning to drive home.

2/9/10: I drive back from Blacksburg and email Dr. Lawson to give him an update of having to reschedule.

2/10/10: I review my work schedule to see when I can reschedule the interviews and schedule follow up interviews. I begin transcribing interviews 5-9. I chose to focus on the interviews that I have scheduled for 2/25 as I need to return them quicker.

2/11/10: I email all participants to see if they can meet 2/25. I hear back from two participants who cannot meet this date as they are out of town that week. One participant suggests Thursday 3/4 so I suggest this to the other participant who can meet on this date. I confirm these two interviews for 3/4 and provide this option for the remaining participants who have not gotten back to me about 2/25 availability.

2/12/10: I contact the remaining PSC participant who I have not set up a meeting time with yet.

2/12/10: I continue to transcribe interviews 5-9. I receive email from one PSC participant whom I have yet to interview with her limited availability.

2/14/10: I email a copy of the transcript to CSB participant. I continue to transcribe other interviews. I mail hard copy.

2/15/10: I email the PSC participant and thank her for her willingness to participate in my study but determine that due to time conflicts, I cannot interview her since she cannot meet during either days that I will be in Blacksburg. This will leave me with 16 total interviews. I also email one PSC participant and ask if she can schedule the second interview for 3/4. She responds that this is a possibility and will confirm this with me at our first interview on 2/25.

2/18/10: I email transcript to CSB participant.

2/21/10: I email a copy of the second transcript to CCC participant. I mail a hard copy of CSB and CCC transcripts later this afternoon.

2/23/10: I send reminder emails to all interviewees.

2/24/10: I drive to Blacksburg in the evening.

2/25/10: I complete interviews 10-13 (see Field notes 10-13 for interview times and content). I email a list of counseling resources to one of the participants as I forgot to give him a hard copy during our second interview. I ask if it is ok that I schedule with the PSC participant next week as that is when I will be in town next. Participant confirms this request. I ask if it is ok to email her the transcript so she will have about a week to review it and will bring a hard copy if she wants to make any revisions. She says this will be fine.

2/26/10: I had write field notes from previous day's interviews. I continue to transcribe interviews with a focus on the interview with the PSC student.

3/1/10: I email transcript to PSC student. I ask if she can meet on 3/4 and request times possible as she had mentioned plausible times at our last meeting.

3/2/10: I send reminder emails to remaining three interviewees.

3/3/10: I drive to Blacksburg in the evening for interviews.

3/4/10: My car gets towed so I call all participants and let them know that I am running late. I arrive at my first of three interviews about 20-25 minutes late. I chose not to get a parking pass on the way to my second interview which results in a ticket. I am almost on time to my third interview.

3/5/10: I type field notes from last three interviews completed yesterday.

3/7/10: I contact Dr. Lawson to let him know that I am finished with my interviews and am transcribing. I follow up with the transcript he was going to review. He replies to this request, provides feedback and guidance and instructs me to proceed with my analysis. I reply with a request to meet in early April and plan to follow up with him in late March/early April to schedule this meeting.

3/11/10: I continue transcribing remaining interviews. I email completed interview to CSB participant and mail hard copy.

3/12/10-3/14/10: I continue to open code interviews.

3/18/10: I type hand written field notes. I email transcript to CSB participant.

3/19/10: I mail hard copy of transcript mailed yesterday.

3/25/10: I email transcript for CCC second interview. This participant confirms receipt of emailed transcript (as requested in our first interview) that he does not need a hard copy of this transcript.

3/25/10: I continue transcribing remaining interviews.

3/27/10: I email transcript of second interview to PSC participant.

3/28/10: I email transcript and list of resources to CCC participant as I forgot to give this to him at last interview.

3/29/10: I continue to transcribe remaining interviews.

3/31/10: I email transcript to PSC participant.

4/1/10: I mail two transcripts to CCC and PSC participants. I decide to consolidate all of my open codes by typing them up and organizing them by question.

4/1/10- 4/8/10: I type up open/in vivo codes.

4/5/10: I cannot recall if I mailed last transcript to PSC participant and offer to mail it asap if I did not.

4/8/10: I send email to Dr. Lawson reporting that I have not begun focused coding ask if we should postpone meeting. He replies that this decision is up to me so I decide to cancel meeting that was scheduled for 4/9/10. I email him questions re: analysis instead. I also ask him if he needs his equipment back.

4/11/10: PSC participant responds to email sent 4/5 and reports he has no corrections to make and does not need hard copy of second interview.

4/12/10: I hear back from Dr. Lawson regarding analysis questions.

4/13/10-4/14/10: I begin to derive focused codes.

4/18/10: Finished focused coding (first round).

5/2 10: Send Gerard field note for format approval.

5/4/10: Phone conference with Gerard. He suggested I go through coding again to get personalized perspective. Send Dr. Burge field note for approval. Gerard has already approved format.

5/5/10, 5/6/10, 5/10/10, 5/12/10: Re-coded.

5/13/10: Emailed Gerard to set up meeting.

5/19/10: Meet with Gerard. We discuss possible themes and article ideas. Also discuss creating table.

6/2: Open coding

6/6: Open coding, created first data chart, sent to Gerard for approval

6/17: Created outline for Shared traumatic exposure article 1 and sent to Gerard

6/19: Received feedback about outline from Gerard

6/20: Fixed data chart

6/26-7/5: Worked on article 1 and sent to draft to Gerard

7/15: Created outline for Humanistic article 2 and sent to Gerard

7/18: Began working on article 2

7/22-8/7: Worked on article 2 and sent to Gerard. Decided to request a meeting with Gerard as I am struggling with deciding the content of Article 3.

8/9: Met with Gerard. Discussed content of first article and what changes needed to be made prior to sending it to Penny. We changed the focus of the article to a research article. Discussed what I will write for Article 3.

8/10: Decided to take one of the themes off my data analysis chart as two of them seemed redundant. Emailed the updated chart to Gerard.

8/12-8/14: Worked on correcting article 1. Sent updated version to Gerard for review prior to sending it to Penny.

8/15: Heard from Gerard. He said to send article 1 to Penny.

8/21: Developed outline for article 3 and sent it to Gerard.

8/25: Did not hear back from Gerard as of yet but I decide to go ahead and begin working on my third article.

8/29: Continue to work on Article 3

8/31: Heard from Gerard. He got Penny's feedback re: the first article I sent to her. He plans to put it in the mail so I can review comments. Continued to work on article 3.

9/2-9/19: Continued to work on article 3.

9/19: Sent article 3 to Gerard for review. Requested to meet with Gerard for advice on preparing for defense. Sent clarification re: three articles to Penny.

9/28: Got feedback from Gerard re: Article 3.

10/2-10/6: Revised Article 3 and sent to Gerard. Requested to meet with Gerard again so I can work on defense.

10/7: Gerard responded to email. Plan to meet with him on 10/18.

10/18: Meet with Gerard, discuss revisions for Article 2 and how I need to prepare for defense. We agree on a timeline for revisions and discuss possible dates to present to committee for defense. I send out Meeting Wizard request to committee.

10/22: I finalize date for defense and work on revisions for Article 2.

10/14: I send in revisions to Gerard for Article 2.