SELF-CARE FOR PSYCHOTHERAPISTS IN TRAINING: DEVELOPMENT AND EVALUATION OF A PSYCHO-EDUCATIONAL WORKSHOP ON MANAGING VICARIOUS TRAUMA

Dissertation presented to the Faculty of

The California School of Professional Psychology

Alliant International University

San Francisco

In partial fulfillment of the requirements of the degree of

Doctor of Psychology

By

Dharna Piyoosh Patel

September 2016

Approved by:

Patrick Petti, Ph.D. Chairperson

Michael Connor, Ph.D.

Kathy Trost, Ph.D.

Dedication

To my parents: Nina and Piyoosh Patel, your blessings, love and support navigated me through this rewarding and challenging journey. From afar your words of encouragement and motivation steered me to the finish line.

Acknowledgements

Thank you **Dr. Patrick Petti,** my chair and mentor for your steadfast guidance and direction during this journey. I appreciated your commitment and availability to take me on as your student. Your expertise has been instrumental in my professional growth.

Thank you to **Dr. Mike Connor**, my committee member whose assurances and support kept my confidence going through to the end of this journey.

Thank you to **Dr. Kathy Trost**, my committee member, for your support and consistent encouragement during this journey. Your humor was also timely.

Thank you ALL for believing in me.

To my beloved Ma (Mother) and Papaji (Father), **Nina and Piyoosh Patel,** who showered me with unconditional love and support during this epic journey. I am eternally grateful for everything you have done for me and for the guidance and wisdom you constantly bestow upon me. Oh, and for all those calls and late night laughs. Thank you for continuing to inspire me.

To my loving Kaki (Aunt) and Kaka (Uncle), **Kiran and Kirit Patel** who encouraged me and patiently listened to my stories about this journey and stood steadfast. And to my aunt for those home cooked hot meals when I was "on a roll" in writing.

To my Sister; my Guru; my Friend, **Dr. Sureli Patel,** who showed constant stream of support during this entire journey especially when things seemed insurmountable. Thank you for being steady as a "rock" and for the brainstorming sessions and ideas whenever I called upon you. Oh, and those protein-packed yummy smoothies.

To my Sister, **Mitu Patel**, who kept encouraging me through her positive words and introductions to new songs that energized me to keep writing, and those impromptu nostalgic trips via YouTube watching videos from our childhood.

Thank you **Krishna** for always being there for me

Thank you to ALL my family who supported me emotionally, financially, and spiritually.

I love you.

I want to thank **Dr. Jane Carey-Kahn** for introducing me to the topic of Vicarious Trauma and her support throughout this process.

To all my friends, near and far, thank you for your time, calls, texts, and meet ups for my self-care indulgence. Your awesome escapades let me live vicariously through you. For those that have passed you will always be in my heart. I hear your encouraging words daily.

I want to thank **Jane Austen** for writing such beautiful novels so I could engage in my own self-care.

Last but not least, thank you **San Francisco, Embarcadero**. Those long walks along the waterfront got me pumped up and reenergized where I was able to reflect upon this journey's challenges and many rewards.

Abstract

The purpose of this dissertation was to develop and evaluate a workshop for reducing vicarious trauma and increasing self-care practices for new psychotherapists in training. Twenty participants enrolled in psychology doctoral programs in the Bay Area participated in a 2-hour workshop, designed and conducted by this author, with a follow-up individual interview two weeks later. It was hypothesized that after attending the workshop, participants would gain a better understanding of vicarious trauma and its effects. It was also hypothesized that after attending the workshop, participants' self-care practices would increase, thereby reducing their symptoms of vicarious trauma.

Pre-test and post-test quizzes were administered to the participants before and after the workshop. Three self-report measures (Self care assessment worksheet, STSS [Secondary Trauma Stress Scale], and TSC-40 [Trauma Symptom Checklist-40]) were administered to the participants before the workshop and 2 weeks later during the follow-up meeting. Participants completed the Workshop Evaluation Survey after the workshop and were asked structured interview questions related to self-care practices during the follow-up meeting. Dependent samples *t*-tests were calculated to determine whether symptoms of vicarious trauma were reduced and if participants utilized self-care. A trend toward significant reductions in vicarious trauma symptoms and increases in self-care were found between pre-test and post-test measures. Results were partially consistent for the self-care evaluation worksheet and STSS, however they were non-significant for TSC-40. Qualitative thematic analysis revealed themes that further explored participants' utilization of the self-care workshop and their experience of vicarious trauma. Implications for training and education of psychotherapists-in-training, limitations, and considerations for future research are discussed.

Table of Contents

List of Tables

CHAPTER I

Introduction

"In working with victims of violence, there's a lot of anguish and grief and pain and sorrow, it really affects your own emotional life."

Laurie Anne Pearlman

When psychotherapists work extensively with trauma clients who have been exposed to violence, they are at risk for experiencing vicarious trauma (Jenkins & Baird, 2002; Neumann & Gamble, 1995; Pearlman & Saakvitne, 1995). Vicarious traumatization is defined as "a process of [cognitive] change resulting from [chronic] empathic engagement with trauma survivors" (Pearlman, 1999, p. 52). According to Pearlman and Saakvitne (1995a), when people experience trauma, they find it hard to incorporate the traumatic event into their existing schemata because the information produced by the trauma often runs counter to one's beliefs about the self and the world. This is also true for vicariously experienced trauma. Years of working with trauma clients can alter the meanings, beliefs, affective experiences, and schemas of a therapist, and clinicians may begin to experience aspects of life in a maladaptive manner similar to that of their traumatized clients. In reference to his work with trauma victims, Ochberg (cited in Landau, 2009) noted, "It is not that I am feeling sorry for them and empathize with them, it's that I'm becoming them;" he concluded that almost all individuals working in the mental health field experience vicarious trauma in the course of their careers. Studies have shown that repeated exposure to the trauma client's world can take an emotional toll on psychotherapists (Figley, 1995; Kassam-Adams, 1995; McCann & Pearlman, 1990), and that psychotherapists who work with trauma victims may not be able to maintain a healthy balance between caring for others and caring for themselves (Pearlman & Mac Ian, 1995). This topic has become even more relevant recently due to the increase in trauma victim survivors seeking therapy, and research that indicates

psychotherapists are often not equipped to deal with such clients (Pearlman & Mac Ian, 1995). In addition, Penzar (1984) found that psychotherapists understand the importance of self-care and advocate it to their clients, but may neglect to do the same for themselves. He added that this could occur because psychotherapists become absorbed in providing treatment and support to their trauma clients. Such negligence in taking care of oneself can steer psychotherapists toward isolating behaviors and bad judgment (Porter, 1995).

It appears clear, particularly for new clinicians, that it is important to be educated about the concept of vicarious trauma and its dangers Regarding the American Psychological Association (APA) Ethical Principles of Psychologists and Code of Conduct (2010), taking care of self is implied through Principle A stating; "Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work" (APA, p. 3). More explicitly stated, the Canadian Code of Ethics for Psychologists (2000) underscores the importance self-care and states: "Engage in self-care activities that help to avoid conditions (e.g., burnout, addictions) that could result in impaired judgment and interfere with psychologists' ability to benefit and not harm others" (CPA, p. 17). Hence, as an ethical mandate, graduate programs and practicum sites should inform students about the effects of working in this field, and also provide training in recognizing vicarious traumatization and dealing with its impact through self-care practices.

In addition, psychotherapists need to be equipped with methods to protect themselves against the negative repercussions of vicarious traumatization. Canfield (2005) stated that it is common for a therapist to lose "balance" while working with traumatized clients, so that having a support system and focusing on coping strategies would be helpful (p. 82). The research points to self-care as a highly effective way of responding to vicarious trauma or to situations that would make one vulnerable to it (Figley, 2002; Rothschild & Rand, 2006; Stamm 1999). Self-care is defined as a variety of actions that constitute caring for the self,

relaxing, refreshing, and strengthening the individual to better deal with the demands of a highly taxing work environment (Howlett & Collins, 2014). Incorporating self-care practices into the daily routine is crucial for psychotherapists because it aids with balancing of caring for self and others and may reduce the impacts of working with trauma survivors and listening to client's trauma material. Research has shown that psychotherapists' who make time for self-care live a balanced life (Faunce, 1990; Norcross, 2000). Some prominent modes of self-care are mindfulness/meditation, engaging in spiritual practices, altering the work experience for the better, hobbies, exercise, and eating healthily. By addressing the needs of the self in more than one sphere, self-care can be even more effective in guarding against the destructive effects of vicarious trauma.

Purpose of the study

My personal experience in working with trauma patients in practicum settings inspired this research. In searching for resources for conducting this clinical work, I became more aware of the lack of research and instruction offered on coping with vicarious trauma and utilizing self-care techniques to manage vicarious trauma. Therefore, the purpose of the proposed study is to develop and evaluate an experiential workshop for psychotherapists-in-training; specifically doctoral-level practicum students in clinical psychology. The goal of the workshop is to create an awareness of, and strategies for, reducing vicarious trauma among new psychotherapists in training. Baker (2012) explained that psychotherapists working with traumatized clients are most likely to experience vicarious trauma; therefore, there is an urgent need to introduce vicarious trauma coursework in graduate schools. Baker's study focused on 11 students from a doctoral program who were working with traumatized clients. His study concentrated on understanding how vicarious trauma affected participants, what strategies they used if any, to manage vicarious trauma, and their suggestions for introducing vicarious trauma as a course in graduate programs. His study found participants struggling

with the symptoms of vicarious trauma, such as having difficulty trusting others and struggling with separating their own life experiences from that of their clients and he concluded that there was a need to educate students about vicarious trauma in graduate programs. Therefore, Baker (2012) proposed that further research is required in this area to prevent and/or reduce the effects of vicarious trauma among new psychotherapists. Because there has been minimal focus on vicarious trauma in the graduate curriculum, students are often not aware of the concept. In addition, psychotherapists-in-training are often unaware of the consequences of working with trauma clients, and therefore, they are typically more vulnerable to its effects. Graduate programs have an ethical duty to share with their students the serious effects of working in this field and ways to manage these hazards.

Current Study

My study was conducted in a group setting and utilized the power of peer consultation to expose practicum psychotherapists to information about vicarious trauma and self-care practices. I conducted a two-hour workshop with follow-up interviews for second, third, and fourth year clinical psychology PsyD and PhD students in the Bay Area who engaged in trauma-related clinical work at their practicum sites. The follow-up interviews were scheduled for two weeks after the workshop, so the participants had time to incorporate the self-care activities into their daily routines. I used a pre-test/post-test and phenomenological research design that assessed the following five questions:

1. Would participants gain a better understanding of vicarious traumatization after attending the workshop?
2. Did the workshop help participants increase self-care activities?
3. Did the workshop help reduce symptoms of vicarious trauma?
4. What were the opinions and experiences of participants regarding the use of self-care techniques presented in the workshop?

5. What feedback would participants offer regarding areas of strength, weakness, and ways to improve the workshop?

It was hypothesized that after attending the workshop participants would gain a better understanding of vicarious trauma and its effects. It was also hypothesized that, due to attending the workshop, participants' self-care practices would increase thereby reducing their vicarious trauma symptoms. The goal of this workshop was to assist psychotherapists-in-training in managing and reducing vicarious trauma in order to facilitate their ability to create a healthy balance between caring for others and caring for themselves. Therefore, by providing education on vicarious trauma and self-care, I hoped this workshop would be beneficial for beginning psychotherapists to learn and practice ways to manage and reduce the effects of vicarious trauma, and also continue to incorporate self-care strategies as a life-long career practice.

CHAPTER II

Literature Review

Vicarious Trauma/Traumatization

Defining trauma. *Trauma,* as explained by Saakvitne and Pearlman (1995a), is a dangerous condition experienced by individuals that affects and changes their original beliefs about themselves and the world. The Diagnostic and Statistical Manual of Mental Disorders, 5th ed. (*DSM-5*; American Psychiatric Association, 2013) describes trauma as, "exposure to actual or threatened death, serious injury, or sexual violence" (p. 271). Experiencing repeated trauma or a singular traumatic incident could lead individuals to become emotionally, cognitively, and physically overwhelmed, as well as distrustful of those around them (Giller, 1999).

Defining vicarious trauma. *Vicarious trauma* can be defined as "the transformation that occurs in the inner experience of the therapist [or worker] that comes about as a result of empathic engagement with clients' trauma material" (Pearlman & Saakvitne, 1995a, p. 31). It is a relatively new concept in the clinical literature and is defined in various ways (Trippany, Kress, & Wilcoxon, 2004). One element researchers agree upon is that vicarious trauma produces negative consequences for caregivers, particularly for psychotherapists (Badger, Royse, & Craig, 2008). Vicarious trauma can cause psychotherapists to experience posttraumatic stress (PTSD) symptoms, which cause negative changes in their thinking, affect, physiological experience, and behavior. The *DSM-5* (American Psychiatric Association, 2013) describes PTSD as follows: Criterion A, "exposure to actual or threatened death, serious injury, or sexual violence;" Criterion B, "presence of one (or more) of the intrusion symptoms associated with the traumatic event(s) beginning after the traumatic event(s) occurred;" Criterion C, "persistent avoidance of stimuli associated with the traumatic event(s) beginning after the traumatic event occurred;" Criterion D, "negative alterations in

cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred;" and Criterion E, "Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred" (p. 271). Therefore, trauma negatively affects psychotherapists in many ways, leading to changes in cognition (negative thoughts about self or the world), intrusive thoughts and memories (flashbacks, nightmares), negative affective responses (numbing, feelings of despair and helplessness), physiological changes (hyperarousal), and behavioral changes (avoidance and withdrawal).

Such negative symptoms can be understood in relation to vicarious traumatization as a transfer of trauma from one person to another through empathic engagement. Thus, psychotherapists may come to feel highly vulnerable and distressed by listening to the traumatic experiences of their clients, observing the hurt and negativity in the world. Throughout the literature, the term *secondary trauma stress* is often used interchangeably with the term *vicarious trauma*. This study will use the term *vicarious trauma*, as it appears to better express how the client's feelings and experiences are transferred to the psychotherapist through the process of empathy.

At a conference on attachment throughout the lifespan, Stern (2002) posed the question, *How do we stop experiencing what others feel so that we are not the prisoner of someone else's nervous system all the time?* Rothschild and Rand (2006) explained that Stern's question is connected with empathy, perhaps the most valuable asset to psychotherapists. However, empathy can also be a liability, as feeling someone else's pain and trauma can cause psychotherapists to experience a taxing level of negative emotions. The researchers further reported that psychotherapists often take on too much negative feeling when confronting something unmanageable to the client; this core capability of the successful psychotherapist also puts that individual at risk for vicarious trauma. Rothschild and Rand

(2006) elaborated that when therapists empathize with their clients, they feel their clients' pain and oftentimes unknowingly take on their clients' feelings of sadness, pain, and trauma. In their study, Boscarino, Adams, and Figley (2010) found that therapists who listened repeatedly to traumatic experiences in post 9/11 New York clinics started to re-experience their clients' trauma in the form of flashbacks and nightmares. Not only did this have a profound negative effect on the quality of life for these therapists, it also negatively affected therapeutic rapport, as the clinicians began to avoid their clients. Overall, by treating clients with traumatic experiences, some researchers suggested that clinicians are prone to experiencing vicarious trauma (Dunkley & Whelan, 2006; Iliffe & Steed, 2000).

Psychotherapists are often personally challenged when working with clients struggling with trauma. Listening to these clients on a regular basis and helping them cope with their trauma can cause the therapist to experience similar fears as those of their clients. For example, a psychologist working with abused and traumatized children may be afraid to let her children out of her sight and worry about them even when they are with her husband (Saakvitne & Pearlman 1996). When therapists experience vicarious trauma, they mirror the direct symptoms of trauma through thoughts, emotions, bodily sensations, and intrusive images, and begin to see the world from their client's point of view (Trippany, Kress, & Wilcoxon, 2004). When trauma challenges a psychotherapist's personal belief systems (i.e. schemas), it can create uncertainty and disrupt the therapist's sense of safety as well (Pearlman & Saakvitne, 1995).

Figley (1995) considered the phenomenon of vicarious trauma more generally, including the experience of any caregiver. He stated that caring for a traumatized person may cause the caregiver to become "traumatized by concern" (p. 5). Figley indicated that vicarious trauma can occur any time someone comes into contact with a person dealing with trauma. Psychotherapists may be particularly at risk for vicarious trauma because their mode

of engagement with the traumatized is particularly involved and empathic. Figley (1989) noticed that those who worked with traumatized clients and believed themselves to be "saviors" or "rescuers" were the ones most affected by their traumatized clients (p. 144-145). In addition, Figley (1995) proposed that little research has been done to look into the "cost of caring," which he described as an assault upon one's sense of personal adequacy (p. 7). He explained that caregivers, in response to constant exposure to a victim's trauma, also experience destruction of their own sense of personal agency. For example, a therapist treating a client diagnosed with post-traumatic stress disorder might experience the continual stress of the client's flashbacks and nightmares, as well as unpredictable behaviors arising out of fear and anger. The therapist might feel inadequate to handle such erratic behavior and be at a loss regarding how to care for the client, leading to symptoms of anxiety and/ or depression.

Conceptualization of vicarious trauma. Further understanding of the theoretical framework upon which vicarious trauma is based can help one more effectively recognize and address this phenomenon. Constructivist Self-Development Theory (CSDT) is built on the belief that people create their own truth based on their life experiences (Srdanovic, 2007). When this truth is disturbed by continuous exposure to traumatic information, one's view of the world and sense of self are negatively impacted. Additionally, an individual's unique history also plays an important role in defining how one manages trauma. Pearlman and Saakvitne (1995) described CSDT as the "progressive development of a sense of self and world view in response to life experiences" (p. 151). Therefore, CSDT not only focuses on the manner in which psychotherapists view the world after constant trauma exposure, but also explains how a psychotherapist's history influences the ability to manage vicarious trauma. For example, if a psychotherapist has learned to cope with stressful situations by using avoidance behavior, it is likely that this therapist may engage in similar coping behavior

when working with the client's trauma (Sabo, 2011). Understanding CSDT helps psychotherapists realize how their life stressors interact with the traumatic material they encounter when working with trauma clients.

Trippany, Kress, and Wilcoxon (2004) explained that the alterations to psychotherapists' cognitive schemas caused by vicarious trauma are pervasive (impacting every domain of the therapist's life) and cumulative (each session with the client may strengthen these negative beliefs and schemas). CSDT emphasizes five domains that can be affected through work with trauma clients: frame of reference, self-capacities, ego resources, psychological needs and cognitive schemas, as well as memory and perception (Saakvitne & Pearlman, 1996). *Frame of reference* refers to sense of personal identity, spirituality, worldview, and outlook on relationships. If this framework is disturbed within the therapist due to exposure to trauma work, the therapeutic relationship can suffer because the therapist may not clearly understand the client's perspective. *Self-capacity* is defined as an individual's inner ability to manage intense emotions and maintain self-worth. If this self-worth is damaged because of the effects of vicarious trauma, therapists may not be able to manage negative thoughts, thus causing significant distress in their personal and professional lives. *Ego resources* refer to one's ability to empathize and one's traits of self-awareness, including maintaining boundaries and protecting one's sense of self. When the ego resources are affected, therapists may not be able to set clear boundaries and may overexert themselves while helping their clients. *Psychological needs and cognitive schemas* include an individual's sense of safety, self-esteem, intimacy, control, and need to trust in others. Being intimate was described as "the need to feel connected to oneself and others" (Pearlman & Saakvitne, 1995a, p. 62); however, therapists experiencing vicarious trauma may either isolate or become overly dependent on their loved ones. Due to exposure to vicarious trauma, the intimacy required to develop a trusting therapeutic alliance can be negatively affected, as

the therapist's trust in others is diminished. Low self-esteem may develop and they may feel incapable of helping their clients. Lastly, *memory and perception* refers to the manner in which the client's memories are received by the therapist via words, images, and bodily sensations. Thus, the CSDT model provides a framework for understanding changes in psychotherapists' worldview after constant exposure to their clients' trauma, and an awareness of how trauma permeates every aspect of therapists' lives. This model can also be utilized to inform treatment, as it provides guidelines for managing, reducing, and preventing vicarious trauma.

To recognize and address vicarious trauma, it is important to distinguish it from other stress reactions with similar symptomatology. Chief among these concepts are *countertransference reactions*, *burnou*t, and *compassion fatigue*. If psychotherapists-in-training learn to differentiate the effects of vicarious trauma from countertransference, burnout, and compassion fatigue, not only will they be able to know when they are experiencing vicarious trauma, but they will also be able to distinguish the effects of the other mentioned concepts.

Vicarious trauma compared to countertransference. Throughout the literature, the concept of countertransference has been closely associated with vicarious trauma. These two terms are often confused with each other, and therefore, to retain clarity they will be reviewed to better understand their meaning. Countertransference stems from psychodynamic theory, and is defined as a psychotherapist's emotional reaction to the client (Stamm, 1999). To understand countertransference, one must also be familiar with the term *transference*. According to Rothschild and Rand (2006), transference describes the client's emotional responses to the psychotherapist during therapy; countertransference is the psychotherapist's emotional response to the client. In other words, when the psychotherapist reacts positively or negatively to the clients due to their own emotional conflicts, it is referred to as

countertransference. Freud explained countertransference as the result of an unconscious transferring of the client's emotions and feelings to the psychotherapist during the session (Freud, 1910). Prasko et al. (2010) explained that countertransference can be positive or negative, ranging from admiration, over-protectiveness, or sexual attraction toward the client, to aggressiveness, derogatory thoughts, boredom, annoyance, and misistrustful of the client's motives. For example, Freudenberger and Robbins (1979) stated that when a psychotherapist's "old scars and injuries are constantly rubbed anew," these are unresolved issues coming forth due to their similarity with the client's issues (p. 287). However, not every reaction of the psychotherapist toward the client is described as countertransference. For example, when a client is hostile toward the therapist and the therapist feels anger or fear, this is considered a normal reaction and not countertransference (Rothschild & Rand, 2006). Therefore, failure to recognize countertransference can be harmful to the therapeutic relationship (Pope & Tabachnick, 1993).

McCann and Pearlman (1990) made a distinction between therapists' experience of vicarious trauma and their countertransference reactions. The researchers described countertransference as "the therapist's unresolved or unconscious conflicts or concerns" in their work with any client (p. 134). Vicarious trauma, however, is strictly the result of trauma-related work. The authors wrote that mental health workers who work with clients who have endured traumatic experiences "may experience profound psychological effects, effects that can be disruptive and painful for the helper and can persist for months and years after work with traumatized persons" (p. 133). Likewise, Jenkins and Baird (2003) distinguished between countertransference as the repercussions of the psychotherapists' previous experiences, and vicarious trauma as the outcome of psychotherapists' constant exposure to their clients' trauma. Thus, countertransference can be experienced in any type of

therapeutic situation, but vicarious trauma is solely a consequence of exposure to traumatic material (Figley, 1995).

It is important to note that the experience of vicarious trauma can further trigger countertransference toward the client (Pearlman & Saakvitne, 1995). Indeed, some countertransference reactions can increase and intensify the symptoms of vicarious trauma. Additionally, countertransference is specific to an individual client, whereas vicarious trauma signifies the cumulative effects of engaging in trauma-related work with several clients (Pearlman & Saakvitne, 1995a). Countertransference involves a shift in experience confined only to direct engagement with the client, but vicarious trauma involves an enduring change to the clinician's worldview (Figley, 1999). Stamm (1997) acknowledged that "countertransference applies more to how our patients affect our work with them, vicarious trauma is about how our patients affect our lives, our relationships with ourselves as well as our work" (p. 1).

Vicarious trauma compared to burnout. Another concept contrasted with vicarious trauma is burnout. Researchers have defined burnout as a "feeling of emotional and physical exhaustion coupled with a deep sense of frustration" (Wolfe, 1981, p. 1046); as not making time to take care of oneself in the midst of a heavy workload (Stern, 2002); and as a combination of symptoms not just associated with emotional and physical exhaustion, but also with a feeling of failure (Maslach, 1993). According to Canfield (2005), burnout is not just the result of a large workload, but can also be caused by lack of professional recognition by supervisors, unhealthy working environments, and not having enough peer support. The definition of burnout given by Pines and Aronson (1988) is a state of physical, emotional, and mental exhaustion due to working an emotionally demanding job. There is the possibility of burnout in any profession, but when the job is emotionally challenging, the chances for

burnout are higher. As therapists disregard their own self-care in the process of working with clients, burnout becomes increasingly likely (Figley, 1995; Kahill, 1998; Sexton, 1999).

Kahill (1998) listed five types of burnout symptoms: (a) physical symptoms, which can cause disturbed sleeping, headaches, and even gastric problems; (b) emotional symptoms such as feeling anxious, irritable, depressed, and guilty for not being able to help their clients; (c) behavioral symptoms, such as feeling defensive, increased cynicism, possible substance abuse, feeling pessimistic about everything, and angry toward life; (d) symptoms that affect work performance, such as calling in sick often, feeling tired when at work, and/or eventually leaving the job; and (e) relational symptoms which affect interpersonal communication with family and friends, cause trouble concentrating, and lead to isolating oneself from others. Pines and Aronson (1988) suggested that, along with these symptoms of burnout, one also may experience a reduced sense of personal accomplishment and increased sense of discouragement, especially when psychotherapists do not see any positive changes in their clients' situations. Additionally, research has shown that burnout may cause rigid behavior patterns (Wolfe, 1981); displacement of anger toward the self onto others, especially the client (Kammer, 1978; Mendel, 1979); and conditions such as alcohol addiction and heart disease (Collins, 1977; Maslach, 1976).

These symptoms of burnout may closely mirror those of vicarious trauma, as both conditions negatively affect one's physical, emotional, and mental wellbeing (Arvay & Uhlemann, 1996; Salston & Figley, 2003). Yet Pines and Aronson (1988) explained that vicarious trauma is different than burnout because the negative impact of vicarious trauma comes from contact with the client's experience of trauma itself rather than from the emotionally demanding nature of the job itself. Thus, trauma is not the only reason for burnout, as is the case of vicarious trauma (Kassam-Adams, 1995; Schauben & Frazier,1995). According to Newell and MacNeil (2010), burnout can happen to anyone in any profession,

but vicarious trauma can only occur while caring for others experiencing trauma, pain, and sadness. The two concepts are difficult to disentangle, however, as psychotherapists who struggle with their clients' lack of progress may then overexert themselves to demonstrate their own capability, thus increasing the chance of burnout (Friedman, 1985; Newell & MacNeil, 2010). More specifically, Pearlman and Saakvitne (1995) concluded that "burnout is related to the situation, but does not incorporate the interaction of the situation with the individual that is essential to vicarious traumatization" (p. 153).

Vicarious trauma compared to compassion fatigue. Another concept that is often used interchangeably with vicarious trauma is compassion fatigue. To understand compassion fatigue, it is important to know the meaning of these two words. Compassion is a "feeling of deep sympathy and sorrow for another who is stricken by suffering or misfortune, accompanied by a strong desire to alleviate the pain or remove its cause" (Webster, 1989, p. 229). Fatigue is defined as "weariness from labor or exertions" (Webster, 1989, p. 304). Figley (1995) coined the phrase compassion fatigue as the "natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other – the stress resulting from helping, or wanting to help, a traumatized or suffering person" (p. 7). Adams et al. (2006) and Figley (2002) believed that the capacity of the psychotherapist to deal with a client's suffering and pain is greatly dependent upon the therapeutic relationship: the higher the empathetic response of a psychotherapist toward a client, the stronger the therapeutic relationship, and the greater the therapist's chances of experiencing compassion fatigue. When compassion and empathy towards a specific client starts to become a "burden" one is experiencing compassion fatigue (Figley, 1995, p. 95).

Therapists working with clients who have experienced trauma must find a balance between maintaining an empathic stance and protecting their own psyche from feelings of grief, anger, pain, and sadness (Stern, 2002). Over time, striving to distance themselves from

these emotions may contribute to an overall reduction in compassion toward the client; thus, compassion fatigue. Figley (1995) proposed that professionals involved in trauma work are particularly vulnerable to this phenomenon. When therapists lessen their compassion for their clients in order to protect themselves, they may be left feeling inadequate and wondering whether they are helping their clients at all (Baker, 2012; King & O'Brien, 2011). In turn, the therapeutic relationship may be negatively impacted, and the positive changes fostered during therapy can be inhibited.

It is clear that compassion fatigue and vicarious trauma both affect the therapeutic relationship, but in different ways. Much like countertransference, compassion fatigue can emerge while working with one client, but vicarious trauma typically transpires while caring for multiple clients experiencing trauma, pain, and sadness (Newell & MacNeil, 2010). Typically compassion fatigue manifests as a reduction in empathy toward the struggles of the client, whereas vicarious trauma changes the therapist's outlook on his or her own life. Additionally, Engstrom, Gangsei, and Hernandez (2010) explained that when vicarious trauma and general stress impact psychotherapists, that can also cause compassion fatigue.

Studies distinguishing vicarious trauma from countertransference, compassion fatigue, and burnout. Cutler (1958) examined two therapists in order to study their countertransference reactions. The author found that these therapists displayed avoidant behaviors with their clients during the session because of their own unresolved issues, which were similar to that of their clients. This study suggested that countertransference is a reaction to the client's transference within the therapy setting. Vicarious trauma symptoms, on the other hand, tend to be experienced even after the session has ended. A study by Boscarino, Adams, and Figley (2010) addressed the concepts of vicarious trauma, compassion fatigue, and burnout in a random sample of senior social workers at a clinic in New York City following the 9/11 attacks. Their aim was to differentiate among the three

concepts and to assess frequency of each among mental health workers interacting with traumatized clients. The researchers found that continually listening to accounts of the traumatic incident led these social workers not only to experience their clients' trauma, but also increased their desire to avoid these clients. Thus, the mental health workers appeared to suffer from both vicarious trauma and compassion fatigue.

Boscarino et al. (2010) developed two reliable, validated scales to test their hypothesis that vicarious trauma differs from compassion fatigue and burnout. Compassion fatigue, defined as the reduced interest in being, or capacity to be, empathic toward clients, was measured using a Likert scale. The researchers found that compassion fatigue contributed to job burnout as therapists became emotionally exhausted through their work with traumatized clients. Therefore, the researchers concluded that vicarious trauma, compassion fatigue, and job burnout are overlapping constructs. Their results also showed that working more hours with traumatized patients increased vicarious trauma in the participating therapist, but did not necessarily increase job burnout.

The research indicates that vicarious trauma, countertransference, burnout, and compassion fatigue are different concepts experienced under different circumstances, but they also frequently overlap. For example, frequent work with trauma clients in an unsupportive work environment can cause a therapist to experience burnout and vicarious trauma simultaneously. Therefore, it is very important for therapists to understand the areas in which these symptoms overlap, circumstances in which they are experienced separately, and the factors that can increase or decrease the symptoms.

Risks and resiliency factors related to vicarious trauma. Not every therapist exposed to a client's trauma will experience vicarious trauma in the same manner; some therapists may be more susceptible to their client's traumatic stories than others. Figley (2000) proposed that the level of distress experienced by a therapist engaged with a client's

traumatic material is moderated by risk and resiliency factors. These included the therapist's personal characteristics, the client's trauma characteristics, how the therapist handled the client's trauma, and the context in which therapy took place.

In a study exploring work with trauma clients and its relationship to symptoms of trauma in therapists, Chrestman (1995) found that psychotherapists with higher caseloads of clients dealing with sexual abuse experienced higher levels of dissociation, anxiety, sexual abuse trauma symptoms, and intrusion than those therapists whose caseload did not include clients with such intense trauma histories. An increase in number of trauma clients also increased psychotherapists' frequency of negative safety-related cognitions for themselves and their loved ones. For example, these therapists would not let their children stay away from home, they were vigilant to outside noise, and they checked doors constantly (Chrestman, 1995). Of all negative factors, the most significant was amount of time spent with trauma-related clients. Psychotherapists who had less clinical experience were also found to suffer from vicarious trauma symptoms at a higher level. Yet Chrestman (1995) found that some factors mitigated the severity of vicarious trauma. Professional experience, high income, and additional trauma training were all associated with a decrease in levels of vicarious trauma symptoms. Limitations of this study included the fact that some survey questions were too general and there were no inquiries about specific responses to vicarious trauma. It was suggested by the researchers that more information should be gathered about the temporal relationship between secondary exposure to trauma and psychotherapists' distress.

Pearlman and Mac Ian (1995) wrote that the rise in victims of violent crimes seeking therapeutic services has challenged psychotherapists' expertise and personal resources. According to these researchers, many psychotherapists have effectively treated some victims of violence, but may not be prepared to treat survivors of violent crimes such as childhood

sexual abuse, war, genocide, or rape. The authors set out to study not only the effects of working with victims of trauma, but risk and resiliency factors of therapists engaged in such work as well. The sample consisted of 136 therapists who had worked with trauma survivors for an average of nine-and-a-half years. Participants attended a day-long professional trauma training seminar and were asked such questions as, *How long ago did you begin working with trauma survivors? How many hours of your clinical work (per week) are spent doing trauma work?*, and *How much exposure do you currently have to clients' trauma material?* (Pearlman & Mac Ian, 1995, p. 559). Other variables used in this study included the therapist's personal trauma history, whether they were receiving consultation/supervision or therapy, and various demographic details such as age, income, education, and work setting. The Traumatic Stress Institute Belief Scale (TSIBS; Pearlman & Mac Ian, 1995) was used to measure disrupted cognitive schemas.

The results showed that experienced therapists with a personal trauma history experienced significantly less burnout than those experienced therapists without a personal trauma history. In addition to burnout, therapists in this latter group experienced negative effects to their self-intimacy and esteem (Pearlman & Mac Ian, 1995). Disruptions in self-intimacy represented a disconnect from the therapist's own inner experience, perhaps to disconnect from the pain of the work, and thus, stave off the effects of burnout for a time. According to the researchers, this disconnect could cause lack of awareness of one's countertransference and an increase in compassion fatigue, ultimately detracting from the effectiveness of the therapy.

Other factors that can contribute towards vicarious trauma need to be considered when psychotherapists conduct therapy with their clients. Van der Kolk (1996) designed the Trauma Work Impact Scale (TWIS, 1996) to measure therapists' reactions to length of time treating survivors, total number of survivors treated during therapists' careers, current

caseload with survivors in therapy, exposure to clients' symptoms, and personal trauma history. The results revealed that therapists with a higher caseload of survivors experienced increased concern for the safety of others, female therapists tended to be more concerned for their own safety, and therapists with a personal trauma history experienced difficulties in their personal relationships. The study also found that if therapists received training for trauma work, they experienced less work-related burnout, and fewer negative feelings resulting from listening to trauma material.

Bennett-Baker (1999) focused on general resiliency as a protective factor against vicarious trauma. Five themes emerged from this study: (a) working with clients with trauma leads to vicarious trauma in therapists; (b) after experiencing vicarious trauma, therapists will change personally and professionally; (c) therapists working with traumatized clients will learn about the significance of relationships in life; (d) as therapists gain experience with vicarious trauma, they become more aware of their own reactions and emotions, increasing their ability to self-soothe and empathize with clients; and (e) having a spiritual connection helps a therapist to heal (Bennett-Baker, 1999). The author stated that themes that emerged due to the study were valuable to students studying trauma, seeking to understand vicarious trauma, and working with clients dealing with trauma.

Boscarino et al. (2010) used a stress-process model as a framework to conceptualize vicarious trauma and job burnout. This model supposes that demanding environmental stressors cause modifications in one's neuroendocrine system and hormones, which impact cognitive functioning. In addition to the impact of the amount of time spent with traumatized clients, the researchers found that characteristics of the mental health professionals' personality and attitudes also influenced the development of compassion fatigue, job burnout, and vicarious trauma. The research suggested that having a positive outlook and appropriate coping strategies can be helpful in reducing vicarious trauma. Additionally, the research

indicates that social support is likely to be effective in decreasing vicarious trauma as well; support from co-workers has been found to reduce vicarious trauma, compassion fatigue, and job burnout (Boscarino et al., 2010).

A study by Iliffe and Steele (2000) discussed the impact on therapists of working with clients who have a history of domestic violence. A semi-structured interview offered a forum for open dialogue and provided rich, descriptive data of the lived experience of trauma counselors. Overall, these researchers came to the conclusion that health professionals are not immune to the effects of their clients' traumatic experiences. Feeling an initial loss of confidence in their work was common among the participants. Therapists also admitted to feeling inadequate, powerless, stressed, and anxious in the initial stage of their counseling work. Most of the participants mentioned that they experienced visual imagery of severe violent incidents that clients had shared with them, and they thought these images would stay with them forever. Participants also experienced anger and sadness when working with children who had been abused. There were no findings focusing on a model for providing trauma-specific supervision to therapists, but these researchers found self-care techniques like consulting with coworkers, taking time off from work and travelling, and spending time with children who have had positive experiences can be effective ways to balance the negative experiences encountered by therapists. Iliffe and Steele (2000) pointed out that to reduce or manage the effects of vicarious trauma, therapists in the study utilized varied coping techniques such as taking time off from work, exercising on a regular basis, and maintaining a support group.

Adams and Riggs (2008) conducted an exploratory study of vicarious trauma among psychotherapist trainees in relation to trauma history, experience level, trauma-specific training, and defense style. The researchers found that, when new therapists experience symptoms of vicarious traumatization, they may also experience anxiety, shame, and feelings

of incompetence. The feeling of shame could inhibit new therapists from seeking help in the form of adequate supervision and support. If nothing is done to treat vicarious trauma, therapists may distance themselves emotionally and become less clinically effective. Ultimately, such negative effects can lead to burnout or quitting the field of psychology completely.

Individuals' risk and resiliency factors depend on their coping styles also known as defense mechanisms. These defense mechanisms play a vital role in how vicarious trauma affects a new therapist. According to the American Psychiatric Association (2000), defense mechanisms are defined as "automatic psychological processes that protect the individual against anxiety and from the awareness of internal or external dangers or stressors" (p. 807). Cramer (1998) and Vaillant (1971) delved into this topic and discussed the two types of defense mechanisms. The first type identified was *immature* defense mechanisms, which typically appear during the early childhood stage of development. The individual is often unaware of these mechanisms, which include isolating, splitting, and acting out. The second type identified were the secondary, or *mature*, defense mechanisms, which emerge as one transitions into adulthood. These processes are developed consciously and include rationalization, humor, and sublimation. Such mature defenses are pro-social and sophisticated approaches to the world, and come without much cost to a person's individual functioning. Immature or primitive defenses are more akin to strategies a young child uses to cope with stressors; they involve a greater warping of reality and a greater social cost.

The link between defense styles and therapists' experience of vicarious trauma was explored by Adams and Riggs (2008) in their study. The researchers chose 129 Caucasian clinical and counseling psychology graduate students from the Texas state universities, ranging in age from 22 to 55 years old. This study had two main objectives: (a) to review, inspect, and understand the relationship between vicarious trauma and therapists in training,

and (b) to recognize the relationship between defense style and symptoms of vicarious trauma. Participants were administered the Trauma Symptom Inventory (TSI; Briere, 1995; Briere, Elliot, Harris, & Cotman, 1995) to determine personal trauma history, trauma training, and length of experience working with traumatized clients. The TSI is a self-report measure comprised of 100 items rated on a 4-point Likert scale. Items address frequency of symptoms of trauma over the preceding six-month period and are broken down into the following sections: hyperarousal, intrusive experiences, defensive avoidance, dissociation, and impaired self-reference. The Defense Style Questionnaire (DSQ; Bond et al., 1983; Bond & Wesley, 1996) was also employed, which is broadly used as a self-report measure for defense mechanisms and is broken down according to quality of defense style: maladaptive action, image-distorting, self-sacrificing, and adaptive styles (Adams & Riggs, 2008; Bond, 2004). The researchers defined maladaptive action as impulsivity, displays of passive aggressive behavior, or acting out. Image-distorting style entails idealizing or demonizing the self and/or others. In the self-sacrificing style, one begins to believe over time that he or she has only good qualities such as being kind, selfless, helpful towards others, and not ever reacting in an angry manner. These above-mentioned styles are classified as immature defense mechanisms. The last defense style addressed by the DSQ is adaptive, a mature defense mechanism that entails positive coping skills such as humor and represents a constructive method of coping with anxiety or dysthymia.

The results of the study by Adams and Riggs (2008) revealed that defense styles play a vital role in how vicarious trauma affects a therapist. The results were as follows: Those participants who more often employed the self-sacrificing style of coping had considerably higher scores on all five trauma measures than those participants who utilized an adaptive style. Participants with a self-sacrificing defense style who had experienced personal trauma reported higher levels of symptoms of vicarious trauma than the adaptive group. However,

participants who displayed a self-sacrificing defense style, but had no personal trauma experience, reported few symptoms of vicarious trauma overall. Comparatively, participants with a maladaptive and image-distorting style who had previous personal trauma displayed fewer symptoms of vicarious trauma than those participants with maladaptive and image-distorting styles who did not have any personal trauma. Furthermore, participants who had received significant training on trauma-related work presented with fewer symptoms of dissociation and vicarious trauma than the participants with less trauma- related training.

Adams and Riggs (2008) acknowledged several limitations to their study. The sample size was relatively small and all participants were female, thus limiting the generalizability of the results. Also, therapists who had resolved their personal trauma experiences may have felt more at ease participating in this study than those who had yet to work through their own trauma-related grief. The authors concluded that further research utilizing more refined evaluation tools to assess symptoms of personal and vicarious trauma is necessary in order to sufficiently understand the relationship between these two terms (Adams & Riggs, 2008).

Lastly, the researchers recommended that new therapists should receive education and/or training in working with trauma clients while also maintaining adequate levels of self-care. This recommendation is congruent with previous research suggesting that education about trauma therapy should grant some understanding of the intensity of the work, its psychological effect on clinicians, and the recovery process for both client and therapist (Adams & Riggs, 2008; O'Halloran & O'Halloran, 2001).

Cultural influences on vicarious trauma. There is limited research on how culture influences vicarious trauma. Culture is defined as commonalities amongst a group of people, such as language, religion, way of thinking, and ethnic traditions (Zimmermann, 2015). The client and therapist may have different cultures and levels of exposure to trauma; hence, vicarious trauma can create a cultural crisis in the therapist's psyche. If a therapist's culture

reinforces notions of safety and protection, it may be difficult for that therapist to accommodate his or her worldview to that of their client. This can lead to empathic failure and vicarious trauma. Sharp (2012) stated that it is crucial for psychotherapists to understand and recognize what activates their own trauma so that they are better able to distinguish it from their clients' trauma. Psychotherapists who are generally aware of cultural differences may have the ability to be more present for their clients during therapy.

It is important to consider cultural factors, as exposure to trauma can bring about different reactions in different individuals and coping styles may differ by culture. Therefore, therapist's cultural influences play an important role in how they are affected by, and cope with, trauma and vicarious trauma. Brown (2008) stated, "To work in a culturally competent manner with trauma each psychotherapist must be willing to understand her or his own participation, directly or historically, in the realities of trauma" (p. 13). Culture impacts the way one understands and recognizes the role of cultural practices and how these influence coping strategies (Brown, 2008). It also plays a profound role in one's protective factors against life's challenges. For example, a collectivist culture can be a protective factor, as it provides the individual with a large social support system.

It is crucial for therapists to understand their own cultural identity and the manner in which it intersects with their client's cultural identity. For example, Tummala-Narra (2014) discussed the therapeutic dyad of a non-Indian therapist and an Indian client who had recently immigrated to the United States from India. The therapist was challenged to understand a stressful situation for the client in the context of her family and culture, but this brought up strong negative feelings in the therapist. Both people in the therapeutic dyad have their own cultural identity and it is important for therapists to remember that their own cultural identities may differ from those of their clients. Cultural awareness can be beneficial to the therapeutic process as long as the therapist is aware of cultural biases and consider them in

therapy. Culturally competent therapists stretch their thinking about what trauma means to an individual rather than following the commonly considered trauma symptoms (Brown, 2008). Because cultural influences are so important to people's lived experiences, integrating awareness of culture, race, and ethnicity into trauma-informed therapy is a must for therapists (Jennings, 2007).

Psychotherapists' experiences of vicarious trauma. Vicarious trauma is a concept of emerging importance in clinical psychology. Therapists, like their clients, can experience feelings of helplessness, anxiety, changes in beliefs about the world, numbing and avoidance, all of which has the impact of harming both the therapist and the client who has sought help. Though it is defined in a variety of ways, there is general agreement that vicarious trauma results in negative experiences for the treating psychotherapist, which may, in turn, harm the therapeutic work itself. It also appears that there are factors inherent to the psychotherapist, the client, and the therapeutic relationship that can either lessen or exacerbate the effects of vicarious trauma. Given these facts, psychoeducation addressing the concept of vicarious trauma is an important aspect of the training process for clinicians.

In her article on the effect of trauma work on therapists, Hesse (2002) shared her own experience with vicarious trauma while working as a social worker. From her own observation and experience, the author concluded that students of clinical psychology are not being taught about the very severe and obvious effects one can experience while working with trauma clients. She also argued that many students, faculty members, and agency workers are not familiar with the term vicarious trauma and what it means; that on a wider, systemic level, the concept is not in our awareness as caregivers. The article focused on two important areas of concern: (a) practice considerations, including an awareness of symptoms of vicarious trauma experienced by mental health workers, and (b) preventing the detrimental effects of vicarious trauma on the individual and within an organization. The author made the

argument that it is important to continue the study of vicarious trauma and to increase awareness of this phenomenon in those who work with trauma clients.

Likewise Simond (1997) found that many psychotherapists are unaware of the effects of vicarious traumatization on self and how that affects their experiences with others. The author further argued that psychotherapists must be educated about the hazards of vicarious trauma in order to prevent its occurrence and/or mitigate its effects. In their own study on this phenomenon, Pearlman and Saakvitne (1995) stated that they witnessed some of their fellow psychotherapists leaving the profession due to having lost their peace of mind. The authors concluded that if vicarious trauma is not addressed early, it can result in the psychotherapist abandoning trauma work altogether.

Schauben and Frazier (1995) examined 148 therapists who worked with victims of sexual abuse, most of whom were diagnosed with PTSD. The participants were given questionnaires about the psychological effects of their work with trauma clients. These therapists were found to display symptoms of PTSD and their personal belief systems were shattered. The researchers explained that constantly listening to clients' suffering caused the psychotherapists to feel emotional exhaustion and exhibit symptoms similar to those of their clients. Furthermore, the psychotherapists acknowledged that these clients had difficulty trusting and forming a positive therapeutic alliance. The study revealed that psychotherapists who worked with trauma clients had more distress and vicarious trauma than those who worked with non-trauma clients. Relationships with family and friends were found to suffer as well. The researchers discussed the importance of training therapists to manage their trauma work and vicarious trauma in order to create a sense of balance in their personal life.

Beaton and Murphy (1995) conducted a study on levels of job-related stress in first responders (including police, emergency medical technicians, doctors, nurses, and firefighters). The researchers discussed how these trauma workers are commonly affected by

vicarious trauma and burnout, and how more protection against such phenomena are required. Simond (1997), in his article on vicarious traumatization in therapists treating adult survivors of childhood sexual abuse, expressed that vicarious trauma is considered a relatively new construct and, if no steps are taken to prevent this phenomenon, it can be a significant threat to people working in caregiving fields. The author proposed that listening to clients' trauma eventually affects therapists' cognitive schemas as well as the therapeutic alliance, yet many providers are unaware of this process. Often therapists do not realize that the symptoms of vicarious trauma are related to their work with clients, or that it can be managed or reduced. Simond (1997) asserted that if vicarious trauma is not addressed early, it could result in the therapist leaving clinical work, thus leaving the field poorer for the loss.

Beginning psychotherapists' vulnerability to vicarious trauma. Pearlman and Mac Ian (1995) studied vicarious trauma in a sample of 188 therapists working with trauma clients. Participants were told to complete questionnaires about their familiarity with clients' trauma and their own psychological functioning. The researchers found that new psychotherapists encountered more psychological challenges as measured by the Traumatic Stress Institute Belief Scale (TSIBS) than those psychotherapists with more work experience. They also found that psychotherapists with prior personal trauma exhibited more harmful effects while working with trauma clients than those with no prior personal trauma. The study recommended training related to trauma work, adequate clinical supervision, and also encouraged a support system for new and old trauma therapists.

Studies utilizing new psychotherapists as participants have shown a correlation between trauma exposure and increased symptoms of intrusion, avoidance, dissociation, and sleep disturbance (Chrestman, 1999; Pearlman & Mac Ian, 1995). Conversely, therapists with more professional experience, higher income, reduced workload, additional trauma training, and who spent time participating in non-trauma related activities showed a decreased trauma

symptoms (Chrestman, 1999). Important studies by Bell, Kulkarni, and Dalton (2003) and Canfield (2005) explored evidence that new therapists are more vulnerable to the negative effects of working with traumatized clients. Bell et al. (2003), using data from a previous study by Schauben and Frazier (1995), found therapists with less experience had higher levels of stress when dealing with more traumatized populations than those psychotherapists with more experience. As an explanation, the researchers proposed that beginning therapists have had less time to produce conscious coping strategies against the secondary experience of their clients' trauma. Canfield (2005) noted some of the stigma in the field surrounding therapists' communication of symptoms of vicarious trauma and the tendency for supervisors to blame therapists for becoming upset or overwhelmed. Canfield's (2005) arguments offered credence to new therapists' vulnerability to vicarious trauma, as early training environments may not provide new clinicians with a safe atmosphere in which to explore such experiences.

Managing Vicarious Trauma Through Self-Care

Definitions of self-care. In simple terms, *self-care* means taking care of oneself; however, the field of psychology has sought to define it more exactly in an effort to better study and promote the practice. As a result, there are a variety of definitions of self-care.

Self-care was first introduced in the 1980s by the healthcare industry, with an agenda to help professionals learn to manage their demanding jobs and still be able to live healthy lives (Meinecke, 2010). Gentry (2002) described it as the "ability to refill and refuel oneself in healthy ways" (p. 48). This definition emphasizes the return to a prior state of health after the implied emotional and physical cost of work. For therapists, this could mean managing stress levels and being aware of emotional reactions while working with clients. Remaining aware of one's thoughts and feelings while being empathetic toward the client is considered an important form of self-care (Tartakovsky, 2013), as are the ability to self-regulate while

managing relationships with others, and balancing one's work and personal life (Baker, 2003).

However researchers parse the definition, most psychologists express that self-care should be a top priority among mental health professionals. Figley (1995) explained that because exposure to trauma is part of the job, self-care for therapists is vital. Similarly, Hesse (2002) stated that self-care is of the utmost importance in the prevention of vicarious trauma, and can take the form of taking time off to relax, maintaining healthy eating habits, exercising, or having a hobby. Self-care not only benefits therapists themselves, but also improves the quality of the therapeutic relationship by allowing them to better tolerate the difficulties that come with clinical practice (Linley & Joseph, 2007).

Self-care, however, is not always straightforward, and the best methods are unique to each clinician. According to Meinecke (2010), people want to take care of themselves but are often unsure of how to do so. This author asserted a distinction between self-care and self-indulgence. For example, when people feel exhausted at the end of their workday, they may partake in overeating and/or drinking alcohol beyond their control (Meinecke, 2010). Such activities often suggest themselves to individuals as forms of self-care, but do not serve that function.

The definition of self-care utilized in the current study was offered by Saakvitne and Pearlman (1996). These researchers described the act of taking care of the self as comprised of three main activities: engaging in self-care, nurturing oneself, and escaping from painful emotions. They further explained that all three techniques should be utilized at different times. *Caring for self* is defined as incorporating into one's life healthy ways of living, maintaining relations with family and friends, understanding one's limits, and retaining balance in one's life. *Nurturing* involves treating oneself kindly by emphasizing relaxation and pampering, thereby giving pleasure to the self. *Escape* is the act of shifting focus from

work thoughts toward a pleasant activity. The definition of self-care used in the current study involves all three modes described by Saakvitne and Pearlman (1996).

Importance of self-care for psychotherapists. There is a lot of evidence to suggest that, among mental health professionals, self-care can be used to reduce the deleterious effects of emotional difficulties encountered during clinical work, including the symptoms of vicarious trauma.

Lindley and Joseph (2007) suggested that because psychotherapists need to take care of their own well-being in order to facilitate a positive therapeutic relationship with their clients, they must avoid or reduce those burnout symptoms closely related to vicarious trauma. Pross (2006) agreed that mental health workers are at a great risk of experiencing burnout and vicarious trauma if self-care is not incorporated into their daily lives, as did Radey and Figley (2007).

In her book about secondary trauma stress and self-care issues for clinicians, researchers, and educators, Stamm (1999) cited Figley to explain the vital nature of self-care. Figley described a variety of self-care techniques found to be effective in dealing with vicarious trauma, including attending training activities for trauma therapists; networking with fellow therapists to have a sense of community and support; balancing one's caseload by mixing up trauma and non-trauma clients; engaging in non-clinical activities such as research; minimizing other stressors in life such as physical health, family, and other interpersonal relationships; and job satisfaction.

Meyerson (1998) found that those health care professionals working with clients with chronic illnesses tended to restrict and curb their emotions. Her research suggested that this phenomenon also applies to mental health professionals in general. Grief counselors were found to have even more challenges, such as the re-triggering of the counselor's own current or past losses that have yet to be resolved. In an effort to explore the emotional toll taken on

trauma counselors and to investigate a self-care intervention, Barlow and Phelan (2007) conducted a qualitative study using data from nine audiotaped sessions of grief counselors in a large urban health region. The researchers sought to explore whether peer collaboration could serve as a form of self-care. The results were transcribed based on the participants' style of conversation: whether they supported each other or interrupted each other, how much laughter was incorporated among them, their pauses during certain answers, and their understanding of their own position in the organization throughout their narrative. A central theme that emerged from this study was that staff would benefit from creating space for self-care both within and outside of their work environment. Another theme was the importance of creating an environment of trust in the organization that would allow for more peer collaboration and positivity.

In order to survey the literature on the efficacy of self-care in reducing work-related trauma, Canfield (2005) conducted a meta-analysis, the results of which suggested that health professionals are not immune to the effects of engaging with their clients' traumatic experiences. This study included ten quantitative and four qualitative studies concentrating on vicarious trauma among mental health workers, with particular attention paid to those working in crisis situations. Researchers involved in the various studies measured vicarious trauma, correlations between vicarious trauma and relevant therapist variables, and self-care and other coping skills used to manage vicarious trauma. Canfield (2005) acknowledged that although the qualitative studies utilized smaller groups the data was explored in great detail, and the results from the studies led the participants to realize that they were in fact suffering from vicarious trauma. Participants reported that they had been unaware of that fact until then and that they felt a loss of confidence in their work. They also admitted to feeling inadequate, powerless, stressed, and anxious in the initial stages of their counseling work. Most of the participants also mentioned that visual imagery of severe violent incidents clients had shared

would stay with them forever. Additionally, feelings of anger and sadness were common among many of these participants while working specifically with abused children.

Canfield (2005) found certain self-care techniques were regularly utilized by the psychotherapists, such as debriefing with colleagues, taking vacations, and engaging with healthy children. Despite the wide reach of the study, there were no findings regarding trauma-specific supervision being offered to the psychotherapists. Almost all of the studies included in this meta-analysis indicated that when coping strategies of various types such as affective distancing, regular exercise, or maintaining a support system were used by psychotherapists, the effects of vicarious trauma appeared to be reduced.

Bell et al. (2003) looked at the organizational sector and its relationship to vicarious trauma. The researchers expressed that, although individuals need to engage in self-care by themselves, organizations must also play a central role in prevention of and intervention strategies for vicarious trauma. The authors described the organization's responsibility to support the staff and offered some helpful strategies, such as allowing psychotherapists to take time off and not promote a culture where working overtime is heavily lauded. In addition, organizations can encourage staff to participate in continuing education and to maintain self-care activities. Another strategy described for producing a self-care culture on an organizational level is encouraging a diverse workload in which staff interact with a range of clientele (Bell, Kulkarni, & Dalton, 2003). Community education, outreach programs, and encouraging staff to influence policies can offer hope and empowerment that can itself be revitalizing. Having a team working together to help clients connect with other services, such as self-help groups, physicians, and in-and-out patient hospitalization, can decrease the therapists' workload while helping clients connect with other support services.

The work environment is another important factor in reducing vicarious trauma. Bell et al. (2003) pointed to research demonstrating the detrimental effect that working in high

crime neighborhoods can have on the mental health of staff. The researchers referenced a study by Dalton (2001), which found that, out of a sample of 210 licensed social workers, 57.6% had been threatened by a client or member of a client's family, and 16.6% had been physically or sexually assaulted by a client or a member of the client's family. Bell et al. (2003) noted that given the necessity for mental health services to be provided in dangerous areas, investing in a security system and having security guards on site can increase the safety and mental health of an organization's staff.

Trauma-related education is one of the most important strategies an organization can use to assist therapists, especially new interns, in handling trauma clients (Bell et al., 2003). Reinforcing the importance of self-care among the staff is vital. Allowing therapists to attend workshops on vicarious trauma, having them share their knowledge, and providing support groups in the workplace allow staff the opportunity to discuss situations and offer each other suggestions. Lastly, the authors indicated that supervision is essential to the prevention of vicarious trauma because discussing client-related issues with their supervisors helps therapists to reduce stress (Bell et al., 2003; Welfel, 1998).

Types of self-care. In caring for the self, researchers agree that it is most effective to address multiple areas of one's life and functioning. According to Scott (2014), a wellness coach and health psychologist, life has unexpected challenges and people can handle those situations more effectively if they take care of themselves first. She added that if the body, mind, and soul are functioning well, it is easier to deal with stress, unexpected situations, and trauma. Scott focused on different aspects of the human experience, prioritizing mindfulness/meditation, spirituality, alterations in the professional sphere, exercise, eating healthily, and partaking in hobbies. Research confirms that the above-mentioned self-care methods have proved to minimize the negative effects of vicarious trauma (Bell et al., 2003; Figley & Radey 2007; Hesse 2002).

Mindfulness and meditation. As Sanderson (2012) described, "When you are mindful, you are awake to life on its terms - fully alive to each moment as it arrives, as it is, and as it ends" (p. 3). Kabat-Zinn (1994) explained mindfulness as a way of living in the present and being aware of our current surroundings. Since the introduction of Kabat-Zinn's mindfulness-based stress reduction training in 1979, mindfulness has been incorporated into many therapeutic modalities and used effectively in various settings with a variety of populations (Astin, 1997). Practicing mindfulness on a regular basis has been found to reduce anxiety, depression, and stress, and to assist people in adjusting to new life situations (Astin, 1997; Shapiro, Schwartz, & Bonner, 1998).

Shapiro, Brown, and Biegel (2007) conducted a study with 54 psychology graduate students, in which the researchers taught mindfulness-based stress reduction to the psychotherapists-in-training. The training lasted for 8 weeks and taught different mindfulness methods. The authors used the 15-item Mindful Attention Awareness Scale to measure level of attentiveness, the 20-item Positive and Negative Affective Schedule, the 10-item Perceived Stress Scale to evaluate the participants' stress levels, and the 12-item Rumination Questionnaire. Participants were instructed to keep a diary of their daily mindfulness activities. Results of the study showed that regular engagement in mindfulness exercises was positively correlated with reduction in stress, anxiety, and negative affect, thereby decreasing ruminating thoughts, and increasing positive affect and kindness toward the self.

In addition to reducing stress and fostering a more positive relationship with the self, practices in mindfulness can also assist therapists with their clinical skills. Mindfulness can help develop the nurturing qualities required of a therapist, such as compassion, empathy, insight, and the ability to manage oneself during difficult times (Kristeller & Johnson, 2005; Magid, 2002). Additionally, mindfulness exercises train the mind to stay focused on the present and to be aware of one's current surroundings—skills that can be generally difficult

to master (Germer, 2005; Sanderson, 2010). Sanderson (2010) further explained that mindfulness can be used as a tool to investigate when and why one is feeling a certain way, thus facilitating problem-solving. Furthermore, Christopher and Maris (2010) shared that activities such as meditating and doing yoga involve being mindful, and have been known to produce positive outcomes among counselors; specifically, they have been helpful in preventing vicarious traumatization. Mindfulness activities also promote self-awareness in therapists, which can lead to better attunement with clients' feelings and behaviors (Christopher & Maris, 2010).

Harrison and Westwood (2009) contributed to the growing evidence that psychotherapists who practice mindfulness acquire compassion and patience. The researchers conducted a qualitative study to explore the self-care practices of clinicians who are effective at working with trauma. The participants' chosen were six experienced psychotherapists known to balance their personal and professional lives successfully while working with clients with severe trauma and abuse. These therapists were interviewed to assess how they negotiated the challenges of their work and personal lives, and what self-care methods they utilized to manage vicarious trauma and promote their overall well-being. Participants stated that being mindful helped them be more conscious of their surroundings and breathing, which resulted in their feeling grounded and focused. The participants further shared that they could manage ambiguous situations and not despair during and after intense sessions due to practicing mindfulness. Being optimistic under challenging situations is a quality from which therapists can benefit tremendously, both in their work with clients and in their personal lives. Mindfulness not only helps with staying in the present, but also helps with understanding one's relationships with others and assists in creating healthy boundaries (Harrison & Westwood, 2009). Although the sample utilized was small, the rich data helps build a case for the efficacy of mindfulness, not only in guarding clinicians against the dangers of vicarious

trauma, but also in assisting them to become better clinicians.

Spirituality. Spirituality means "breath" and "air" in Latin (Bloemhard, 2008, p. 22). Rumbold (2006) posited that people begin to connect with their spiritual selves when they start answering questions such as *Who am I?, What is my purpose in life?*, and *Where am I going?*, and to consider their ultimate goals in life (as cited in Bloemhard, 2008, p. 8). Rumbold also asserted a belief that spirituality is connected to one's purpose and potential in life. To understand one's purpose and reason for breathing, he explained, one needs to be aware. Hesse (2002) shared that getting in touch with one's spiritual side helps a person become more self-aware and, according to Baker (2003), being self-aware is an essential aspect of self-care.

Suran and Sheridan (1985) recommended that therapists must find meaning in their work, as this can assist them in coping with vicarious trauma. As therapists attempt to understand their role in helping clients cope effectively with trauma, and also come to realize that not all stories have happy endings, it can be beneficial for therapists to connect with something beyond themselves (Suran & Sheridan, 1985). Howell (2013) conducted a study with 30 participants to understand the gains achieved from spirituality. He found that spiritual awareness was highly associated with optimism, as it gave life purpose and meaning, especially during challenging times. According to Sherfield (n.d.), an esteemed educator, optimism is learned and requires a spiritual framework in which one puts one's fate into the hands of some larger and benevolent force. He acknowledged that a powerful trait of the optimist is perseverance through life's unexpected hurdles and challenges. During their study of 243 psychologists, Medeiros and Prochaska (1988) found that the "optimistic perseverance" technique was very helpful for therapists while working with clients dealing with trauma (p. 113). Therefore, psychotherapists who maintain a positive outlook while working with clients with a trauma and abuse history can be more effective in assisting them.

Brady and Guy (1999) surveyed 1,000 female psychotherapists to investigate the value of managing trauma work by focusing on spirituality as a form of self-care. These researchers explained that when people experience or witness trauma, it is common for them to begin questioning the meaning of this life and their reasons for being alive. The authors found that the therapists who incorporated spirituality into their lives were better able to aid their clients while simultaneously managing their own vicarious trauma.

Howlett and Collins (2014) conducted a qualitative study with 10 volunteers of Indian ethnicity working in crisis situations to learn how they managed self-care to minimize the effects of vicarious trauma. These participants were interviewed and asked to share the impact of their work on their lives and how their support system had influenced them. Half of the volunteer group stated that spirituality was a main part of their self-care practices. Being in touch with their spiritual side helped them learn to "let go" and let God take care of challenging situations (p. 186). Some volunteers shared that their spirituality was composed of meditation twice a day, which helped them separate themselves from the problems in their work and/or personal life. These participants indicated that spirituality helped them realize that they could only try their best, as changing the world is not within their power. The sample, apart from being small, was comprised of a specific ethnicity and therefore it is difficult to generalize the results from this study. Being spiritual does not mean simply understanding why good people must suffer through negative and traumatic experiences in life; rather, it helps people attain a sense of internal calmness and strength (Ellerby, 2014). In other words, looking for support from beyond oneself provides encouragement and helps us manage the unexpected turns in life.

The study by Harrison and Westwood (2009) mentioned in the previous section also explored spirituality and self-care. The participants who utilized spirituality as a form of self-care reported that their faith in something greater than themselves became evident when

faced with the suffering of others. Even as they worked with traumatized clients and witnessed a great deal of pain, these participants realized that spirituality had changed their belief system: they had faith that people are capable of healing, that hope can exist even after trauma is experienced, and that one can learn that there is more to life than simply negative experiences (Harrison & Westwood, 2009).

Alterations in the professional sphere. Figley (1995) explained that because exposure to trauma is part of the psychotherapist's job, self-care must happen within the professional sphere. This author suggested integrating self-care through such professional practices as attending training activities about trauma, networking with fellow therapists to have a sense of community and support, balancing one's caseload with trauma and non-trauma clients, and engaging in non-clinical activities such as research. Pearlman and Saakvitne (1995) also discussed the importance of balancing psychotherapy work with various other work activities to manage vicarious trauma. Congruent with Figley, these authors stated that working with a variety of clients, some of whom are dealing with trauma and others who are non-traumatized, could be beneficial in managing vicarious trauma, as such balance shields the therapist from continuous exposure to trauma work.

Dalton (2001) noted that therapists-in-training should receive more education about self-care and the potential negative effects of working with trauma. New psychotherapists are studying, attending practicum, and balancing their personal lives, thus juggling many roles and dealing with different kinds of stress. However, these psychotherapists-in-training might not have many options in choosing their clients, especially at practicum and internship. Bell et al. (2003) recommended that, in addition to an individual's learning to engage in self-care, organizations focus on ways to manage and prevent vicarious trauma among all staff. The authors emphasized the organizational aspect of self-care, and advised the organization to support the staff by allowing them to take time off, encouraging self-care practices, allotting

time to attend various workshops and modes of community education, creating a healthy and positive working environment by celebrating birthdays and festivities, and most importantly, offering a diverse workload to their staff to balance trauma and non-trauma clientele. Supervision also plays a very important role in the management of vicarious trauma because therapists can discuss their case-related issues with their supervisors, which can release stress and allow them to feel supported (Bell et al., 2003).

Figley (1995) mentioned that professional therapists have a responsibility to their students and trainees to inform them about the job requirements before these students become overwhelmed and leave the field in disillusion. He also stated that including education on stress, burnout, compassion fatigue, and vicarious trauma related to being a therapist would be valuable for the therapists-in-training, as they would become aware of the risks and rewards of this profession early in their careers. Figley (2007) compared self-care to airline rules about first putting the oxygen mask on oneself before helping others put on their masks. In other words, if students and new psychotherapists-in-training learn how to focus on self-care while working at their practicum sites, they will become more effective in helping their clients.

Exercising, eating healthily, and hobbies. In order to cope with and prevent vicarious trauma, many researchers suggest activities that allow for relaxation and renewal (Harrison & Westwood, 2009; Howlett & Collins, 2014; Scott, 2014). Incorporating exercise into one's daily routine, eating healthily, and having a creative hobby are typically suggested as self-care activities for psychotherapists. Barlow and Phelan's (2007) study of grief counselors showed that health care professionals tend to suppress and control their emotions, especially when working with intense cases. Therapists listen to a client's stories and naturally hold the client's pain and various other negative emotions while assisting them. Research shows that when one holds stress within, the body weakens. Therefore, it is important to keep the body

active by exercising, to increase circulation and provide energy (Scott, 2014). Exercise also releases endorphins and keeps one mentally and physically balanced (Scott, 2014).

Tartakovsky (2013) wrote about psychotherapists whose self-care regimen included being active. However, due to the physical exertion, busy schedules, and any number of excuses, it is often difficult for clinicians to follow a consistent exercise routine. Tartakovsky suggested that finding athletic activities one enjoys, such as walking, dancing, swimming, or playing an organized sport, can ensure that a person will adhere to a routine. In addition, doing activities with one's family or playing with a team can make exercise more pleasurable, and scheduling activities into a calendar can ensure one makes time for them during the day.

In Canfield's (2005) meta-analysis incorporating fourteen studies on the phenomenon of vicarious trauma and self-care, results indicated that therapists are clearly vulnerable to vicarious trauma, but also suggested that self-care methods are widely understood to buffer some of these negative effects. Among the self-care methods presented, exercising regularly was favored as an effective way to care for one's physical health and to express negative feelings in a pro-social manner.

Not much research has been done on the importance of a healthy diet as a form of self-care. However, Scott (2014) explored eating habits as part of a cycle of stress that was ultimately deleterious to the body. She explained that cortisol, a hormone secreted in response to stress, tends to bring about cravings for foods that are high in salt, sugar, and fat. Stress can also cause people to skip meals and then consume such unhealthy foods later in the day. Scott described a construct called *emotional eating*; a type of mindless eating brought about by stress, during which one is less aware of food selection or level of fullness. Tending to the way one eats is an effective form of self-care, as it can interrupt this unhealthy cycle.

Other researchers have addressed healthy eating as one behavior that should be incorporated into one's self-care routine. Howlett and Collins (2014) shared findings from their study that participants who focused on different forms of self-care also incorporated eating healthy, exercising, and trying not to isolate from their support system. Harrison and Westwood (2009) looked at combining healthy eating habits, exercise, regular sleep and the incorporation of laughter and humor into life as an effective holistic approach to self-care.

As with healthy eating, there is very little in the research that directly addresses incorporating hobbies as an important form of self-care, although many researchers mentioned hobbies in a list of self-care practices. Figley (1995) more directly emphasized, in addition to taking care of one's physical health, making time to enjoy hobbies. He stated that partaking in a pleasurable hobby can take the therapist's mind off his or her trauma-related work. Additionally, Scott (2014) explained that a hobby can be a diversion from stress, helping one stay in the present moment as the person is absorbed in the enjoyment of that leisure activity. This connects with the escape technique discussed by Saakvitne and Pearlman (1996), wherein if one focuses on a leisure activity, he or she tends to forget worries for that period of time, thus allowing the mind and body to relax and experience some positive moments. Examples of hobbies that often produce an in-the-moment flow state are reading, drawing, listening to music, playing an instrument, and gardening (Scott, 2014).

Support system. When one is affected by vicarious trauma, that individual tends to develop a negative worldview, making socializing challenging and isolation more likely (Pross, 2006). Certainly, vicarious trauma tends to make one view others with fear, and everyday life can become threatening and challenging as observing the good in others becomes difficult. Research shows, however, that having a support system increases one's well-being and quality of life (Figley & Barnes, 2005; Stamm, 1999). Strong support systems can provide guidance to people during challenging times; when one is overwhelmed, the

support of loved ones can bolster a person's ability to cope. Markway (2014) suggested keeping in touch with family and friends, providing support to others, accepting assistance when it is needed, having open lines of communication, and understanding one's boundaries and limitations. If a social network is not already established, one can volunteer, join a club, or attend professional workshops and seminars. Maintaining connections within the community enables a person to experience various emotions, rather than suppressing them and negatively affecting one's mind, body, and soul (Hesse, 2002).

Harrison and Westwood (2009), in their description of many domains of self-care, particularly stressed the importance of avoiding social isolation. For new therapists especially, staying connected with peers can help them realize that they are not the only ones struggling to balance their academic, practicum, and personal life, nor are they the only ones who fall prey to vicarious trauma. Settings such as group supervision can foster the creation of a strong support system (Salteil, 1998). By witnessing the phenomenon among other providers in group settings, therapists can realize and accept the fact that vicarious trauma is not uncommon. This normalization can help clinicians focus on their self-care and eliminate feelings of shame and hopelessness (Hesse, 2002).

Educating beginning therapists about self-care. Many psychologists agree that educating beginning psychotherapists on different types of self-care techniques would prove invaluable for these budding professionals. O'Halloran and O'Halloran (2001) stated that new psychotherapists should receive education and/or training in working with trauma clients and taking care of themselves. According to Saakvitne and Pearlman (1996), who theorized about the relationship between self-care and vicarious trauma, therapists need to understand the importance of different aspects of self-care so they can get the most out of their self-care methods. For example, therapists must emphasize physical, psychological, emotional,

spiritual, and workplace self-care, and not merely pursue self-care methods in one category alone (Saakvitne & Pearlman, 1996).

In addition to the importance of educating new clinicians about a variety of methods of self-care to meet many domains of experience, having variety allows each clinician more choices, making it easier for them to follow their self-care routines. According to Harrison and Westwood (2009), mental health professionals who manage to keep vicarious trauma symptoms under control practice self-care techniques to which they can adhere. These researchers emphasized the importance of selecting methods that are most pleasurable to the individual and suggested the following possibilities: maintaining a positive outlook through humor, keeping boundaries with clients by not overextending themselves, keeping a diverse workload, attending trainings related to vicarious trauma, staying physically active, eating healthily, practicing mindfulness, and not isolating themselves from peers, family, and friends.

Self-care as a strategy for reduction and treatment of vicarious trauma. Psychologists working with trauma clients are vulnerable to vicarious trauma, which involves changes in beliefs and schemas that negatively impact their mental health and functioning (Bloom 2003; Figley, 1995; Pearlman & Saakvitne, 1995). Beginning therapists are highly vulnerable to a degradation in their ability to act therapeutically and may be prone to fatigue and burnout. New therapists are a vitally important group for which to provide training on vicarious trauma and importance of self-care, as they may lack the coping skills and clinical experience necessary to maintain healthy boundaries against the negative effects of clients' trauma. Development of good practices of self-care could be incorporated in the daily routine of beginning psychotherapists in order to foster the integration of such practices throughout their career as psychologists. In addition, new therapists are often fearful in response to their

clients' trauma and are in need of ways to cope with it. Knowledge about vicarious trauma, and effective modes of managing it, can be extremely helpful.

The literature shows a dearth of education on, and intervention for, vicarious trauma. Furthermore, there is little research regarding the impact of self-care on the management and/or reduction of vicarious trauma, as well as whether frequency of self-care changes the intensity of vicarious trauma in the psychotherapist. Therefore, the purpose of the current study is to educate the participants about vicarious trauma and ways to reduce its negative effects through utilization of self-care practices. My study focused on developing and evaluating a psychoeducational workshop for beginning psychotherapists which describes vicarious trauma and its effects, and focuses on common self-care practices that have been identified in the literature as beneficial in the reduction of symptoms of vicarious trauma and effective in creating a balance between caring for others as well as the self.

Summary

Working with clients with trauma can be challenging and can cause therapists or other caregivers to experience vicarious trauma. Vicarious trauma is produced when a person has emotional contact with another who has been traumatized. It can cause individuals to shift to a negative worldview, often affecting their overall health and functioning. Therapists-in-training are particularly vulnerable to vicarious trauma, and experiencing it and its deleterious effects can be disheartening, causing these emerging professionals to leave the clinical practice of mental health. Research states that it is important for therapists to understand the concept of vicarious trauma in order to defend against it.

In addition to learning about vicarious trauma, it is important for new clinicians to learn how to manage and/or prevent it effectively. Research suggests that self-care is the most effective mode of addressing this occupational hazard. Self-care is a concept that is growing in popularity in the field, particularly as therapists are increasingly confronted with victims of

all forms of trauma, including severe and complex cases. Therapists-in-training continue to get little direct training or support around this essential concept; therefore, receiving training in their academic programs and/or at their practicum sites on self-care and how it can aid in managing vicarious trauma would be invaluable to new therapists. Such training would enhance the therapeutic work of these budding professionals, improve patient care, and ultimately save the field from the attrition of highly trained practitioners.

CHAPTER III

Method

Research Design

This workshop was created based on common themes in the literature, including vicarious trauma and its effects; common terms which tend to overlap and are often mistaken for vicarious trauma, such as countertransference, burnout, and compassion fatigue; Constructivist Self Development Theory (CSDT); risks and resiliency factors and how they affect vicarious trauma; symptoms of, and factors contributing to, vicarious trauma; and self-care as a coping skill to manage vicarious trauma.

The purpose of this workshop was to create an awareness of vicarious trauma in new psychotherapists-in-training and to introduce strategies for reducing it, including increasing self-care practices. For this study, a 2-hour workshop was conducted and, two weeks later, a follow-up interview with each participant took place to assess the following: (a) Did participants gain a better understanding of vicarious traumatization after attending the workshop?; (b) Did the workshop help participants increase self-care activities?; (c) Did the workshop help reduce the symptoms of vicarious trauma?; (d) What were the opinions and experiences of participants regarding the use of self-care techniques presented in the workshop?; and (e) What feedback did participants offer regarding areas of strength, weakness, and ways to improve the workshop? It was hypothesized that after attending the workshop, participants would gain a better understanding of vicarious trauma and its effects. It was also hypothesized that due to attending the workshop, participants' self-care practices would increase, thereby reducing their symptoms of vicarious trauma.

The research questions stated above were investigated using a combination of both quantitative and qualitative measures, which included participants' numerical ratings to surveys and open responses to interview questions. Therefore, this study employed a mixed methods research design, which included a pre-test/post-test design and a phenomenological

research design in order to best address the research questions and the data collected. Sieber (1973) recommended the mixed methods design in circumstances in which data is both qualitative and quantitative, and this design has been found to increase the validity of the study (Creswel & Plano, 2007). A pre-test/post-test design was used to understand whether the workshop increased participants' knowledge of vicarious trauma and whether symptoms of vicarious trauma were reduced when self-care activities were increased. This design assisted in determining if there was a significant positive relationship between self-care and vicarious trauma.

Participants

Convenience and homogeneous purposive sampling was used to recruit 20 participants for this study. Convenience sampling consists of participants who are easily available and interested in contributing to the study (Teddlie & Yu, 2007). Homogeneous purposive sampling focuses on particular traits of the participants "based on a specific purpose rather than randomly" (Tashakkori & Teddlie, 2003, p. 713). In this sampling approach, the chosen participants are expected to be able to offer more specific and homogeneous information related to the research questions (Maxwell, 1997).

Participants were graduate students who were working with traumatized clients at their practicum sites. Second, third, and fourth year doctoral students in the PsyD and PhD program from three graduate schools in the Bay area were recruited to participate in this study; first year students do not always engage in one-on-one clinical work. Participants also had to be working currently with at least 5 of the categories that define the parameters of trauma-related work, based on information from the U.S. Department of Justice (Travis, 1997) and on related research (Nelson, 1996). This meant working with clients who had been victims of crime: child molestation and domestic violence, suffering from chronic pain/illness, loss of loved one, and/or survivor of a natural disaster or war. The participants

were not discriminated against based on their ethnicity, gender, socioeconomic status, or age. Participants were given monetary compensation for their time: a $20 gift card to a local grocery store or eatery as per their choice.

Instruments

In order to gather descriptive data of the sample, participants were asked to complete the Demographic Information Form (See Appendix C). This form was self-developed and consisted of 11 questions to obtain information regarding participant's name, age, gender, marital status, ethnicity, and year level in graduate school. The questionnaire also evaluated current practicum experience, including type of patients treated in psychotherapy, how many clients seen in a typical week, how many clients were trauma clients, and what kind of support their practicum site provided for trainees to deal with the stress of working with clients. The participants were also asked if they would like to receive the results of the study; if so, the results would be emailed to them.

In order to investigate the first research question, *Will participants gain a better understanding of vicarious traumatization after attending the workshop?*, participants completed a Pre-test and Post-test Quiz. This quiz was in multiple-choice answer format, incorporating workshop topics (See Appendix D). It was given to the participants before and after the workshop to evaluate whether the workshop helped the participants learn about vicarious trauma and self-care practices. It was expected that participants would answer more questions correctly on the post-test as compared to the pre-test, suggesting that their knowledge in this area would increase as a result of attending the workshop.

In order to investigate the second research question, *Did the workshop help participants increase self-care activities?*, The Self-Care Assessment Worksheet was completed by each participant (See Appendix E). This worksheet was given to the participants before the workshop and at the follow-up meeting two weeks later to examine if

there were any changes in their self-care activities. The results of this questionnaire were used to explore the difference in self-care and whether it increased after the workshop.

The Self-Care Assessment Worksheet was developed by Saakvitne and Pearlman (1996) and is commonly used in self-care workshops to measure self-care activities. Although there is no research on this measure and no standardized method of scoring, this worksheet was created for use with psychotherapists and workers vulnerable to vicarious trauma (e.g., police, firefighters, and crisis workers) to address and improve self-care practices. The assessment worksheet is categorized into six areas of self-care: physical, psychological, emotional, spiritual, workplace or professional, and balance. There is also a section to add other self-care activities that may be relevant to the user in any of the first 5 categories. Each category has questions rated on a 5-point Likert scale: 1 = *It never occurred to me*; 2 = *Never*; 3 = *Rarely*; 4 = *Occasionally*; and 5 = *Frequently*. This worksheet assists in assessing one's self-care practices, understanding one's self-care patterns, and observing and tracking whether there has been an increase or decrease in self-care practices over time. Higher ratings indicate that higher level of self-care was attained. To best understand if self-care was utilized, the total scores for each category were computed and the pre-test and post-test totals of each participant were compared. The sixth area of self-care, balance, is divided into two sections to distinguish between balances within work-life and striving for overall balance between work, family, relationships, play and rest. Scores for this area were calculated as separate categories to determine differences in self-care within the sphere of work as compared to home-life. Therefore, I collected data for seven categories of self-care. The results of this questionnaire were used to evaluate the difference in self-care over time and whether it had increased during posttest.

In order to investigate the third research question, *Did the workshop help reduce symptoms of vicarious trauma?*, participants completed the Secondary Traumatic Stress Scale

(STSS) and the Trauma Symptom Checklist-40 (TSC-40). The STSS (See Appendix F) was administered to participants prior to the workshop and at the follow-up meeting two weeks later in order to observe any changes in vicarious trauma symptoms. The STSS is a self-report measure specifically designed to track trauma symptoms among psychotherapists when working with their clients (Bride, Robinson, Yegidis, & Figley, 2004). The instrument consists of seventeen 5-point Likert scale items: 1 = *Never*; 2 = *Rarely*; 3 = *Occasionally*; 4 = *Often*; and 5 = *Very Often*. This instrument has three subscales that measure symptoms of intrusion, avoidance, and arousal. Scores between 28 and 37 indicate *mild* vicarious trauma, scores between 38 and 43 signify *moderate* vicarious trauma, scores in the range of 44 to 48 suggest *high* vicarious trauma, and scores 49 and above are considered indicative of *severe* vicarious trauma. Cronbach Alphas for this scale demonstrate good internal consistency at .93 and .94, as well as good validity and reliability (Bride et al., 2004). The results of this questionnaire were used to evaluate differences in vicarious trauma over time and whether it had decreased after the workshop.

The Trauma Symptom Checklist-40 (TSC-40) was given to the participants before the workshop and at the follow-up meeting two weeks later to assess any changes in their vicarious trauma symptoms. The TSC-40 (See Appendix G) is a self-report, 40-item checklist which yields a total score as well as individual scores for six subscales: Anxiety, Depression, Dissociation, Sexual Abuse Trauma Index (SATI), Sexual Problems, and Sleep Disturbance (Briere & Runtz, 1989). Each item is scored using a 4-point Likert scale: 0 = *Never* and 3 = *Often* (based on frequency of occurrence within the last month). This measure takes approximately 15 minutes to complete and scoring takes approximately 10 minutes (Briere & Runtz, 1989). This measure is found to be both reliable and valid in measuring the effects of vicarious trauma on psychotherapists and is considered a reliable tool with alphas ranging from .89 and .91 (Briere & Runtz, 1996). The results of this questionnaire were used to

evaluate the difference in vicarious trauma symptoms over time and whether they had decreased after the workshop.

In order to investigate the fourth research question, *What were the opinions and experiences of participants regarding the use of self-care techniques presented in the workshop?*, participants were asked follow-up interview questions (See Appendix I) two weeks following the workshop. These interview questions were developed by this researcher to explore participants' subjective experiences related to self-care practices such as: were the self-care practices incorporated, the frequency of the activities, impact of the workshop on self-care, motivation factors, deterrents if any, their experience of self-care, and their opinion regarding the impact of self-care activities on vicarious trauma.

In order to investigate the fifth research question, *What feedback will participants offer regarding areas of strength, weakness, and ways to improve the workshop?* Participants completed the Workshop Evaluation Survey (See Appendix H) at the end of the workshop. This survey was developed for this workshop based on the course climate survey employed by Alliant International University (AIU) to evaluate student feedback on course curriculum and instructors. Each item was scored using a 5-point Likert scale: 1 = *Not at all* and 5 = *Extremely*. The AIU survey was adapted to fit the content of the workshop with the aim of obtaining general feedback: whether participants found it helpful, whether they learned new information, what they found most useful, what they found least useful, and any suggestions to improve the workshop.

Procedures

After receiving approval from the Institutional Review Board, participants for this study were recruited using convenience and purposive sampling from second, third and fourth year students in the PsyD and PhD clinical psychology programs throughout the Bay Area. Flyers were posted throughout various campuses in the Bay Area and at three of my

practicum sites. Additionally, along with flyers at California School of Professional Psychology (CSPP) at Alliant International University, San Francisco, students who had expressed interest were also contacted via email for participation. The flyer and the email contained the criteria and incentive for participation in the workshop, and the follow-up procedures (See Appendix A).

Before beginning the workshop, participants were asked to sign the informed consent form (See Appendix B). Participants were informed that, during the course of the workshop, if they experienced stress, anxiety, or any trauma-related symptoms, they would be allowed to take a break and join the group later. They were also informed that Dr. Petti, a licensed clinical psychologist, would be available to offer a maximum of 3 consultations free of charge to participants who required assistance. To safeguard their confidentiality, participants were given identification numbers, which were written on their package consisting of the demographic information form, the three questionnaires, the pre-test and post-test quiz, and the interview question form.

The workshop was repeated on four separate occasions in order to accommodate the availability of the participants. The workshops took place within two weeks. The first workshop had 4 participants, the second workshop consisted of 8 participants, the third workshop had 3 participants, and the fourth (final) workshop included 5 participants. The consent form and demographic questionnaire were given at the start of each workshop. The pre-test quiz, which was a quantitative measure, was administered at the start of the workshop and post-test quiz was administered immediately after the workshop. The other three quantitative measures (Self-Care Assessment Worksheet, STSS, and TSC-40) were administered at the beginning of the workshop and during the individual follow-up two weeks after the workshop. The two qualitative measures included the workshop evaluation

survey, which was administered after the workshop, and the interview questions, which were administered during the individual follow-up meeting two weeks post-workshop.

Participants had to submit the signed consent form, demographic questionnaire, the pre-test quiz, and the three questionnaires before the formal introduction of the presenter and the study. Research materials were utilized to formulate the presentation for the workshop. A hard copy of the PowerPoint presentation (See Appendix J) was given to the participants. The workshop covered information on the following main concepts related to this study: vicarious trauma and its effects, countertransference, burnout, compassion fatigue, Constructivist Self Development Theory (CSDT), risks and resiliency factors, and symptoms of and contributing factors to vicarious trauma. Before moving on to the self-care section of the presentation, the group was asked if they had any questions or thoughts on the terms presented. After educating the participants on the importance of self-care and before ending the workshop, mindfulness and breathing exercises were practiced. Participants were then given articles of testimonials from psychotherapists who incorporated self-care successfully. Lastly, participants were given the post-test quiz and the workshop evaluation survey. For a detailed outline of the workshop, see Appendix K.

The follow-up meeting was conducted individually in-person, and lasted between 20 and 25 minutes. The participants completed the three quantitative questionnaires and the qualitative interview questions. The interview questions were audio recorded. All of the participants were compensated for their time with a $20 gift card to a local grocery store or eatery. Participants who requested the results were sent a summary of the study's results by email (See Appendix L).

CHAPTER IV

Results

The research questions were investigated using a combination of both quantitative data analysis of responses to the quiz and four questionnaires, and qualitative analysis of responses to the workshop evaluation and the individual interview on self-care experiences and opinions. This chapter provides a summary of participant demographics, quantitative outcomes from the Pre and Post Quiz, Self-Care Assessment Worksheet, Secondary Trauma Stress Scale, Trauma Symptom Checklist-40, and themes that were drawn from the qualitative analysis of the interview questions during the follow-up meeting and the workshop evaluation survey.

Demographic Information

This workshop included 20 participants who were graduate students working with traumatized clients at their practicum sites. Second, third, and fourth year doctoral students in the PsyD and PhD programs in the Bay area were recruited to participate in this study. The following tables 1-4 include participant's demographic information.

Table 1

Gender of Participants

Gender	*n*	Percentage
Female	16	80%
Male	4	20%

Table 2

Marital Status of Participants

Status	*n*	Percentage
Single	15	75%
Divorced	3	15%
Married	2	10%

Table 3

Ethnicity of Participants

Ethnicity	*n*	Percentage
Asian	7	35%
Caucasian	10	50%
African-American	1	5%
Latino/a	2	10%

Note. Asian: Chinese, Indian, Taiwanese, and Vietnamese.

Table 4

Descriptive Statistics

	Minimum	Maximum	Mean
Age	23	48	30.15
Year in Graduate	2	4	2.75
Clients Per Week	3	12	7.65
Trauma clients Per Week	3	10	5.60

In addition to the above information, two open-ended questions were asked to gather more information. The first question assessed the types of clients seen. Eleven participants reported working with trauma clients in various forms within the community, such as "community violence, assault, physical and sexual abuse, neglect, poverty, complex trauma, post-traumatic stress disorder (PTSD), and bullying" (n = 20; 55.0%). Six participants endorsed working with "low income minority individuals and families, and also elementary and high school settings" (n = 20; 30.0%); one participant mentioned working with clients dealing with grief (n = 20; 5.0%); one participant endorsed working with a "disabled population and behavioral concerns" (n = 20; 5.0%); one participant mentioned working with clients with psychosis (n = 20; 5.0%); three participants reported working with incarcerated clients (n = 20; 15.0%); and three participants stated that they work with adolescents and adults with substance abuse problems (n = 20; 15.0%).

The second question gathered information on the kind of support received at the students' practicum sites. Ten participants reported having "weekly individual and group supervision," but they also added that this was not enough when working with trauma clients (n = 20; 50.0%). Three participants denied receiving any kind of social support (n = 20; 15.0%); two participants mentioned receiving "support from peer groups" (n = 20; 10.0%); two participants shared that they received training on "self-care techniques" at their practicum sites (n = 20; 10.0%); two participants reported having "didactic trainings" but not specifically related to trauma work or self-care (n = 20; 10.0%); one participant received "didactic training on stress reduction and burnout" (n = 20; 5.0%); one participant mentioned getting "didactic training twice a year on self-care" (n = 20; 5.0%); one participant shared receiving "occasional trainings in vicarious trauma" (n = 20; 5.0%); one participant reported having "occasional self-care discussion during grand rounds" (n = 20; 5.0%); one participant reported receiving "self-care workshop once a month" (n = 20; 5.0%); and one participant mentioned getting "time off when needed" (n = 20; 5.0%).

Data Analysis

The current study included a statistical analysis of quantitative data, as well as interpretation of qualitative data. Quantitative data was analyzed using SPSS statistical software. Due to a small sample size (n = 20) and violation of normality in some variables, bootstrapping —a nonparametric statistical analytic procedure—was conducted to regulate the distribution; results are based on 1000 bootstrap samples. Bootstrapping was first applied in 1979 with the assumption that the sample data is treated as if it is the population (Efron, 1979). Descriptive statistics, dependent samples t-tests, and qualitative themes determined whether symptoms of vicarious trauma decreased, self-care increased, and knowledge of vicarious trauma increased due to attending the workshop.

A phenomenological research method was utilized to gain insight into the participants' viewpoint. This approach is employed to identify the participants' perspectives and examine the common themes that emerged among them in order to assist the researcher in interpreting the results (Lester, 1999). In order to analyze the qualitative data, participants' interviews were transcribed verbatim. NVivo software was used to analyze the themes among the experiences and opinions of participants toward self care practices. Transcripts were imported into NVivo and analysis was done using constant comparison method (Leech & Onwuegbuzie, 2007). Passages that shed light on the research questions were highlighted and imported into *nodes,* or codes. Nodes were merged and developed into themes and some nodes were divided into subthemes when multiple participants made similar statements that further explained a broader theme (Creswell, 2009). The qualitative answers captured each participants' experience and provided opinions as to whether attending the vicarious trauma workshop helped the participant understand concepts of vicarious trauma as well as the motivating and deterring factors for practicing self-care. Also, general feedback to improve the workshop was synthesized.

Quantitative Results

Evaluation of parametric assumptions. The assumption of normality was evaluated prior to conducting dependent samples *t*-tests using the bootstrapping technique. Normality was evaluated through consideration of descriptive statistics, visual inspection of score distributions, and computations of normality statistics. The normality assumption was met for most studied variables with the exception of the total score for the STSS (Secondary Trauma Stress Scale) at post-workshop, anxiety at post-workshop, dissociation at pre-workshop, sexual abuse at pre-workshop and post-workshop, sexual problems at pre-workshop, and sleep disturbance at pre-workshop and post-workshop. Due to a small sample size ($N = 20$)

and violation of normality in some variables, bootstrapping was conducted and results are based on 1000 bootstrap samples.

Analyses of means. Descriptive statistics on the continuous study variables and results of the dependent samples *t*-tests are presented in Tables 5 through 8. Because the sample size was small ($N = 20$), the following results should be reviewed with caution.

Hypothesis 1. Hypothesis 1 was based on Research Question 1 and predicted that participants would gain a better understanding of vicarious traumatization after attending the workshop. There was a significant difference between pre-test and post-test scores ($p = .001$) whereby participants reported greater understanding of vicarious traumatization after attending the workshop than they reported at baseline (Table 5). Therefore, results were consistent with Hypothesis 1.

Hypothesis 2. Hypothesis 2, based on Research Question 2, predicted that all factors of self-care would increase after participants attended the workshop. Consistent with Hypothesis 2, participants reported higher means for physical self-care, emotional self-care, psychological self-care, spiritual self-care, work balance, and overall balance (Table 5). Inconsistent with Hypothesis 2, results were non-significant for professional self-care, but there was a trend shown by the data that was in support of the hypothesis ($p = 0.86$).

Table 5

Dependent Samples t tests of Study Variables [VTQ and Self-care factors] and Time

	Time						
	Pre[a]		Post[b]				
Study Variable	*M*	*SD*	*M*	*SD*	*t*	*p*	95% CI
VTQ	6.00	1.52	9.25	1.41	-9.58	.001	[-3.90, -2.60]
Physical Self-care	52.00	6.06	54.70	5.90	-2.68	.015	[-4.79, -0.85]
Psychological Self-care	38.55	7.94	43.60	6.24	-3.55	.011	[-8.00, -2.40]
Emotional Self-care	36.45	6.13	39.25	4.02	-2.58	.031	[-5.15, -0.90]
Spiritual Self-care	48.70	8.38	52.25	8.94	-2.55	.022	[-6.10, -0.75]
Professional Self-care	41.20	7.59	43.05	6.53	-1.84	.086	[-3.75, 0.10]
Work Balance	3.45	.89	4.25	.55	-4.00	.001	[-1.20, -0.40]
Overall Balance	3.60	.75	4.35	.59	-3.68	.001	[-1.15, -0.35]

Note. CI = confidence interval.
p = 0.05
Results are based on 1000 bootstrap samples. VTQ = Vicarious Trauma Quiz.

Hypothesis 3. Hypothesis 3, based on Research Question 3, predicted that all factors and the total score of STSS (Secondary Trauma Stress Scale), and all factors and the total score of TSC-40 (Trauma Symptom Checklist-40), would decrease after participants attended the workshop. Consistent with Hypothesis 3, participants reported lower means for STSS-intrusion, STSS-avoidance, and overall secondary trauma (STSS) after attending the workshop (Table 6). Inconsistent with Hypothesis 3, results were non-significant for STSS-arousal (Table 6) and all subscales and the total score of TSC-40 (Table 7). Therefore, results were partially consistent with Hypothesis 3.

Table 6

Dependent Samples t tests of Study Variables [STSS] and Time

	Time						
	Pre[a]		Post[b]				
Study Variable	*M*	*SD*	*M*	*SD*	*T*	*p*	95% CI
STSSArousal	12.30	3.29	10.95	3.59	1.68	.141	[-0.35, 2.95]
STSSIntrusion	11.90	2.85	9.85	2.74	3.13	.006	[0.80, 3.30]
STSSAvoidance	16.75	4.85	14.25	3.77	4.34	.016	[0.75, 4.30]
STSSTotal	40.95	9.92	35.05	8.45	9.87	.006	[2.30, 9.70]

Note. CI = confidence interval.
p = 0.05
Results are based on 1000 bootstrap samples. STSS = Secondary Trauma Stress Scale.

Table 7

Dependent Samples t tests of Study Variables [TSC-40] and Time

	Time						
	Pre[a]		Post[b]				
Study Variable	*M*	*SD*	*M*	*SD*	*t*	*p*	95% CI
TSC_Anxiety	5.80	3.75	5.60	3.14	0.36	.730	[-0.85, 1.30]
TSC_Depression	6.45	3.36	6.00	2.81	0.63	.553	[-0.95, 1.90]
TSC_Dissociation	4.10	2.79	3.50	3.09	1.29	.217	[-0.25, 1.50]
TSC_SATI	2.80	2.78	2.20	1.99	1.27	.251	[-0.20, 1.60]
TSC_SexualProblems	2.95	4.08	2.35	2.78	1.02	.360	[-0.40, 1.90]
TSC_SleepDisturbance	6.55	3.14	6.10	3.70	0.63	.540	[-0.95, 1.65]
TSC_Total	26.40	12.98	23.55	10.66	1.30	.205	[-1.10, 7.25]

Note. CI = confidence interval.
p = 0.05
Results are based on 1000 bootstrap samples. TSC = Trauma Symptom Checklist-40.
SATI = Sexual Abuse Trauma Index.

Table 8

Difference in STSS scores in Participants

Participants	STSS-Pre	STSS-Post
1	51	44
2	24	27
3	23	34
4	47	42
5	39	41
6	46	44
7	51	45
8	34	19
9	38	41
10	39	34
11	34	40
12	50	35
13	43	30
14	64	47
15	38	20
16	41	25
17	39	31
18	52	38
19	28	25
20	40	40

Note. STSS = Secondary Stress Traumatic Scale.

As per the developers of this scale, scores between 28 and 37 indicated mild vicarious trauma, scores between 38 and 43 signified moderate vicarious trauma, scores in the range of 44 to 48 suggested high vicarious trauma, and scores 49 and above were considered indicative of severe vicarious trauma. Two participants' baseline scores were less than 28; however, during the post-test, one participant's score increased into the mild range. Three participants' scores at baseline were in the mild range, out of which two participants scores decreased significantly during post-test to less than 28; however, one participant's score increased during post-test into the moderate range. Eight participants' scores at baseline were in the moderate range; during post-test, three participants scores decreased into the mild range, two participants' scores decreased significantly below 28, and there was no change in

the range for the remaining three participants. Two participants' scores at baseline were in the high range, out of which one participant decreased to the moderate level and the other remained in the high range. Five participants' scores at baseline were in the severe range, of which three decreased to the high range, one decreased to the moderate range, and one decreased significantly to the mild range. Overall, thirteen participants' scores decreased (n = 20; 65.0%); three participants' scores stayed in the same range (n = 20; 15.0%); three participants' scores increased from baseline (n = 20; 15.0%); and one participant was consistent and stayed below 28 (n = 20; 5.0%).

Workshop Evaluation Survey. The workshop evaluation survey was scored on a Likert scale from 1 (*Not at all*) to 5 (*Extremely*) to indicate whether they learned new information, what they found most useful, what they found least useful, and any suggestions to improve the workshop. Question 11 had the lowest scores (M = 4.30). See Table 9 for mean scores of participants' ratings on the quality of the workshop.

Table 9

Workshop Evaluation Survey

Questions	Mean
1. Were the workshop objectives clearly communicated?	4.75
2. To what extent did the workshop achieve its objectives?	4.65
3. Did you achieve the learning outcomes specified for the workshop?	4.65
4. Was the material on vicarious trauma and self-care presented clearly?	4.70
5. Were materials such as handouts and/or visuals helpful?	4.75
6. Were workshop evaluation techniques (such as tests and surveys), consistent with workshop objectives?	4.85
7. Did the instructor clearly communicate the material of the workshop?	4.75
8. Were workshop discussions and/or exercises effective in helping you learn?	4.75
9. Was the instructor's communication style clear and effective?	4.75
10. To what extent did you learn from this instructor/presenter?	4.65
11. To what extent did this workshop prepare you to work efficiently with trauma clients?	4.30
12. Was the instructor conscientious concerning duties and responsibilities to the class (e.g. preparedness, efficient use of time, being well-organized)?	4.85
13. Did the instructor behave in an appropriate and professional manner?	5.00
14. How would you rate the workshop taking into account the course objectives?	4.80

In addition to the above information, all the participants were asked two open-ended questions to gather more information. The first question was, *Overall, was the workshop helpful? If yes, what was helpful about it? If no, what do you think was not helpful about it?* Participants had to circle yes or no to answer the first part of this question; all participants circled yes (n = 20; 100.0%). Fourteen participants mentioned that definitions and differences between the terms vicarious trauma, countertransference, compassion fatigue, and burnout were very helpful (n = 20; 70.0%). Five participants added that vignette examples of vicarious trauma, countertransference, compassion fatigue, and burnout were helpful to differentiate the terms (n = 20; 25.0%).

The second question inquired, *What is your feedback for improvements or changes in the workshop?* Four participants mentioned the need for more group participation and interaction (n = 20; 20.0%); three participants stated the need for examples and handouts of the vignettes shared during the presentation (n = 20; 15.0%); and one participant said interactive activities and video clips would have been helpful (n = 20; 5.0%).

Qualitative Results

Research question 4 utilized a structured interview and asked each participant if they incorporated self-care practices, types of self-care used, frequency and their motivation for self-care, was there any structure or more spontaneous, their opinions and experiences regarding practicing self-care, most important self-care activity, the impact of self-care on vicarious trauma if any, what prevented them from engaging in self-care, will they continue practicing self-care, and their recommendations of self-care practices for psychotherapists-in-training. Participants' responses were categorized into the following themes that represented the workshop's impact on self-care: awareness, increase in self-care, type of self-care, current frequency of self-care, obstacles to self-care, impact of self-care, goals for self-care, and what

sustains motivation to practice self-care. Table 10 and 11 presents the themes for the interview responses of this study.

Table 10

Awareness, Increase in Self-Care, Types of self-care: Subthemes, Number of Participants, and Representative Quotes

Theme	Subtheme	Number of participants	Representative quotes
1. Awareness			
	Awareness due to workshop	10	P1: Trying to be more aware of how I am feeling and how to take care of myself better.
		6	P20: Because I did the workshop I was more attuned.
	Awareness of burnout due to workshop	7	P16: I was noticing that I wasn't really giving it a lot of importance and attention and I was giving all my energy to practicum and school and I was starting to feel burned out."
2. Increase in self-care		17	P17: I have started a mindfulness practice every day.
3. Types of self-care		7	
	Being in nature	5	P7: being in the nature yesterday, I don't know but I am realizing more and more that I like getting outside. I like being in the quiet nature spot even thought it was a tourist area I went to, it was just quiet and peaceful and lot of green
	Being with people	3	P12: ' It was just good to sit and just relax and be social and get to know others and see how everybody else is doing cause we are all going through the same kinda stuff.
	Meditation	7	P17: meditation, it really centered me, grounded me, really helped me to kind of slow down and separate the days
	Healthy eating	5	P5: I started eating a little healthier.
	Sleep	4	P6: after the workshop I have been focused more on getting more sleep especially with the practicum applications all going on, so definitely getting more sleep
	Stretching	3	P8: I did the 30 seconds relaxation and it worked wonderfully I felt so rejuvenated I felt that I was myself again
	Other types of self-care	9	P13: I have been coloring a lot more."
	Most effective	11	P9: I like what you introduced like the 30 seconds meditation."

Table 11

Current Frequency of Self-Care, Obstacles to Self-care, Impact of Self-Care:Subthemes, Number of Participants, and Representative Quotes

Theme	Subtheme	Number of participants	Representative quotes
4. Current frequency of self-care		11	P4: The journaling and meditating was every day and then going to the gym a few times a week.
5. Obstacles to self-care		17	P17: I have started a mindfulness practice every day.
	It takes time	15	P10 stated, "I have really been struggling with managing my own time."
	Feeling guilty because of the time	9	P14: "Just the time needing to be productive and the guilt of not having things done already, so there's really no time for self-care
	Too much work to do	7	P13: I just really easily get caught up in trying to finish everything else before taking care of myself
	Exhausted	2	P1: I don't feel like it 'cause I am tired.
6. Impact of self-care			
	Feels good	14	P12: I think it was a good experience. It felt good to just finally not feel guilty about doing something that's good for me
	Can work more effectively	3	P19: So it gives room for me to be excited about what I am doing as supposed to just getting through them, so and I find that when I am doing tasks I have the energy
	Positive impact on vicarious trauma	9	P2: I do think it impacts–it's kind of grounding. You are prioritizing yourself, it kind of detracts from a flight fright response
	More mindful of impact of trauma on self	4	P20: So it's really kinda hard to correlate the two I would say but I think just having the time to like reflect on what you have done to self-care that maybe opens the window to realize how much you are being affected by vicarious trauma
7. Goals for self-care		7	P11: Try to do it every day so–at least something every day
8. What sustains motivation to do self-care		8	P19: , I saw that I was able to attend to my work and actually better especially with clients like way better, I was like, oh! This is actually working really well.

Ten participants mentioned that being aware of how they were feeling was the first step after the workshop (n = 20; 50.0%); six participants stated that the increased awareness was due to

the workshop (*n* = 20; 30.0%); and seven participants said the information given on various concepts at the workshop brought awareness of burnout they were experiencing (*n* = 20; 35.0%). Participants endorsed incorporating various types of self-care practices after the workshop: five participants enjoyed being in nature (*n* = 20; 25.0%); three participants liked spending time with people (*n* = 20; 25.0%); seven participants introduced meditation in their weekly routine (*n* = 20; 35.0%); five participants were motivated to eat healthy (*n* = 20; 25.0%); four participants focused on getting enough sleep (*n* = 20; 20.0%); three participants included stretching exercise in their routine (*n* = 20; 15.0%); nine participants said they incorporated other types of self-care such as coloring, reading, watching movies (*n* = 20; 45.0%); and eleven participants stated that the 30 second meditation/stretching introduced in the workshop was very effective.

Eleven participants shared an increase in the frequency of self-care in their weekly schedule (*n* = 20; 55.0%). Seventeen participants stated that the obstacles to self-care included not having the time, feeling guilty when taking time to do self-care, too much work to perform, and feeling too exhausted to practice self-care (*n* = 20; 85.0%). Fourteen participants shared that that they felt good when they engaged in self-care (*n* = 20; 70.0%); three participants noticed that they worked more effectively when they practiced self-care (*n* = 20; 15.0%); nine participants stated understanding how self-care positively impacts vicarious trauma symptoms (*n* = 20; 45.0%); and four participants mentioned they became more mindful of the trauma effects on themselves (*n* = 20; 20.0%). Seven participants said their goal for self-care was to try doing something every day (*n* = 20; 35.0%). Eight participants mentioned that experiencing how they felt after practicing self-care motivated them to schedule self-care into their daily routine (*n* = 20; 40.0%).

CHAPTER V

Discussion

The aim of the study was to develop and evaluate an experiential workshop for psychotherapists-in-training, specifically doctoral-level practicum students in clinical psychology. The goal of the workshop was to create an awareness of, and strategies for reducing, vicarious trauma among new psychotherapists-in-training by increasing self-care practices. Research indicated that there has been minimal focus on vicarious trauma in the graduate curriculum and at training sites; hence, students are often unaware of the concept of vicarious trauma and the importance of self-care. In addition, psychotherapists-in-training are often unaware of the consequences of working with trauma clients and, therefore, they are typically more vulnerable to the effects of vicarious trauma.

This study employed a workshop setting to expose psychotherapists-in-training to information about vicarious trauma and self-care practices. Four 2-hour workshops were conducted with follow-up interviews scheduled two weeks after the workshop for second, third, and fourth year clinical psychology PsyD and PhD students in the Bay Area who are engaged in trauma-related clinical work at their practicum sites. This chapter will discuss the findings in this study, and focus on implications, limitations, and recommendations for further study.

Key Findings

The research questions, which were used to navigate this study, will be crucial in understanding the findings of the study. Findings will be summarized by looking at each of the research questions and the hypothesis associated with it.

Research question 1. *Will participants gain a better understanding of vicarious traumatization after attending the workshop?* It was hypothesized that after attending the workshop, participants would gain a better understanding of vicarious trauma and its effects.

Results supported this hypothesis. Participants reported greater understanding of vicarious traumatization after attending the workshop and this was demonstrated by an increase in 19 participants' scores from pre-test to post-test (n = 20; 95.0%). One participant maintained the same score during pre-test and post-test (n = 20; 5.0%). It appears that participants seemed open to knowing about vicarious trauma, its consequences, and ways to manage it. Hence, reminders in the form of monthly workshops, meetings, or didactic training in this area would benefit graduate students.

Research question 2. *Did the workshop help participants increase self-care activities?* It was hypothesized that, due to attending the workshop, participants' self-care practices would increase, as they would better understand the importance of self-care while working with trauma clients. Results partially supported this hypothesis. Although participants were motivated to integrate self-care into their weekly routine and had increased self-care in physical, psychological, emotional, spiritual, work balance, and overall balance, they still struggled with managing professional self-care (e.g., taking breaks during the workday, having a balanced caseload, negotiating needs, and setting limits with clients and co-workers). In their role as practicum trainees, students do not have much control over their caseloads, and being evaluated by their supervisors may make them nervous to negotiate for their emotional needs. Also, graduate students typically have demanding school schedules full of due dates and deadlines for readings, assignments, projects, and papers. Therefore, for psychotherapists-in-training, professional self-care must include a balance between being a student and being a practicum trainee. Based on the results of professional self-care it was evident that participants struggled with professional self-care the most, thereby confirming the need for graduate programs and training sites to introduce and incorporate self-care into their curriculum and trainings. If graduate programs follow the ethical mandate of educating their students the consequences of vicarious trauma and ways to manage it by incorporating it

into their Ethics class coursework then they would be committing to the welfare of their students. Also, neglecting self-care can impair clinicians' competence, which goes against the Ethics Code. Graduate school program could easily incorporate this concept into their ethics coursework.

Research question 3. *Did the workshop help reduce symptoms of vicarious trauma?* It was hypothesized that, due to attending the workshop, participants' vicarious trauma symptoms would be reduced as they learned better ways to take care of themselves while working with clients with trauma. Results partially supported this hypothesis. As self-care activities increased, symptoms of vicarious trauma reduced in the following subscales: STSS-intrusion, STSS-avoidance, and overall secondary trauma (STSS); however, STSS-arousal scores had increased by the post-meeting. Most students reported having anxiety and stress about their mid-semester deadlines and practicum application due dates. This may have affected the arousal scores, as one of the questions was related to getting adequate sleep. Although most participants scored lower in their overall STSS, three participants reported having an intense two weeks after the workshop due to negative physical health and acquiring challenging clients. This suggests that students are vulnerable to many environmental factors, which plays a major role in managing their symptoms of vicarious trauma and practicing self-care. Even though their vicarious trauma symptoms had increased, students still managed to keep them in the same range as they were during pre-test, which may be attributed to the self-care activities they practiced. It can also be speculated that psychotherapists-in-training who are new to the field and also juggling many responsibilities (such as being a student and a practicum trainee) may not fully realize the consequences of doing trauma work and may neglect engaging in self-care to manage vicarious trauma**.**

Also, TSC-40 subscale scores on dissociation, anxiety, depression, sexual abuse trauma (SATI), sleep disturbance, sexual problems, and overall scores during the post-

meeting were inconsistent. Because TSC-40 had subscales, which involved questions related to dissociation, sexual trauma, and/or sexual problems, it is assumed that participants may have been less forthcoming about these issues.

As noted previously, perhaps TSC-40 scores were higher during post-test because some participants shared that their anxiety and stress level was high as they were approaching mid-semester, which meant looming deadlines for assignments and projects. They also added that practicum and internship applications were due in a couple weeks, which was causing additional stress and anxiety. As TSC-40 also measures anxiety and sleep disturbance, the participants may have responded to questions related to anxiety, restlessness, and sleep disturbance based on their current status. This suggests that, even though participants had incorporated self-care practices into their weekly routines, they were still vulnerable to other stressors.

Research question 4. *What were the opinions and experiences of participants regarding the use of self-care techniques presented in the workshop?* This was a structured interview, as the focus was to gather qualitative data in order to understand whether participants utilized the knowledge gained from the workshop during the two-week period prior to the post-workshop interview.

Themes: Impact of workshop on self-care. Themes that emerged due to impact of workshop on self-care were awareness, increase in self-care, type of self-care, current frequency of self-care, obstacles to self-care, impact of self-care, goals for self-care, and what sustains the motivation to practice self-care. Participants stated that being aware of the need to engage in self-care was critical to engaging in it. It seemed to be the first step in motivating them to do it in spite of barriers, such as the time it takes to engage in self-care and the amount of schoolwork they had to do. For these reasons, for many, engaging in self-care was initially a struggle; however, once they began to do it, they felt good, and continued on. Some

stated that the goal was to integrate it into their lives, feeling that structure would help them sustain it.

Awareness. During the workshop, participants were reminded of the need for self-care due to the potential for vicarious trauma as an effect of working with trauma clients. Participants indicated that awareness seemed to be the first step to actually practicing self-care more regularly. There were two subthemes to this theme: awareness due to workshop and awareness of burnout due to workshop.

Awareness due to workshop. Ten participants mentioned awareness, reflection, or the process of thinking about or noticing the need for self-care due to attending the workshop. These thoughts appeared to motivate participants to engage in new behaviors. Their statements indicated that awareness of the need to perform self-care, even though it was a struggle, seemed to be the first step in doing it. P1 stated, "So I became mindful of it every day. Sometimes I still didn't feel like doing it even though I know I should." P1 added, "I was more mindful of it, but I definitely engaged more than I usually would." P11 mentioned that self-care helped her "realize and reset self-control and distance from the drama." P12 shared a change in awareness or mindset helped her to do more self-care, "I wasn't doing any kind of self-care then, so it was really hard . . . I was noticing that there was something I had to change . . . because I was like, I don't really feel this way, but [then] why am I feeling like that?" P12 added the following:

> So I think what motivated me to engage in self-care was the way I conceptualized it in my head—it's not something like that I have to do, like you have to do your homework, you have to study for class.

P13 stated, "I realized that I need to pay attention to myself and like take care of myself" after noticing and feeling "myself really bogged down and loaded with stress." It also seemed to be important to keep in mind that oneself is a priority. P13 added, "I think just

losing sight of the idea that I am important as well." P14 stated, "I am becoming more in touch with the need for it, so it's likely" that P14 will continue to engage in self-care. P14 added, "When they are brought to your awareness over and over again you kind of have to face it." P18 stated that the awareness of the need to do self-care finally hit home:

> I really think it is really important. The first year I did a practicum I didn't really understand what self-care was. I didn't really take a lot of time for that and so in my second year I am really cautious and aware of it.

P18 went on to say, "It was kind of like a more active choice, it's kind of like, oh I have been watching re-runs of *Friends* and Netflix for a little while and maybe I should read a book or something like that, it's a little bit more engaging, kind of a more awareness of" it. P19 stated, "It took a little while to figure it out and I was not aware of self-care in my first or second year." P20 stated the following:

> I think I was just really trying to be reflective to what I wanted to do, you know? Like for instance, the other day I had plans but had a couple minutes and instead of worrying about my work or my clients, I just picked up a book and started reading it.

P7 shared, "to be mindful of that, like, without taking care of ourselves we may not be as effective with the client." P9 stated, she came to an awareness that "I was answering the questions last time they were really bothering me, and I was being honest and not having time for me." P11 said she was motivated by awareness that she needed it. When asked, *What motivated you to engage in self-care?* P11 stated, "Feeling bad knowing that I needed self-care."

Graduate programs usually focus on academic coursework and equip students with the theoretical knowledge required to be able to work with various clients to help them better their circumstances. In this process, however, students' well-being is often neglected. Based on participants' statements and comments, it is evident that constant reminders of the effects

of vicarious trauma and the importance of self-care during graduate school would be advantageous to the students. Students lead busy lives and reminders for self-care or introducing different ways to practice self-care might make them more likely to participate in self-care activities and, consequently, improve their clinical work.

Although it seems likely that all participants in this theme were made aware of the need to do self-care because of the workshop, the following six participants specifically referenced the workshop in their responses. P1 stated, "I think we need the reminders because I always forget. So the lecture did help me to be more mindful at least in the last two weeks." P10 mentioned, "I forget self-care; a lot the workshop kind of reminded me that there were different ways my clients could be impacting my emotional life." P8 shared, "I just realized during the session that a lot of things that we spoke about during the workshop we had was happening to me, and I realized that I had to stop it there. So immediately after her I had a client and I did the 30 seconds relaxation and it worked." P20 said, "Perhaps maybe because I did the workshop I was more attuned." P18 stated the following:

> I think it was the opportunity to read and the workshop kind of got me motivated, like oh yeah, I really need to start taking time away 'cause I don't really have a lot of the other things that were on the list, like oh yeah that!

Although P12 did not specifically mention awareness, it is evident in the response that the workshop brought awareness to the need for self-care:

> So we did have a training similar to yours, but I didn't incorporate [it] then because, again, the supervisor was like, this is something that you need to do and practice, and this is what it is, and I felt like it was just unrealistic for me to do [it before].

P12 went on to say practicing self-care now had come to seem more practical.

Participants appeared to be more attuned to their behavior and reactions during their daily routine as evidenced by their statements that the workshop equipped them with the tools

to do so. They were able to notice the changes in their thought processes after therapy sessions and also realized that they did not prioritize self-care often. Participants' statements indicated the need for increased awareness of self-care practices to help students consciously take care of themselves and understand their own needs. If graduate programs were to introduce students to terms such as compassion fatigue, burnout, and vicarious trauma early in the program, students would be better able to recognize these symptoms. Guiding new psychotherapists-in-training in practicing self-care and offering them suggestions for creative ways to lead a balanced life, especially when in graduate school, would be beneficial to the students' overall well-being.

Awareness of burnout due to workshop. The following seven participants specifically mentioned being aware of the need to practice self-care due to being made aware of burnout during the workshop. P16 stated, "Well I was noticing that I wasn't really giving it a lot of importance and attention and I was giving all my energy to practicum and school and I was starting to feel burnt out." P1 said, "if you notice that you are overworking yourself and you are burned out, then you should take a step back. And if you really need to be doing everything that you are doing." P18 also said, "burn-out and compassion fatigue; it's like I really need to be doing this before I get to a point where I need to take a week off for self-care or something like that, like a more preventative measure." P5 stated, "I guess after the workshop I would categorize myself in the burnt out phase so…" Like Participant 5, many others specifically said the workshop brought awareness to this need. P17 mentioned, "Like I said, it's been a really stressful time because of internship apps and all, and school and practicum so this workshop was a good reminder to do self-care."

P6 stated:

> After the workshop, just bringing all that to mind the potential risk of vicarious trauma working with the population that I do and about compassion fatigue and burnout—all those things just started making me feel more like this is a priority."

P6 said the following:

> Gosh, engaging in the reflecting practice of noticing of how, when you are outside of practicum, your clients' experiences [and] stories might be impacting your perspective of the world, and when you talked about that in the workshop, how that changes your world.

P8 made a similar statement:

> I should say probably the workshop, as I just realized that I was at the burnout stage, and I needed to. It was like okay now, awaken. It was that moment where I realized, if not now, never. And then it's going to be a point of no return.

It is evident from participants' statements that learning about the similarities and differences between the various concepts of burnout, compassion fatigue, and vicarious trauma made them more aware of the ways in which their clients were affecting their lives. It appears they were better able to distinguish the signs of burnout versus vicarious trauma and, therefore, able to tend to it. Through answering the surveys and questionnaires, the participants realized the symptoms they were experiencing, which also made them realize the seriousness of the matter and the need for self-care.

Increase in self-care. Participants were obviously motivated to practice self-care after the workshop. Only three stated that they were doing what they had been doing before the workshop. Their answers were as follows: P15 stated, "I usually go out with friends so yeah, just the usual stuff I normally do." P4 stated, "Yes, but did not add anything after the workshop, just the same. P2 responded by saying that self-care was always a part of the routine. The following are the other participants' responses of their increases in self-care

post-workshop. P10 mentioned, “I have been putting off getting a dog and I finally got a dog.”

P12 stated:

> I went to a concert with my sister and her friends and it was during the week, and usually I am like I can’t go anywhere because I have school and I need to go to school and that’s all it is Monday through Friday–Can’t have any outside contact but I got out.”

P12 added, “I would say that it was at least twice a week that I tried to incorporate it. The biggest tool was the social piece.” P14 stated, “I started coloring more often, like making time and space to do that. I also took a day off completely from everything, which was really helpful to kind of like, recharge.”

P16 said:

> So I made more of an effort to spend more time with my parents. . . so I gave myself an hour to. . . they like watching movies at night so I watched movies with them, and I made more of an effort to fit exercise into my schedule.

P17 mentioned:

> I have started a mindfulness practice every day. I started it 4 days ago, and I have been doing it 10 minutes every day. Besides mindfulness, it’s been a really stressful time because of internship apps so it’s kind of an odd time in my life, but in terms of self-care I really did make sure to get enough sleep when I could.”

P18 stated:

> I started reading more for leisure so, no psychology related books . . . very relaxing and a nice little break . . . I tried to read every day for at least 10 minutes. I had a trip planned, a one-day trip and then I guess I have been trying to cook more. Cooking is

also something that I also find is really self-care for me. So yeah, I have been trying to do that more often."

P19 said, "I have been doing this [running] for a long time but last few weeks I have been doing exploratory running." P20 stated, "Maybe not really purposely but I really did have a couple of good weekends in between, since the workshop." P5 stated, "I probably engaged a lot more than I usually do. . .I tried to exercise a little bit more."

P7 stated:

> I have been trying to eat better and I have gone to the gym a little bit more. I have taken time out to do things I enjoy like going for a walk, or trying to be in nature more, trying to take more breaks.

P7 added, "Maybe six to seven times compared to before, which was less, maybe a couple times." P9 stated, "I went to [get] a massage a couple days after the workshop."

P1 shared:

> I usually never cook and I usually never stretch. I started cooking more at home so in the last week I have already cooked three meals at home instead of eating out which is what I usually do. So doing stretching every 2 days and cooking three times a week is way more than I ever would have done.

P9 talked about doing more hiking:

> Hiking was more. I usually go hiking only once in a while you know like . . . I tend to be more of a spectator, you know, watching the kids do sports but I tried to get outside more myself so that was good. I have been hiking since the last two weekends so that.

The need to take care of themselves so that they would be better able to take care of others was apparent after the workshop. Overall, participants reported having increased their self-care practices after the workshop. Some shared increasing the self-care activities they

were already doing, and some mentioned introducing a new self-care activity into their routine. Some participants mentioned doing fun things during the week to change up their weekly routine.

Types of self-care. There was a variety of ways participants engaged in self-care. The most frequent activities formed the following subthemes: meditation, being in nature, being with people, healthy eating, and sleep. Other types of self-care included running, hiking, biking, walking with a dog, reading for pleasure, therapy, listening to music, and coloring.

Being in nature. Four participants talked about how helpful it was to be in nature. P11 stated appreciating, "Being alone in nature." P11 also said, "Getting out there in as much nature as possible." P18 stated, "It's like getting back to the surrounding and the nature."

P7 mentioned:

> Being in the nature yesterday, I don't know but I am realizing more and more that I like getting outside. I like being in the quiet nature spot even though it was a tourist area I went to, it was just quiet and peaceful and lot of green.

P8 stated, "I try to do walks in the nature like in the open.

Being with people. Six participants talked about how helpful it was for them to be with people. P6 stated she increased her "time to spend with loved ones." P11 said, "I hung out with my roommates."

P12 mentioned:

> I could be reading but I said, 'let me talk to people cause I don't really know them.' It was just good to sit and just relax and be social and get to know others and see how everybody else is doing cause we are all going through the same kinda stuff.

P15 and P2 shared enjoying spending time with friends and P5 stated the following:

> I gave myself some time to go and do stuff for full day instead of saying, no, I have work, and so having people over to the house just hanging out with friends from school and hanging out with my partner more.

P5 added, "So I think it was really nice being able to build those connections so that I was able to talk with other people outside of work type stuff."

Meditation. Seven participants talked about engaging in meditation as a self-care practice. P11 stated, "I mediated," and added elsewhere, "mediating at the beach; it's just special to me." P17 said she engaged in doing "meditation, it really centered me, grounded me, really helped me to kind of slow down and separate the days." P4 explained utilizing "meditation and journaling" to "improve mood." P8 shared, "So, I have been doing meditation. That is, when I can, probably that's not regular." P9 mentioned, "I also meditate occasionally." Something very similar to meditation was spiritual self-care self-reflection. P10 stated appreciating to, "Meditate before falling asleep." P6 mentioned incorporating more spiritual reflection, "like more self-reflection, allowing myself time to reflect on things that come up, experiences . . ." and added, "reflecting lot more in the past couple weeks about some of the things you talked to us about in the workshop like compassion fatigue or potential signs of burnout . . ."

Healthy eating. Five participants talked about wanting to eat more healthily. P1 stated:

> I'm also trying to be more thoughtful with my diet, I have been trying to eat better . . . I started cooking more at home so in the last week I have already cooked three meals at home instead of eating out which is what I usually do.

P12 stated it was important to "eat healthy, but I am trying to be realistic as I don't know how many times we can eat healthy so eat period, just eat!" P2 shared, "taking care that I am eating and bathing and taking care of my hygiene." P5 said, "I started eating a little

healthier." P7 mentioned, "But just also being mindful of allowing myself to maybe eat a fruit that I like or just not be hard on myself, trying to be positive."

Sleep. Four participants talked about how sleep is important to self-care. P1 stated, "making sure I get enough sleep every night regardless of the amount of work I have to do." P6 mentioned, "after the workshop I have been focused more on getting more sleep, especially with the practicum applications all going on, so definitely getting more sleep." P6 added, "Even by 30 minutes or an hour, I am making sure I am getting that extra sleep." P17 said, "In terms of self-care, I really did make sure to get enough sleep when I could." P19 stated "I forgot to mention that like prioritizing sleep."

Stretching. Three participants mentioned the importance of stretching as a self-care practice. P1 shared, "I started putting in my calendar to stretch, every day. . .I have been stretching, but maybe not every day, but I have been doing it every 2 days or so more than I would usually do." P6 stated, "I have been doing the 30 second exercise that you taught us and its awesome and it does make a huge difference just in something as simple as stretching or taking some deep breaths." P8 mentioned, "I did the 30 seconds relaxation and it worked wonderfully, I felt so rejuvenated I felt that I was myself again."

Other types of self-care. The other activities participants mentioned were hiking, biking journaling, listening to music, and two participants recommended personal therapy. P10 stated, "Actually going for a 3-hour walk with my dog." P9 said, "Weekends I also went hiking with my kids, partner also, so with family and that was good." P11 shared that "disc golfing" was a way to practice self-care, and P13 mentioned, "I have also been running everyday so I consider that like one of my biggest things of self-care." P13 also added, "I have been coloring a lot more." P18 stated both reading and singing: "reading, yeah, I can do that one and singing too. Actually, I have been singing more. I was thinking about that while doing the checklist. Something I really enjoy so, in the car and whenever I get a chance." P2

said, “Listen to music.” and added, “lots of biking around every day for an hour or so; I do that.” P20 stated, “I got my nails done” and added, “your own therapy I guess, too, depending on how you choose to use it.” P7 also mentioned “personal therapy.” P4 mentioned, “I did journaling and meditating.” P8 recommended “listen[ing] to some meditative music” as a useful form of self-care.” P9 shared liking hot showers and said, “I don’t know if it is considered self-care but I like to stand in hot shower . . . that is something I can do on a daily basis . . . it’s a time where I sometimes meditate too and do self-reflection.”

Most effective self-care practices. Participants mentioned a variety of self-care activities they felt were particularly effective for them. P1 shared stretching really helped:

> Stretching every day because I think that I’m constantly sore on my body and I have headaches and I am always sitting all the time and I feel like I hold all that stress in my neck and my shoulder, so I am always cracking my neck.

P12 stated, “I think it would be actually spending time with my best friend and visiting her and her baby ‘cause I have not seen him since he was like 4 months.” P13 said, “Probably running because I want to lose weight and gain muscle, so like being able to stay on track with that was the most important for me.” Participant 14 mentioned coloring really helped with anxiety:

> I think we had an elective class a week after we met and I was having a really bad anxiety attack during class and so I was coloring for the entire 7 hours so that [was] probably the most important cause I think that it really grounded me on that day.

P16 stated, “I would say that one, spending time with my family because I was able to involve them a little more in what’s going on at school and so then they then in turn were able to understand.” P18 said being near water seemed most effective:

I think it was the mini vacation, I just went to Santa Cruz for the weekend and just the beach and the water is really rejuvenating for me. I actually live close by to the water now so I can just walk by and smell the ocean. I like seeing all the waves.

P19 mentioned really enjoying running:

I would say running because running has been really important to me because I don't think. Like it gives me a break from being in my head and I guess just be curious and there's not agenda to what I am doing and I get to use my body and all that good stuff.

P5 said being with people was most effective:

I think the most important part was just spending more time with people because I tend not to do that and I tend to isolate myself and I tend to make excuses to why I don't have time to hang out with people.

P6 stated, "Even by 30 minutes or an hour I am making sure I am getting that extra sleep." P9 stated, "I like what you introduced like the 30 seconds meditation." P20 stated, "Reading for pleasure just because I don't know I really like it perhaps because I am still working my brain but doing something that I still enjoy so it feels like a good compromise I guess."

Often, self-care is narrowly interpreted as only physical activities or it is mistaken for self-indulgence (e.g., overeating and other unhealthy habits). Some participants stated that the self-care assessment worksheet gave them creative ideas for self-care, which they would not have considered to be self-care prior to the workshop, such as cooking, eating healthy, singing, and reading for fun. Widening the choices of self-care activities may have made self-care more enjoyable for participants to partake in. Participants also added that the 30-second stretching during the workshop gave them ideas to create other brief self-care techniques.

Students often hear at their graduate programs and practicum sites, to make time for self-care and take time off from schoolwork, but then they are reminded of the deadlines to

submit assignments, readings to do, and client paperwork to finish. This may leave many psychotherapists-in-training confused and thus the one thing that they are constantly reminded of doing may actually be the last thing on their to-do list. Hence, it is important to guide and support students in their journey of becoming psychotherapists. Explaining the importance of balancing work and life may be beneficial to these budding psychotherapists.

Current frequency of self-care. Several participants stated they engaged in self-care every day. P10 said, "Oh my God, every day." P13 stated, "Running and coloring every day and mindfulness probably like 3 days out of the week." P14 shared, "I would say at least once a day." P17 mentioned, "Let's say about once every day." P19 stated, "I run every day, on weekends I run almost for a longer amount of time and on Sundays and I have been doing more like exploratory runnings." P2 said, "Pretty much every day." P4 shared, "The journaling and meditating was every day and then going to the gym a few times a week." P8 mentioned, "I should say almost every day now." P6 stated, "I would say maybe 30 minutes to an hour a day and on weekends spending a lot more time with loved ones." P16 mentioned, "I would say exercise, I tried to do an hour, three or four times a week. And then at night I would spend every night at least an hour just unwinding with my family." P7 stated, "Maybe six to seven times compared to before which was less." Only a few participants mentioned engaging in self-care with less frequency than before.

As participants grasped the meaning of self-care, this may have helped them to engage in it more often. For example, participants reported thinking that spending time with family, friends, and co-workers was not considered to be a self-care activity. They thought they might actually be procrastinating when spending time with loved ones. Also, participants seemed to realize that different self-care activities targeted different parts of themselves. For example, reading, cooking, listening to music, and spending time with loved ones seemed more relaxing as compared to physical exercise like running or hiking. Participants'

statements conveyed the increase in various types of self-care as their understanding of self-care itself increased. Some participants added an activity to their routine, whereas others introduced self-care practices into their routine.

Obstacles to self-care. Participants talked about the difficulties of implementing self-care into their lives. Many stated that they had so much work to do that they sometimes felt guilty if they spent time on themselves. There appeared to be a feeling that they should do more work to accomplish their goals and not take time for themselves. There were also a few participants, such as P1, who said the focus was sometimes more on others, or that it was easy to get caught up in what one has to do if one is not aware of the toll it can take. P1 mentioned, "I work really hard and I don't think about how it's affecting me" and "when you do this work you get so focused on other people that I forget to focus on myself." Others struggled with incorporating enough self-care into their routine, such as P4, who stated, "Guess, I do some, and then I just kind of just do my routine instead of adding any more."

Participants' responses for barriers to implementing self-care fell into four subthemes: *It takes time, Feeling guilty about the time it takes, Too much work to do,* and *Exhausted.*

It takes time. Fifteen participants stated that practicing self-care was difficult because of the time it took away from what they had to do. P1 stated, "It takes time, so I'm not someone who has a lot of extra time on my hands." P10 said, "I have really been struggling with managing my own time." P12 mentioned, "I just didn't see where I was going to find time for it." P16 shared, "I think that for us as students we have so much to juggle that it's always that I can't spend this time doing self-care." P16 said, "So lot of times we put our health or whatever we enjoy on the back burner to be as productive as we can and yeah, I would say that. Time for sure." P18 stated time was always an obstacle:

> When I noticed I wanted to, I think time. It's kind of like, you know, I would love to cook tonight but I don't want to chop an onion and chop a pepper and then like chop all this other stuff and like make a soup…It's like, I'm just going to order pizza.

P19 mentioned:

> Thinking I couldn't get things done in time, so like school, yeah lot of different priorities, and assuming I was not a fast enough worker and not thinking that it would be responsible to do self-care I guess, or even thinking I didn't need it.

P20 stated, "There's not enough time." P6 mentioned, "Time management. When I didn't manage my time right. and . . . especially with practicum applications, I was like, I don't have time to go have fun or take care of myself because I have to finish these." P7 said it was hard to take time for self as, "It's a lot to juggle with clients and school, and then when you have family and it's a lot." P7 stated, "Time getting away." P8 said, "Its just lack of time and having responsibilities." P9 stated, "Time is always a concern–just a lack of time with school with a lot is going on and other responsibilities as well." P13 shared, "I think that there's so many competing activities like with grad school, and with clients that it's hard to remember to take time for yourself."

As students, participants were perhaps busy juggling schoolwork, practicum work, and managing various relationships; it may have been hard for them to make time for self-care. Psychotherapists-in-training are constantly changing hats from being a student, a practicum trainee, to being with loved ones. As they transition between these different roles, they often tend to put themselves last. If graduate programs were to acknowledge the challenges of their students and encourage them to do self-care while they manage their various roles, then perhaps these psychotherapists-in-training would be more open to putting time aside for self-care practices. Most participants stated family and various other

responsibilities outside of school and practicum work took precedence over their own self-care.

Feeling guilty about the time self-care takes. Nine participants even said they felt guilty about taking time for themselves. P1 stated, "I take time to do self-care sometimes I feel like I'm taking away from doing other work that I probably should or could be doing." P10 mentioned, "and then there's guilt [with taking time] and then I get depressed and then blah, blah." P14 shared, "Just the time needing to be productive and the guilt of not having things done already, so there's really no time for self-care." P17 stated, "I guess strong feelings that I should be doing something more umm, valuable with my time even though it's probably the most valuable thing." P19 said that it was just hard to take a break because of the guilt:

> It was hard at first–like I felt a lot of guilt kind off feelings like I should be doing homework like I am gonna get anxiety like I am gonna get behind in my work, other people are not taking breaks, like wondering what was my motive, like am I procrastinating?

P5 mentioned:

> It was really nice to take time off, but then I think after taking the time and practicing self-care, I was overwhelmed and kinda felt guilty about taking the time because I had all the stuff that I should have been doing.

P12 stated, "I changed it in my head to where something that I need versus something that I want because then I feel guilty if it is something that I want, like a piece of cake."

As students, it may have been natural to feel pressured to utilize time effectively; however, graduate programs and practicum sites should stress the importance of taking the time to care for one's mental, physical, and emotional well-being. If the instruction includes education on the importance of setting time aside for themselves, then perhaps these students

would not feel so guilty about self-care. Due to the demanding and competitive culture of graduate school, it is important for graduate students to hear often in their programs and at their practicum sites that it is essential to take time for themselves. It often seems like a no-win situation for these students; if they take time for self-care, they may feel guilty and if they do not take this time, they endure the negative effects of vicarious trauma.

Too much work to do. Seven participants talked about how they had so much to do that it was hard to fit in self-care. P1 shared, "I do overwork myself." P10 stated, "There's so much I feel like I need to be doing for school." P11 mentioned, "Too much to do." P12 stated, "Grad school is so demanding and you just eat, sleep, and breathe school." P13 said, "I just really easily get caught up in trying to finish everything else before taking care of myself." P7 stated, "Working on practicum and school related assignments." P20 mentioned the following:

> Sometimes it's just too much work and I have to sit down and address it so that actually gets in the way too, the influx of school work and practicum work sometimes is just too much and I just can't even try to do the self-care to better situate myself.

Exhausted. Two participants talked about being too tired to do self-care. P1 mentioned, "I do push myself really hard, really to take care of other people but by the time I get home I don't always want to exert any more energy than I have to." P1 also stated, "I don't feel like it 'cause I am tired." P1 added, "Sometimes I am just still lazy like I said or too tired." P5 said, "I think the one just isolating myself especially the days I am with clients all day, like the last thing on my mind is to be around people or even do anything cause I'm just emotionally exhausted."

Participants' statements indicated their challenges to engage in self-care. Participants mentioned that they were too busy for self-care, had too much work to do, or were too exhausted to engage in self-care activities. Perhaps, students feel that schoolwork and self-

care are mutually exclusive and they cannot give the same importance to both in their daily schedule. If self-care were to become part of the specific training coursework in graduate school, perhaps students would be more inclined to do it.

Impact of self-care. Participants talked about the impact of increasing their self-care practices. The most significant subthemes were: feels good, can work more effectively, and positive impact on vicarious trauma and more mindful of impact of trauma on self.

Feels good. Fourteen participants said that self-care actually feels good. P1 stated, "Doing self-care feels really good." P10 said, "It was good. It was hard at first, but once I got into it, it came very easily." P18 mentioned that reading for pleasure seemed to lessen the guilt:

> It was relaxing, it's kind of it was distracting in a relaxing way I guess. It gives me something else to work on so it still makes me feel like I am doing something, not like, oh my gosh, I should be doing my [homework].

P12 also stated that after doing it, she felt less guilty about it: "I think it was a good experience. It felt good to just finally not feel guilty about doing something that's good for me." P6 said, "I noticed a big difference it made in my day." P8 stated, "I did the 30 seconds relaxation and it worked wonderfully, I felt so rejuvenated I felt that I was myself again." P8 added, "It was like finding my lost self." P11 shared, "I enjoy it, I mean self-care is needed, and I like doing self-care." P13 talked about the experience of running and coloring:

> Oh my God! It was so refreshing. I felt so much better especially after I got done running. It feels really, really good to like know that you are taking care of yourself and have the endorphins and doing the mindfulness and the coloring is very calming…It feels really good to be able to do that.

P16 talked about how good it felt to spend time with family:

> I really enjoyed spending time with my family, it's something that I didn't really pay any type of importance on and so I noticed that you know spending time with them you know whether it was actually conversing about . . . what we did that day or just sitting with them watching TV, that really helped reenergize me and keep me going.

P17 shared, "I love it, it's super awesome." P4 stated, "It's been good. I think that I feel better and with the journaling. I can see the trend of how my moods are so that's good." P6 mentioned, "So the experience of practicing some self-care was very relieving and de-stressing and also made me feel good because I was making myself a priority." P7 said, "I liked it. I felt better after." P9 stated, "It feels good," adding, "You know it's just when your life is so hectic almost always forget to take care of yourself but then when you set aside time and do it and you feel good, body feels refreshed and mind feels rested."

Can work more effectively. Several participants mentioned the impact that self-care had on their work. They discovered it actually helped them do their work better and be more effective with clients. P7 mentioned in amazement the feeling of being able to accomplish more:

> I felt like I could get more things done, I was more motivated and it was probably a combination of things but it felt good knowing it's okay to take a break and that its okay to have an evening off because I have been doing things like before and after the break.

P19 stated that being more effective with clients was motivating:

> Definitely gonna continue 'cause I have seen it and what it['s] like when I get enough sleep–that's been a big thing for me. I forgot to mention that like prioritizing sleep. Sleep and exercise for me are the biggest, and if I don't do those things then all I want to do is get to the end of the day as supposed to be there with my client or do research or whatever I am doing.

P19 also stated, “So it gives room for me to be excited about what I am doing as supposed to just getting through them, so and I find that when I am doing tasks I have the energy.” P19 also said that certain tasks take more time without it: “If I am not using self-care than I do take longer because I don’t have that energy.” P20 made a similar statement:

> Actually that I had a lot of work to do and so I knew that I needed to not stress about it and really do something for myself and . . . to be able to accomplish it because usually what happens to me is I stress about it and then I get writer’s block.

As participants tried doing various forms of self-care in the two-week period, they realized the positive effects from it as confirmed by their statements. Some aspects of self-care also needed effort. For example, cooking dinner to eat healthy and physical exercise to feel reenergized are activities that require some effort. The rewards, however, appeared to be worth the effort, as most participants experienced feeling good afterward and also observed being more efficient in their work. Although challenging, this experience may have pushed participants to practice more self-care as they realized the benefits from it. This was corroborated by most participants expressing their desire to continue with self-care practices. Some even shared wanting to add self-care into their daily routine, even if only for ten minutes a day.

Positive impact on vicarious trauma. Nine participants commented on the positive impact self-care had on trauma. P12 stated:

> Well, I know in my head that it’s a positive impact in which vicarious trauma can be reduced . . . because we are taking care of ourselves and we are being mindful of what’s going on for us. With self-care I think that it would be easier for.

P13 mentioned:

> I definitely feel as though that self-care can help to mediate and eradicate some of the impact that vicarious trauma has, like I find myself just kind of letting my thoughts go

wherever and kind off releasing a lot of what I am holding on to when I [practice self-care].

P17 said, "I think they have a huge impact in helping you cope whatever feelings you are having, whether you are feeling traumatic due to your clients so I think they have a tremendous impact on your well-being." P2 stated, "I do think it impacts–it's kind of grounding. You are prioritizing yourself, it kind of detracts from a flight fright response." P4 stated, "I think if you take care of yourself you are less likely to engage in vicarious trauma because it helps you understand yourself." P5 stated;

I feel like if you have like maybe a routine or incorporate self-care activities into your daily life that you may experience a little bit less vicarious trauma or be able to cope with it better than you might have if you do.

P7 said that self-care has a positive impact in being able to model to clients the importance of self-care:

I think it's important that when you are working with or working through vicarious trauma that there is an outlet for you, the therapist, because its kind of you need to practice what you preach and to take care of yourself.

P8 shared, "Oh I think it's unbelievable, I didn't realize that vicarious trauma would have such impact on me and then doing practicing self-care would help or benefit in drastic way. It kind of just helps you relax totally." P9 stated the need for self-care to prevent vicarious trauma:

It's definitely very important. We are impacted by clients a lot significantly and I think without a good self-care plan we would take things home and that's the last place you want to bring you know work and especially trauma, when you go home.

As participants experienced how they felt after incorporating self-care, they seemed to realize the importance of it, especially when doing trauma work. Participants began to notice

the difference between how they felt when they practiced self-care and when they did not engage in it. Realizing the impact that vicarious trauma can have on an individual and how that can hinder professional growth seems to have made participants more invested in engaging in self-care.

More mindful of impact of clients trauma on themselves. Four participants talked about how it helped to be mindful of the impact of trauma on themselves. P1 mentioned, "I think that if I am more aware of taking care of myself, then I can also distance myself a little more my own experiences versus somebody else's experience." P10 said, "Well obviously they can alleviate it, you know for me, it's like just being present." P19 stated:

> I think there is lot of impact because I don't know, like if you are at least for me working with clients with trauma it's really exhausting and if I don't take care of myself then I can't help them.

P20 mentioned the following:

> So it's really kinda hard to correlate the two, I would say, but I think just having the time to like reflect on what you have done to self-care that maybe opens the window to realize how much you are being affected by vicarious trauma.

Based on participants' comments, the other challenges to practicing self-care were: feeling guilty, having too much work to do, and being exhausted. These thoughts seem to be interconnected. As participants felt that they had too much work to do, they felt exhausted; if they took time for self-care, they struggled with the guilt of not finishing their work from school or practicum. However, when they did engage in self-care, they felt good and were more productive during their day. Participants indicated that self-care impacted them in a positive manner. Therefore, more structured attention should be paid to self-care in both the curriculum and practicum experiences in psychology graduate training.

Goals for self-care. Seven participants talked about their goals for self-care. They often included structuring it into their schedules and trying to do it every day. P16 stated, "I hope I can set a routine and maintain something like a habit but I am sure that you know there will be times when it's perfect and other times I'm like, oh! What happened to my self-care?" P4 said, "Yeah, I kinda want to do it consistently and I think the more consistent is better because then it is a sense of accomplishment." P1 stated, "I think I am gonna maintain doing stretches and trying to . . . stretches my goal is to do it every day, and if I think it do it every other day I will be happy." P11 said, "Try to do it every day so–at least something every day." P9 mentioned, "I hope I can stick with it." P9 added, "To be conservative I would say once every 2 weeks I would do something and hiking. Except the hot showers: that I can definitely do every day, but something more outdoor every two weeks." P9 stated, "Hiking is once a week, and massage was once, so my plan is to try to get massage once a month or every two months." P9 added, "Setting up goals for myself and my husband too, creating more time and space for each other and also for the kids." P1 shared, "cooking at home I think I want to do it at least realistically once or twice a week." P18 said, "I started reading more for leisure so, non-psychology related books and I think I am going to keep trying to do that from now on because I find that, that's very relaxing and a nice little break."

When made aware of the impact of vicarious trauma, participants found creative ways to include self-care techniques in their weekly routine. They stated that time, however, was their biggest challenge. Self-care requires time and, when there is shortage of time, self-care is often not a priority. As participants realized that self-care did not always have to be lengthy, but could be done in a short period of time, they seemed open to experiment with different self-care techniques. Engaging in a 30-second stretch during busy days and listening/singing to music while commuting were examples of how participants could

allocate short periods of time dedicated to self-care. Some even realized reading for leisure during a quick break was relaxing.

What sustains motivation to practice self-care. Eight participants talked about what helped them to stay motivated. They talked about how self-care is valuable, structuring it into their schedules helped, that it feels good, and that they worked more effectively because of it. P1 stated, "It takes time, but in the end, it was worth it and I think I want to try and keep it up." P1 added, "After I did it once I was like, oh this is pretty cool and I wanted to do it more." When asked how likely P13 was to continue practicing self-care, he/she stated, "Likely! Because it makes me feel so much better when I do and I think that once I get myself in a more like regimented routine, then it's something that I can stick with a little bit more." When asked the same question, P17 said the following,

> Very likely because, well, I am taking a mindfulness course this semester and the professor had a good analogy, actually it was brought up by one of the student's. He said, "If you treat meditation like to brushing your teeth than it is easier to do each day."

P19 stated, "So, after, I don't know, a little while, I saw that I was able to attend to my work and actually better especially with clients like way better, I was like, oh! This is actually working really well." P2 stated, "Just sort of like having it structured into my daily routine kind of makes it easy to maintain and not feel like a chore." P20 stated, "Once I had engaged in it I was aware that it was good for me and so that kind of motivated me to keep at it." P6 stated that it was likely to keep practicing because it felt good and had good effects:

> It's more likely now, not only because you brought a lot of awareness to it but also getting to practice it more in these last couple of weeks and seeing how rewarding it is to me, emotionally, spiritually, physically, and that the good outcomes and good

feelings after doing self-care is reinforcing for me so its more likely that I am going to do it.

P7 mentioned, "knowing how important it is and knowing I felt better even when I had taken an hour or so to myself to go do something. I am definitely mindful of it so hopefully likely, very likely." P8 stated:

> Oh, I think I would like to incorporate it as a daily routine. Now it's more spontaneous but I want to kind of have a time-table, maybe wake up a little earlier and start my day with that or something but I definitely want to keep that in my time-table.

Participants reported that the benefits of practicing self-care definitely outweighed the drawback of making the time for it. Although it had been challenging, most participants reported that they gradually engaged in self-care and planned to include self-care in their daily schedule. It may have been a novel idea for them to know that self-care does not always have to be time-consuming and this realization may have also persuaded participants to engage in self-care. Graduate programs could benefit from integrating peer group meetings, self-care support groups, and workshops on the effects of vicarious trauma into their curricula.

Research question 5. *What feedback will participants offer regarding areas of strength, weakness and ways to improve the workshop?* The first question asked *Overall, was the workshop helpful? If yes, what was helpful about it? If no, what do you think was not helpful about it?* All participants reported the workshop to be helpful. For example, P5 shared that it helped, "identify how much I truly need to work on taking care of my self." P6 stated, "Learning about VT [vicarious trauma], as well as CF [compassion fatigue] and burnout helped me identify the ways in which I am being affected by these. This workshop, as well as the self-care assessment, motivates me to practice better self-care." P8 mentioned, "To learn

about VT [vicarious trauma] and how to manage self-care even in a short duration such as 30 sec[ond]s." P18 added, " It's a topic not often discussed in classes or practicum and learning about it and hearing experiences made me aware of VT [vicarious trauma] in my life and how to deal with it." P20 said, "Define differences in very similar concepts but that needed distinction in order to address them properly." Other comments regarding what was helpful to the participants were mindfulness practices, normalizing vicarious trauma, the importance of managing vicarious trauma, validating the need for support, and getting ideas for self-care. Participants' statements indicated the urgent need to bring awareness of self-care to students, especially in the initial stages of their graduate program; such education can help early-career psychologists learn to manage and reduce vicarious traumatization and other adverse effects of working with clients with trauma.

One participant stated that the workshop was not helpful in explaining how to work with trauma clients and the overall rating was low from other participants for the question, *How well did this workshop prepare you to work with trauma clients?* The focus of the workshop was on the psychotherapists-in-training and it addressed how they can learn to manage and reduce vicarious trauma by incorporating self-care practices into their daily routine when working with trauma clients; hence, the question asked during the survey did not pertain to the agenda of the workshop. Because the workshop did not focus on how psychotherapists-in-training can better work with trauma clients, this was likely the reason for this low rating.

The second question inquired, *What is your feedback for improvements or changes in the workshop?* The most popular response was that participants wanted to have more group interaction and participation. For example, P9 said, "more interaction with the audience." P11 mentioned needing more interaction and stated, "For me it helps to be engaged when I am talking or discussing." P12 mentioned, "maybe asking people to share their experiences with

vicarious trauma (if they are comfortable) and how they worked through it or what type of support they received." P16 said, "more interaction between presenter and students." P19 stated, "more group discussion, personal experiences, coping strategies would have been fun and helpful."

These statements indicated the importance of peer learning, as participants may have felt comfortable getting support and learning from their peers, who tend to share the same challenges as them. Because graduate program curricula and/or practicum sites typically do not have methods for assisting students in coping with the effects of working in this field, students may not be forthcoming about experiencing vicarious trauma or their lack of adequate self-care. Therefore, it would be advantageous for graduate programs and practicum sites to invest in educating students on vicarious traumatization and self-care. When experts share their own challenging experiences of working with clients with trauma and how they managed, they normalize the process for students who may feel vulnerable sharing their struggles with vicarious trauma.

Implications for Training and Education of Psychotherapists-in-Training

This study was conducted to increase understanding of vicarious trauma and its effects on psychotherapists-in-training, so they can better manage it by integrating self-care into their daily routine. The participants mentioned being unaware of the effects of vicarious trauma and, more importantly, most of them did not realize that they were affected by it. Many participants stated that practicing self-care is recommended by their graduate programs and at their practicum sites, but not much is discussed about it. Participants also stated that students are constantly trying to catch up with their school and practicum workload and often sacrifice their self-care. This likely gives students a feeling of being trapped between practicing self-care and managing school and practicum work. Instead, they should be given guidance and training in learning creative ways to balance their workday and personal time.

Additionally, vicarious trauma is a neglected topic in psychology training programs. When students experience vicarious trauma symptoms, they most likely do not share this fact with teachers or clinical supervisors due to their fear of exposing vulnerability. Psychotherapists-in-training often doubt their professional ability and are unaware that they are experiencing vicarious trauma or how to overcome this barrier. This problem can represent a serious threat to their future career as psychotherapists.

This study concentrated on the well-being of psychotherapists-in training by educating them to manage vicarious trauma symptoms by way of incorporating self-care practices. However, students in graduate programs would benefit from receiving extensive training and assistance regarding managing their emotions while working with traumatized clients. Students conducting psychotherapy with trauma clients may be apprehensive of the outcome of therapy and may require additional support to cope with their vicarious trauma symptoms. They also need training and support around managing their emotions when with the traumatized client within the therapy room because these one-on-one interactions are often when vicarious trauma symptoms begin to develop within the psychotherapist. Discussing the importance of self-care with psychotherapists-in-training not only helps manage and reduce vicarious trauma symptoms in their lives, but also offers clarity and brings awareness to manage their various emotions within the therapy room.

As there is limited literature in the area of graduate students and their limited knowledge of vicarious trauma, it would benefit psychotherapists-in-training if graduate programs would provide training related to vicarious trauma and self-care to these students beginning in their first year. Just as the required coursework is important, it is the responsibility of the graduate program to teach about the effects of working in this field so that therapists-in-training can be successful in their careers. Creating a safe place where students can gain knowledge from their instructors about the consequence of doing trauma

work, and learning early on that vicarious trauma symptoms can be managed by incorporating self-care, is essential for the well-being of beginning psychotherapists. The practicum and internship sites should promote self-care activities, such as practicing meditation or mindfulness exercises as part of the training. One recommendation might include creating a "Buddy System" to check in on their peers, especially at practicum sites, thereby creating a culture of self-care as a holding environment for beginning therapists. Also, integrating information on vicarious trauma and self-care techniques into trainings could be beneficial to graduate students, for example, inviting practicing psychologists to share their own experiences including their initial struggles and continuing challenges in managing vicarious trauma and how they sustain themselves.

These findings are important for psychotherapists-in-training so they can learn to recognize the symptoms of vicarious trauma, take responsibility of their own self-care, and find ways to create space and time for it. If these students are made aware of their changing worldview or the way their relationships are being negatively affected due to trauma work, then they can take the necessary steps to recover. Therefore, facilitating open communication about vicarious trauma in graduate programs and practicum sites can open communication, especially among peers, and would thereby create strong peer support. Constant reminders of the consequences of vicarious trauma and the positive impact of self-care are vital and would help to mitigate students' tendencies to forget the importance of self-care in the context of their busy lives. Therefore, arranging psychoeducational workshops, monthly meetings about vicarious trauma, and encouraging discussions on self-care would be beneficial for these budding psychotherapists.

Limitations

Due to the limited time and breadth of the project, this study involved a sample size of 20 participants from the Bay Area. Due to the small sample size, bootstrapping was utilized

when analyzing data; however, all bootstrap samples are chosen based on the original sample. Therefore, conclusions drawn for the overall psychotherapists-in-training population were based on the small sample size that was used for this study. Thus, it is important to take into consideration that participants' attitude about life may have impacted the study. For example, if participants had a positive outlook toward self-care, this may have increased the probability that they would participate in this study. On the other hand, potential participants who did not give much importance to self-care and the effects of vicarious trauma may have chosen not to participate in this study. The researcher would have preferred to select more participants from across the country and from various graduate programs in order to expand the generalizability of the study. Also, having participants from various graduate programs from all over the country would have given various perspectives of self-care practices and the effects of doing trauma work. This study would have also benefitted from a more diverse and multicultural pool of participants, as there was only one African American and two Latino/as who participated in the workshop.

This study followed up with the participants for a post-test two weeks after the workshop. Due to the short duration of the follow-up period, it is difficult to be certain whether it was a chance occurrence that most participants managed their vicarious trauma and included self-care practices in their weekly routine. It is possible that the workshop content was still fresh in their minds, or it could also be that the participants were able to integrate self-care practices into their daily routines to manage their vicarious trauma. Therefore, future longitudinal research is necessary to explore whether participants would continue to utilize the tools from the workshop and also to observe whether self-care would continue to have a positive effect on vicarious trauma. Following up at different intervals and observing the participants to see if they were managing their vicarious trauma symptoms by utilizing self-care techniques would have been of value. For example, tracking participants'

self-care activities at one-month, two-month, and six-month intervals would have been helpful in understanding if the workshop was beneficial to the participants over time.

Lastly, this study focused only on the psychotherapists-in-training population. The present findings obtained were from psychotherapists-in-training who are graduate students, and this may not necessarily generalize to newly graduated psychotherapists or to practicing psychotherapists. Therefore, it is not known how other psychotherapists at various stages of their careers may cope when working with trauma clients and dealing with the effects of vicarious trauma. Restricting participation to psychotherapists-in-training may have limited the learning opportunity to observe how seasoned psychotherapists sustain themselves in this field, and how newly graduated psychotherapists cope with their trauma workload and manage their own well being. Studying psychotherapists at different stages in their careers would have assisted in gathering qualitative data about how they were introduced to vicarious trauma and their journey toward maintaining their well being.

Suggestions for Future Research

There is not much research on beginning psychotherapists' experience of managing vicarious trauma and employing self-care techniques. Future research with a larger sample size in this area would be vital in gaining a broader understanding their trials and successes in managing vicarious trauma and practicing self-care. Also, it is recommended that future research participants with vicarious trauma symptoms be monitored over a longer period of time, perhaps from one-month to six-month intervals, in order to help understand how these symptoms manifest across a longer time-frame. In addition, observing the frequency of self-care and its relation to working with trauma clients would be of value in understanding how and when self-care is utilized and what obstacles exist that prevented therapists from practicing self-care over a period of time. For example, it would be important to investigate

whether psychotherapists-in-training, who are on break from practicum and schoolwork, increase their self-care and how that affects their vicarious trauma symptoms.

Future studies could also address the differences between psychotherapists who engage in self-care and those who do not. This study could shed some light on how psychotherapists maintain themselves in this field. Also, it would be important to examine if self-care decreases or increases as working with trauma clients increases. A study could be conducted to explore whether levels of vicarious trauma symptoms are different between psychotherapists working in different environments, such as hospitals, mental health clinics, residential care facilities, halfway houses, correctional facilities or prisons, VAs, or within the educational system. In addition, the trainings offered at different sites and the working environment plays a vital role in one's work with trauma clients; therefore, it would be interesting to observe if and how the degree of training and the influence of the working environment impact the level of vicarious trauma that psychotherapists experience.

This study focused on self-care as a way to manage vicarious trauma, but it would be interesting to examine if psychotherapists' resiliency impacts their ability to manage vicarious trauma. Comparing how psychotherapists with resiliency skills manage vicarious trauma as compared to those psychotherapists who struggle with coping strategies would be helpful in understanding what role resiliency factors play in doing trauma work. It would also be beneficial to study psychotherapists' cultural influences and the effects of vicarious trauma.

Lastly, it would be interesting to compare the manner in which psychotherapists-in-training, newly graduated psychotherapists, and experienced psychotherapists manage vicarious trauma. Perhaps conducting a study involving these three groups to gather how they sustain themselves and manage vicarious trauma would help in knowing more about this

topic. It would be interesting to observe whether vicarious trauma symptoms decrease or increase as one progresses in this field.

Conclusion

The purpose of this workshop was to provide participants with a better understanding of vicarious traumatization and the importance of practicing self-care. This workshop included 20 participants who were graduate students working with traumatized clients at their practicum sites. The results of this research suggest that participants gained a better understanding of vicarious traumatization after attending the workshop. Participants were motivated to integrate self-care into their weekly routines in the following areas: physical, psychological, emotional, spiritual, work balance, and overall balance. They still struggled however, with managing professional self-care. This implies an urgent need to include training in vicarious trauma and to educate psychology graduate students on its consequences. It is equally important to explain the importance of self-care and encourage self-care practices. As self-care increased for participants in this study, results indicated that most symptoms of vicarious trauma were reduced. This endorses the hypothesis that self-care does, in fact, impact vicarious trauma in a positive manner.

Based on a structured interview regarding self-care practices, the following themes were identified: importance of awareness toward this topic, increase in self-care practices due to awareness, obstacles to self-care, positive impact of self-care, and motivation to practice self-care. This corroborates the discussion that graduate programs and practicum sites should invest in bringing awareness about vicarious trauma to their students and trainees. They should also offer teachings and trainings on managing vicarious trauma by promoting self-care practices.

All participants stated that the workshop was helpful and their feedback to improve is summarized as follows: the need for more group participation and interaction, handing out

the examples and handouts of the vignettes shared during presentation, and incorporating interactive activities and video clips within the workshop. This feedback confirms the need for conducting peer consultation groups so the students can share their challenges and stories about doing trauma work and learn from their peers, thereby providing a strong support system among themselves.

References

Adams, R. E., Boscarino, J. A., & Figley, C. R. (2006). Compassion fatigue and psychological stress among social workers: A validation study. *American Journal of Orthopsychiatry*, *76*(1), 103-108.

Adams, S. A., & Riggs, S. A. (2008). An exploratory study of vicarious trauma among therapist trainees. *Training and Education in Professional Psychology, 2,* 26-34.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.

American Psychological Association (2010). *Ethical principles of psychologists and code of conduct (2002,Amended June 1, 2010).* Retrieved from http://www.apa.org/ethics/code/index.aspx

Arvay, M. J., & Uhlemann, M. R. (1996). Counselor stress in the field of trauma: A preliminary study. *Canadian Journal of Counseling, 30*, 193-210.

Astin, J. A. (1997). Stress reduction through mindfulness meditation: Effects on psychological symptomatology, sense of control, and spiritual experiences. *Psychotherapy and Psychosomatics, 66*, 97-106.

Badger, K., Royse, D., & Craig, C. D. (2008). Hospital social workers and indirect trauma exposure: An exploratory study of contributing factors. *Health and Social Work, 33*, 63-71.

Baker, A. A. (2012). Training the resilient psychotherapist: What graduate students need to know about vicarious traumatization. *Journal of Social, Behavioral, and Health Sciences, 6,* 1-12.

Baker, K. E. (2003). Caring for Ourselves as Psychologists. *American Psychological Association*. Retrieved from http://e-psychologist.org/index.iml?mdl=exam/show_article.mdl&Material_ID=1

Barlow, C. A., & Phelan, A. M. (2007). Peer collaboration: A model to support counselor self-care. *Canadian Journal of Counseling, 41,* 1-14.

Beaton, R. D., & Murphy, S. A. (1995). Working with people in crisis: Research implications. In C. R. Figley (Ed.), *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder (pp. 51-81).* New York: Brunner/Mazel.

Bell, H., Kulkarni, S., & Dalton, L. (2003). Organizational prevention of vicarious trauma. *Families in Society: The Journal of Contemporary Human Services, 84,* 463-470.

Bennett-Baker, A. (1999). The resilient psychotherapist: A heuristic inquiry into vicarious traumatization. *Dissertation Abstracts International: Section B: The Sciences & Engineering, 60(*1-B), p.0357.

Bloemhard, A. (2008) *Spiritual Care for Self and Others. An information booklet for professionals and volunteers working in health care with a focus on age and spiritual care.* Mid North Coast Division of General Practice, Coffs Harbour.

Bloom, S. L. (2003). Caring for the caregiver: Avoiding and treating vicarious traumatization. In A. Giardino, E. Datner, & J. Asher (Eds.), *Sexual assault, victimization across the lifespan* (pp. 459-470). Maryland Heights, MO: GW Medical Publishing.

Bond, M. (2004). Empirical studies of defense style: Relationships with psychopathology and change. *Harvard Review of Psychiatry, 12*, 263-278.

Bond, M., Gardner, S. Christian, J., & Sigal, J. J. (1983). Empirical study of self-rated defense styles. *Archives of General Psychiatry, 43*, 786-794.

Bond, M., & Wesley, S. (1996). *Manual for the Defense Style Questionnaire (DSQ)*. Montreal, Quebec, Canada: McGill University. (Original work published 1984).

Boscarino, J. A., Adams, R. E., & Figley, C. R., (2010). Secondary trauma issues for psychiatrists, identifying vicarious trauma and job burnout. *Psychiatric Times,* 24-26.

Brady, J., & Guy, J. (1999). Vicarious traumatization, spirituality, and the treatment of sexual abuse survivors: A national survey of women psychotherapists. *Professional Psychology: Research and Practice, 30*, 386–393.

Bride, B., Robinson, M., Yegidis, B., & Figley, C. (2004). Development and Validation of Secondary Traumatic Stress Scale. *Research on Social Work Practice, 14*(1).

Briere, J. N., (1995). *Trauma symptom inventory: Professional manual*. Odessa, FL: Psychological Assessment Resources, Inc.

Briere, J. N., & Runtz, M. G. (1989). The Trauma Symptom Checklist (TSC-33): Early data on a new scale. *Journal of Interpersonal Violence, 4*, 151-163.

Briere, J., Elliott, D. M., Harris, K., & Cotman, A. (1995). Trauma Symptom Inventory: Psychometrics and association with childhood and adult victimization in clinical samples. *Journal of Interpersonal Violence, 10*, 387-01.

Brown, L. S. (2008). *Cultural competence in trauma therapy: Beyond the flashback*. Washington DC: American Psychological Association.

Canadian Psychological Association. (2000). *Canadian Code of Ethics for Psychologists*. Ottawa, Canada: Author.

Canfield, J. (2005). Secondary traumatization, burnout, and vicarious traumatization: A review of the literature as it relates to therapists who treat trauma. *Smith College Studies in Social Work, 75,* 81-101.

Chrestman, K. R. (1999). Secondary exposure to trauma and self reported distress among therapists. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers and educators* (pp. 29-36). Lutherville, MD: Sidran Press.

Christopher, J., & Maris, J. (2010). Integrating mindfulness as self-care into counselling and psychotherapy training. *Counselling and Psychotherapy Research, 10*, 114–125.

Collins, G. (1977). Burn-out: The hazard of professional people helpers. *Christianity Today, 21*, 12-14.

Cramer, P. (1998). Coping and defense mechanisms: What's the difference? *Journal of Personality, 66*, 919–946.

Creswell, J. W., & Plano, C. V. (2007). *Designing and conducting mixed methods research*. Thousand Oaks, CA: SAGE Publications.

Cutler, R. L. (1958). Countertransference effects in psychotherapy. *Journal of Consulting Psychology, 22*, 349–356.

Dalton, L. E. (2001). Secondary traumatic stress and Texas social workers. Unpublished doctoral dissertation, The University of Texas at Arlington.

Dunkley, J., & Whelan, T. A. (2006). Vicarious traumatization: Current status and future directions. *British Journal of Guidance and Counseling, 34*(1), 107-116.

Efron, B. (1979). Bootstrap methods: Another look at jackknife. Ann. Stat. 7, 1-26.

Ellerby, J. H. (2014). Trauma and the spiritual path. Retrieved from http://ptsdassociation.com/ptsd-coping-strategies.php?Trauma%20and%20The%20Spiritual%20Path-12

Engstrom, D., Gangsei, D., & Hernández, P. (2010). Exploring the impact of trauma on therapists: Vicarious resilience and related concepts in training. *Journal of Systemic Therapies*, *29*, 67–83.

Faunce, P. S. (1990). The self-care and wellness of feminist therapists. In H. Lerman & N. Porter (Eds.), *Feminist ethics in psychotherapy* (pp. 185-194). New York: Springer.

Figley C. R. (1989). *Helping traumatized families*. San Francisco: Jossey-Bass.

Figley C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In: C. R. Figley (Ed.). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* (pp. 1–20). New York: Brunner/Mazel.

Figley, C. (1999). Compassion fatigue: Toward a new understanding of the costs of caring. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self care issues for clinicians, researchers and educators* (2 ed., pp. 3-28). Lutherville: Sidran.

Figley C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self care. *Journal of Clinical Psychology*, *58*,1433–1441. Doi:10:1002/jclp.10090.

Figley, C. R., & Barnes, M. (2005). External trauma and families. In P. C. McKenry, & S. J. Price (Eds.), *Families and change* (3rd ed.). Los Angeles: Sage Publishers.

Figley, C. R., & Kleber, R. J. (1995). Beyond the "victim:" Secondary traumatic stress. In R. J. Kleber, C. R. Figley, & P. R. Gersons, *Beyond trauma: Cultural and societal dynamics* (pp. 75-98). New York: Plenum Press.

Freud, S. (1910). The future prospects of psycho-analytic therapy. *Collected Papers, 2*, London: Hogarth Press, 1946.

Freudenberger, H., & Robbins, A. (1979). The hazard of being psychoanalyst. *Psychoanalytic Review*, *66*(2), 275-296.

Friedman, R. (1985). Making family therapy easier for the therapist: Burnout prevention. *Family Processes*, *24*, 549-553.

Gentry, E. J. (2002). Compassion fatigue: A crucible of transformation. *Journal of Trauma Practice. 1*(3/4), 37-61.

Germer, C. K., Siegel, R. D., & Fulton, P. R., (2005). *Mindfulness and Psychotherapy.* New York: The Guilford Press.

Giller, E. (1999). *What is psychological trauma?* Retrieved from http://www.sidran.org/sub.cfm?contentID=88&sectionid=4.

Harrison, R. L., & Westwood, M. J. (2009). Preventing vicarious traumatization of mental health therapists: Identifying protective practices. *Psychotherapy Theory, Research, Practice, Training*, *46*, 203-219.

Hesse, A. R., (2002). Secondary trauma: How working with trauma survivors affects therapists. *Clinical Social Work Journal,30*, 2930–309.

Howell, R. (2013). Why be spiritual? Five benefits of spirituality. Retrieved from http://www.psychologytoday.com/blog/cant-buy-happiness/201302/why-be-spiritual-five-benefits-spirituality

Howlett, S. L., & Collins, A. (2014). Vicarious traumatisation: Risk and resilience among crisis support volunteers in a community organization. *South African Journal of Psychology, 44*(2), 180-190. DOI: 10.1177/0081246314524387.

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

Jenkins, S. R., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validation study. *Journal of Traumatic Stress, 15*(5), 423–432.

Jennings, A. (2004). Blueprint for Action: Building Trauma-Informed Mental Health Service Systems: State Accomplishments, Activities and Resources. *Psych Central*. Retrieved from http://traumaticstressinstitute.org/wp-content/files_mf/1276537287BuildingTraumaInformedSystemsofCareJennings.pdf

Kabat-Zinn, J. (1994). *Wherever you go, there you are: Mindfulness meditation in everyday life.* New York, NY: Hyperion.

Kammer, A. (1978). "Burn-out": A contemporary dilemma for the Jesuit social activists. *Studies in the Spirituality of Jesuits, 10*, 1-20

Kahill S. (1998). Interventions for burnout in the helping professions. *Canadian Journal of Counselling Review*, *22*(3), 10-42.

Kassam-Adams, N. (1995). The risks of treating sexual trauma: Stress and secondary trauma in psychotherapists. In B. H, Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (p. 37-48). Lutherville, MD: Sidran.

King, R., & O'Brien, T. (2011). Transference and countertransference: Opportunities and risks as two technical constructs migrate beyond their psychoanalytic homeland. *Psychotherapy in Australia, 17*(4), 12-17.

Kristeller, J. & Johnson, T. (2005) Science looks at spirituality. *Zygon, 40*(2), 391-407.

Landau, E. (2009). Treating trauma victims may cause its own trauma. *CNN*. Retrieved from http://www.cnn.com/2009/HEALTH/11/06/military.psychiatrists.fort.hood/index.html?iref=24hours

Lester, S. (1999). *An introduction to phenomenological research*. Taunton UK, Stan Lester Developments.

Linley, P., & Joseph, S. (2007). Therapy work and therapists' positive and negative well-being. *Journal of Social and Clinical Psychology, 26,* 385–403. doi:10.1521/jscp.2007.26.3.385.

Magid, B. (2002). *Ordinary mind: Exploring the common ground of zen and psychoanalysis.* Massachusetts: Wisdom Publications.

Markway, B., (2014). Seven types of self-care activities for coping with stress. Retrieved from http://www.psychologytoday.com/blog/shyness-is-nice/201403/seven-types-self-care-activities-coping-stress

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

Maslach, C. (1993). Burnout: A multidimensional perspective. In W. B. Schaufeli, C. Maslach, & T. Marek (Eds.), *Professional burnout: Recent developments in theory and research (pp.19-32)*. Washington DC: Taylor & Francis.

Mathieu, F. (2007). Running on empty: Compassion fatigue in health professionals. *Rehab and Community Care Medicine*, 1-6.

Maxwell, J. (1997). Designing a qualitative study. In L. Bickman & D. J. Rog (Eds.) *Handbook of applied social research methods* (pp. 69-100). Thousand Oaks, CA: Sage.

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

Medeiros, M. E., and Prochaska, J. O. (1988). Coping strategies that psychotherapists use in working with stressful clients. *Professional Psychology: Research and Practice, 1,* 112-114.

Meinecke, C. (2010). Self-care in a toxic world. *Everybody Marries the Wrong Person.* Retrieved from http://www.psychologytoday.com/blog/everybody-marries-the-wrong-person/201006/self-care-in-toxic-world.

Mendel, W. (1979). Staff burn-out: Diagnosis, treatments, and prevention. *New Directions in Mental Health Services, 2*, 75-83.

Meyerson, D. E. (1998). Feeling stressed and burned out: A feminist reading and revisioning of stress based emotions within medicine and organizational science. *Organizational Science, 8*,103-118.

Nelson, T. S. (1996). Vicarious trauma: Bearing witness to another's trauma. Retrieved from http://www.uic.edu/orgs/convening/vicariou.htm

Neumann, D., & Gamble, S. (1995). Issues in the professional development of psychotherapists: Countertransference and vicarious traumatization in the new trauma therapist. *Psychotherapy: Theory, Research, Practice, Training, 32,* 341–347.

Newell, J. M., & MacNeil, G. A. (2010). Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue: A review of theoretical terms, risk factors, and

preventative methods for clinicians and researchers. *Best Practices in Mental Health, 6*(2), 57-68.

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

O'Halloran, M. S., & O'Halloran, T. (2001). Secondary traumatic stress in the classroom: Ameliorating stress in graduate students. *Teaching of Psychology*, *28*, 92–97.

Pearlman, L. A. (1999). Self-care for trauma therapists: Ameliorating vicarious traumatization. In B. Hundall Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 51-64). Baltimore, MD: Sidran Press.

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

Pearlman, L. A., & Saakvitne, K. W. (1995). Treating therapists with vicarious traumatization and secondary traumatic stress disorders. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 150-177). New York: Brunner/Mazel.

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

Penzer, W. N. (1984). The psychopathology of the psychotherapist. *Psychotherapy in Private Practice, 2*(2), 51-59.

Pines, A., & Aronson, E. (1988). *Career burnout: Causes and cures*. New York: Free Press

Pope, K. S. & Tabachnick, B. G. (1993). Therapists' anger, hate, fear, and sexual feelings: National survey of therapist responses, client characteristics, critical events, formal complaints, and training. *Professional Psychology: Research and Practice, 24*(2), 142-152.

Porter, N. (1995). Therapist self-care: A proactive ethical approach. In E. J. Rave & C. C. Larsen (Eds.), *Ethical decision making in therapy: Feminist perspectives* (pp. 247-266). New York: Guilford Press.

Prasko, J., Diveky, T., Grambal, A., Kamaradova, D., Mozny, P., Sigmundova, Z.,…Vyskocilova, J. (2010). Transference and countertransference in cognitive behavioral therapy. *Biomed Pap Med Fac Univ Palacky Olomouc Czech Repub*, *154*, 189-198.

Pross, C. (2006). Burnout, vicarious traumatization and its prevention. *Torture 16*(1), 1-9.

Radey, M. & Figley, C. R. (2007). The social psychology of compassion. *Clinical Social Work Journal, 35,* 207-214.

Rothschild, B., & Rand, M. (2006). *Help for the helper: Self-care strategies for managing burnout and stress*. W. W. Norton & Company.

Rumbold, B. (2006). *Spiritual Care Workshop Notes*. Mid North Coast Division of General Practice, Coffs Harbour.

Sabo, B. (2011). Reflecting on the concept of compassion fatigue. *OJIN: The Online Journal of Issues in Nursing*, *(16)*1.

Saakvitne, K. W., & Pearlman, L. A. (1996). *Transforming the pain.* New York: W. W. Norton.

Salston, M., & Figley, C. R. (2003). Secondary traumatic stress effects of working with survivors of criminal victimization. *Journal of Traumatic Stress, 16*(2), 167-174.

Saltiel, I. M. (1998). Defining collaborative partnerships. In I. Saltiel, A. Sgori, & R. Brockett (Eds.), *The power and potential of collaborative partnerships* (pp. 5-13). San Francisco: Jossey-Bass.

Sanderson, C. (2010). *Introduction to counselling survivors of interpersonal trauma.* London, England: Jessica Kingsley Publishers.

Sanderson, C. (2012). Mindfulness for clients, their friends, and family members. Retrieved from http://behavioraltech.org/downloads/Mindfulness_for_clients_and_family_members.pdf

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

Scott, E. (2014). The importance of self care for health and stress management. Retrieved from http://stress.about.com/od/lowstresslifestyle/a/selfcare.htm

Sherfield, R. M. (n.d.). The power of optimism. Retrieved from http://www.netplaces.com/self-esteem/visualization-and-positive-thinking/the-power-of-optimism.htm

Sexton, L. (1999). Vicarious traumatization of counselors and effects on their workplaces. *British Journal of Guidance and Counseling, 27*(3), 393-403.

Shapiro, S. L., Brown, K. W., & Biegel, G. M. (2007). Teaching self-care to caregivers: Effects of mindfulness-based stress reduction on the mental health of therapists in training. *Training and Education in Professional Psychology, 1*, 105–115. doi:10.1037/1931-3918.1.2.105

Shapiro, S., Schwartz, G., & Bonner, G. (1998). Effects of mindfulness based stress reduction on medical and premedical students. *Journal of Behavioral Medicine, 21*, 581-599.

Sieber, S. D. (1973). The integration of fieldwork and survey methods. *American Journal of Sociology, 78*(6), 1335-1359.

Simonds, S. L. (1997). Vicarious traumatization in therapists treating adult survivors of childhood sexual abuse. *Dissertation Abstracts International, 57,* 8-B, p.5344.

Srdanovic, M. (2007). Vicarious traumatization: An occupational hazard for helping professionals. *Visions Journal, 3*(3), 15-16.

Stamm, B. H. (1997). Work-related secondary traumatic stress. *PTSD Research Quarterly, 8*, 1-3.

Stamm, B. H. (1999). *Secondary traumatic stress: Self-care issues for clinicians, researchers, & educators* (2nd ed.). Baltimore, MD: The Sidran Institute.

Stern, D. B. (2002). Words and wordlessness in the psychoanalytic situation. *American Psychoanalytic Association, 50*, 221-247.

Stern, D. B. (Speaker) (2002). Conference: *Attachment: From early childhood through the lifespan* (Casette Recording No. 609-617). Los Angeles: Lifespan Learning Institute.

Suran, B. G. & Sheridan, E. P. (1985). Management of burnout: Training psychologists in professional life span perspective. *Professional Psychology: Research and Practice, 16*, 741-752.

Tartakovsky, M. (2013). Practicing self-care during stressful times. *Psych Central*. Retrieved from http://psychcentral.com/blog/archives/2013/11/24/practicing-self-care-during-stressful-times/

Tashakkori, A., & Teddlie, C. (Eds.). (2003). *Handbook of mixed methods in social & behavioral research*. Thousand Oaks, CA: Sage.

Teddlie, C., & Yu, F. (2007). Mixed methods sampling: A typology with examples. *Journal of Mixed Methods Research, 1*, 77-100.

Travis, J. (1997). National Institute of Justice. Retrieved from https://ncjrs.gov/pdffiles/165369.pdf

Trippany, R. L., White Kress, V. E., & Wilcoxon, S. A. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors. *Journal of Counseling & Development, 82,* 31-37.

Tummala-Narra, P. (2014). Cultural identity in the context of trauma and immigration from a psychoanalytic perspective. *Psychoanalytic Psychology, 31,* 396-409.

Vaillant, G. E. (1971). Theoretical hierarchy of adaptive ego mechanisms: 30-year follow-up of 30 men selected for psychological health. *Archives of General Psychiatry, 33*, 535–545.

Van der Kolk, B. (1996). The black hole of trauma. In B. A. van der Kolk, & A. C. McFarlane, (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 3-23). New York: The Guilford Press.

Webster's Encyclopedic Unabridged Dictionary of the English Language. (1989). NY: Gramercy Books.

Welfel, E. R. (1998). *Ethics in counseling and psychotherapy.* Pacific Grove, CA: Brooks/Cole.

Wolfe, G. A. (1981). Burnout of therapists: Inevitable or preventable? *Physical Therapy, 61*(7), 1046-1050.

APPENDIX A

Recruitment Flyer

Volunteers Needed for a Dissertation Research Study

Self-care for therapists in training: Workshop for managing vicarious trauma.

Participants will receive a $20 gift card

Light refreshments provided!

Participation will include:

- **A 2-hour workshop**
- **Individual 20-minute follow-up interview conducted in person. (2 weeks after the workshop)**
- **Participation is voluntary and confidential**

This workshop is for:

- **Second, Third, or Fourth Year Ph.D and Psy.D students currently enrolled in practicum**
- **Fluent in English language**
- **Not currently in psychological distress**
- **Providing therapy to clients dealing with trauma history**

You are currently working with clients who have been a victim of:

***Domestic Violence**
***Suffering from Chronic pain/illness**
***Lost loved one due to accident/murder/illness**
***Lost loved one due to kidnap/abduction**
***Survivor of natural disaster or war**
***Robbery**
***Burglary**
***Mugged**
***Assaulted**
***Raped**
***Child Molestation**

If you answered YES to at least 5 of the Exposure to trauma-related categories ABOVE you are eligible to participate in the workshop

Exposure to trauma-related work Checklist (based on information from the U.S. Department (Travis, 1997).

Dharna Patel
(510) 629-0307
dpatel@alliant.edu
Dharna Patel
(510) 629-0307
dpatel@alliant.edu
Dharna Patel
(510) 629-0307
dpatel@alliant.edu
Dharna Patel
(510) 629-0307
dpatel@alliant.edu
Dharna Patel
(510) 629-0307
dpatel@alliant.edu
Dharna Patel
(510) 629-0307
dpatel@alliant.edu
Dharna Patel
(510) 629-0307
dpatel@alliant.edu
Dharna Patel
(510) 629-0307
dpatel@alliant.edu
Dharna Patel
(510) 629-0307
dpatel@alliant.edu

APPENDIX B

Consent To Participate

I, _____, have agreed to participate in the Self-Care for Psychotherapists in Training: Development and Evaluation of A Psycho-educational Workshop on Managing Vicarious Trauma conducted by Dharna Patel as part of her requirement to attain a doctorate degree in clinical psychology. I have been selected to participate in this study because I meet the criteria for the study: I am currently working with clients dealing with trauma at my practicum site.

I understand that using code-numbers on all research materials instead of my name will protect my confidentiality. The consent form will be the only place where my name will appear. I have been informed that the consent form along with the audio recording of individual interview during the follow-up session will be kept under lock and key under the researcher's supervision for five years after the completion of the study and will be then destroyed as per APA standards. If someone is hired to transcribe the results they will sign a letter of confidentiality to protect my privacy. If I request the results of the study they will be emailed to me when ready. All the participants will be compensated for their time with a $20 gift card to a local grocery store or eatery. My participation is voluntary and I can choose to terminate it at my will and I realize that if I do so I will not be eligible to receive the $20 gift card.

I agree to attend a one-day workshop for 2 hours with a follow-up in two weeks lasting for approximately 20 minutes. I will be asked to provide general demographic information, take a quiz based on the information received at the workshop, answer interview questions during follow-up meeting, three self-measure questionnaires, and workshop evaluation form. I also acknowledge that if any question makes me feel uncomfortable, I may choose to not answer it. I understand that if the researcher uses the recorded information in quotes, this will not be connected with my identifying information.

The only time the confidentiality will be broken is if: (1) I am a danger to myself; (2) I am a danger to others; (3) I report any elder, child, or dependent adult abuse. The researcher is required by law to report these things to the appropriate authorities.

As a participant in this study, I could benefit from learning about vicarious trauma and its effects on a psychotherapist. I will also learn about the importance of self-care and some popular self-care activities. I understand that there can be some risks in participating in the study due to the topic of trauma. I have been informed that if I become distressed during the workshop and/or interview I can take a break to regain my composure. If I experience further distress as a result of the study, Dharna Patel has agreed to provide a maximum of 3 consultations with a licensed clinical psychologist at no cost to me.

If I have any questions, I may ask them now or contact the researcher (Dharna Patel) at (510) 629.0307 or her Chair Dr. Petti at (415) 955.2160 if they should arise after the interview. I can also contact the Institutional Review Board at Alliant International University to voice questions or concerns at (415) 955.2151 or irb-sf@alliant.edu. I have been given a copy of this Consent form to keep.

Participant's Initials _____

_____ _____

Participant's signature Date

_____ _____

Researcher's signature Date

APPENDIX C

Demographic Form

1) Name_____

2) Age____

3) Gender_____

4) Marital Status: single_____ married_____ divorced_____ widowed_____ life-long partner_____

5) Ethnicity _____

6) Year in Graduate School (circle one)_____1 2 3 4

7) What type of patients do you provide psychotherapy for? _____

8) How many clients do you typically see in a week? _____

9) How many of these clients are trauma clients? _____

10) What kind of support does your practicum site currently provide for trainees to deal with the stress of working with clients? _____

11) Would you like to receive the results of this study? Yes_____ No_____

(If you check "YES" the results will be sent to you via email.)

APPENDIX D

Pretest- Posttest Quiz

1. What is vicarious trauma?

a. Psychotherapist experiences this from a life threatening experience

b. A type of defense mechanism that plays a vital role in how psychotherapists relate to their clients

c. Psychotherapists start re-experiencing their client's trauma

d. I don't know/I am not sure

2. What is the difference between vicarious trauma and countertransference?

a. Countertransference is about how our clients affect our work, while vicarious trauma is how our clients affect our lives

b. Countertransference appears over time, conversely, vicarious trauma can be sudden compared to countertransference

c. Countertransference is the result of being concerned over the struggles of the client's life for a prolonged period, while vicarious trauma is the change in one's own outlook on life through secondary contact with a trauma

d. I don't know/I am not sure

3. What is the difference between vicarious trauma and compassion fatigue?

a. Compassion fatigue is sudden, while vicarious trauma is the cause of being exposed to client's trauma over a period of time.

b. Compassion fatigue is emotional and physical erosion and unable tp refuel, whereas vicarious trauma transpires while caring for multiple clients.

c. Compassion fatigue occurs in session in the presence of the client, whereas vicarious trauma is the cumulative effect of performing trauma work with several clients

d. I don't know/I am not sure

4. What is the difference between vicarious trauma and burnout?

a. Burnout can be experienced with or without trauma, whereas vicarious trauma is a consequence of being exposed to traumatic material

b. Burnout can be sudden where as vicarious trauma can appear over time

c. Burnout can emerge while working with one client, whereas vicarious trauma transpires while caring for multiple clients

d. I don't know/I am not sure

5. What are the symptoms of vicarious trauma?

a. Lack of energy for self

b. Change in identity and worldview

c. Both a and b

d. I don't know/I am not sure

6. What are the contributing factors for vicarious trauma?

a. Individual's inability to accept assistance when needed

b. Individual's defense mechanisms

c. Both a and b

d. I don't know/I am not sure

7. What does defense mechanism mean?

a. Defense mechanisms is known as coping styles of each individual

b. Defense mechanism is the component of personality that is responsible for dealing with reality

c. Both a and b

d. I don't know/I am not sure

8. Which is immature defense mechanism?

a. Sublimation

b. Isolation

c. Suppression

d. I don't know/I am not sure

9. Which is mature defense mechanism?

a. Suppression

b. Isolation

c. Repression

d. I don't know/I am not sure

10. What is self-care?

a. Being self-aware and able to self-regulate

b. Being selfless and magnanimous

c. Both a and b

d. I don't know/I am not sure

11. What is self-indulgence?

a. Treating ourselves to something that in the moment makes us feel better

b. Fostering physical and mental health necessary to our happiness

c. Both a and b

d. I don't know/I am not sure

Answers to quiz: 1=c, 2=a, 3=b, 4=a, 5=c, 6=c, 7=a, 8=b, 9=a, 10=a, 11=a

APPENDIX E

Self-Care Assessment Worksheet

This assessment tool provides an overview of effective strategies to maintain self-care. After completing the full assessment, choose one item from each area that you will actively work to improve.

Using the scale below, rate the following areas in terms of frequency:

5 = Frequently

4 = Occasionally

3 = Rarely

2 = Never

1 = It never occurred to me

Physical Self-Care

___ Eat regularly (e.g. breakfast, lunch and dinner)

___ Eat healthy

___ Exercise

___ Get regular medical care for prevention

___ Get medical care when needed

___ Take time off when needed

___ Get massages

___ Dance, swim, walk, run, play sports, sing, or do some other physical activity that is fun

___ Take time to be sexual—with yourself, with a partner

___ Get enough sleep

___ Wear clothes you like

___ Take vacations

___ Take day trips or mini-vacations

___ Make time away from telephones

___ Other:

Psychological Self-Care

___ Make time for self-reflection
___ Have your own personal psychotherapy
___ Write in a journal
___ Read literature that is unrelated to work
___ Do something at which you are not expert or in charge
___ Decrease stress in your life
___ Let others know different aspects of you
___ Notice your inner experience—listen to your thoughts, judgments, beliefs, attitudes, and feelings
___ Engage your intelligence in a new area, e.g. go to an art museum, history exhibit, sports event, auction, theater performance
___ Practice receiving from others
___ Be curious
___ Say "no" to extra responsibilities sometimes
___ Other:

Emotional Self-Care

___ Spend time with others whose company you enjoy
___ Stay in contact with important people in your life
___ Give yourself affirmations, praise yourself
___ Love yourself
___ Re-read favorite books, re-view favorite movies
___ Identify comforting activities, objects, people, relationships, places and seek them out
___ Allow yourself to cry
___ Find things that make you laugh
___ Express your outrage in social action, letters and donations, marches, protests
___ Play with children
___ Other:

Spiritual Self-Care

___ Make time for reflection
___ Spend time with nature
___ Find a spiritual connection or community
___ Be open to inspiration
___ Cherish your optimism and hope
___ Be aware of nonmaterial aspects of life
___ Try at times not to be in charge or the expert
___ Be open to not knowing
___ Meditate
___ Pray
___ Sing
___ Spend time with children
___ Have experiences of awe
___ Contribute to causes in which you believe
___ Read inspirational literature (talks, music, etc.)
___ Other:

Workplace or Professional Self-Care

___ Take a break during the workday (e.g. lunch)
___ Take time to chat with co-workers
___ Make quiet time to complete tasks
___ Identify projects or tasks that are exciting and rewarding
___ Set limits with your clients and colleagues
___ Balance your caseload so that no one day or part of a day is "too much"
___ Arrange your work space so it is comfortable and comforting
___ Get regular supervision or consultation
___ Negotiate for your needs (benefits, pay raise)
___ Have a peer support group
___ Develop a non-trauma area of professional interest
___ Other:

Balance

___ Strive for balance within your work-life and workday
___ Strive for balance among work, family, relationships, play and rest

Source: Transforming the Pain: A Workbook on Vicarious Traumatization. Saakvitne, Pearlman & Staff of TSI/CAAP (Norton, 1996)

APPENDIX F

Secondary Traumatic Stress Scale (STSS)

The following is a list of statements made by persons who have been impacted by their work with traumatized clients. Read each statement then indicate how frequently the statement was true for you in the past seven (7) days by circling the corresponding number next to the statement.

NOTE: "Client" is used to indicate persons with whom you have been engaged in a helping relationship. You may substitute another noun that better represents your work such as consumer, patient, recipient, etc.

	Never	Rarely	Occasionally	Often	Very Often
1. I felt emotionally numb……	1	2	3	4	5
2. My heart started pounding when I thought about my work with clients……	1	2	3	4	5
3. It seemed as if I was reliving the trauma(s) experienced by my client(s)……	1	2	3	4	5
4. I had trouble sleeping……	1	2	3	4	5
5. I felt discouraged about the future……	1	2	3	4	5
6. Reminders of my work with clients upset me……..	1	2	3	4	5
7. I had little interest in being around others	1	2	3	4	5
8. I felt jumpy……	1	2	3	4	5

9. I was less active than usual……	1	2	3	4	5
10. I thought about my work with clients when I didn't intend to……	1	2	3	4	5
11. I had trouble concentrating……	1	2	3	4	5
12. I avoided people, places, or things that reminded me of my work with clients……	1	2	3	4	5
13. I had disturbing dreams about my work with clients……...	1	2	3	4	5
14. I wanted to avoid working with some clients……..	1	2	3	4	5
15. I was easily annoyed……	1	2	3	4	5
16. I expected something bad to happen……	1	2	3	4	5
17. I noticed gaps in my memory about client sessions……..…	1	2	3	4	5

Intrusion Subscale (add items 2, 3, 6, 10, 13) Intrusion Score _____

Avoidance Subscale (add items 1, 5, 7, 9, 12, 14, 17) Avoidance Score _____

Arousal Subscale (add items 4, 8, 11, 15, 16) Arousal Score _____

TOTAL (add Intrusion, Arousal, and Avoidance Scores) Total Score _____

Citation: Bride, B.E., Robinson, M.R., Yegidis, B., & Figley, C.R. (2004). Development and validation of the Secondary Traumatic Stress Scale. Research on Social Work Practice, 14, 27-35.

APPENDIX G

Trauma Symptom Checklist-40 (TSC-40)

TSC-40

How often have you experienced each of the following in the last two months?

0 = Never 3 = Often

1. Headaches	0 1 2 3
2. Insomnia (trouble getting to sleep)	0 1 2 3
3. Weight loss (without dieting)	0 1 2 3
4. Stomach problems	0 1 2 3
5. Sexual problems	0 1 2 3
6. Feeling isolated from others	0 1 2 3
7. "Flashbacks" (sudden, vivid, distracting memories)	0 1 2 3
8. Restless sleep	0 1 2 3
9. Low sex drive	0 1 2 3
10. Anxiety attacks	0 1 2 3
11. Sexual overactivity	0 1 2 3
12. Loneliness	0 1 2 3
13. Nightmares	0 1 2 3
14. "Spacing out" (going away in your mind)	0 1 2 3
15. Sadness	0 1 2 3
16. Dizziness	0 1 2 3

17. Not feeling satisfied with your sex life 0 1 2 3

18. Trouble controlling your temper 0 1 2 3

19. Waking up early in the morning and can't get back to sleep 0 1 2 3

20. Uncontrollable crying 0 1 2 3

21. Fear of men 0 1 2 3

22. Not feeling rested in the morning 0 1 2 3

23. Having sex that you didn't enjoy 0 1 2 3

24. Trouble getting along with others 0 1 2 3

25. Memory problems 0 1 2 3

26. Desire to physically hurt yourself 0 1 2 3

27. Fear of women 0 1 2 3

28. Waking up in the middle of the night 0 1 2 3

29. Bad thoughts or feelings during sex 0 1 2 3

30. Passing out 0 1 2 3

31. Feeling that things are "unreal" 0 1 2 3

32. Unnecessary or over-frequent washing 0 1 2 3

33. Feelings of inferiority 0 1 2 3

34. Feeling tense all the time 0 1 2 3

35. Being confused about your sexual feelings 0 1 2 3

36. Desire to physically hurt others 0 1 2 3

37. Feelings of guilt 0 1 2 3

38. Feelings that you are not always in your body 0 1 2 3

39. Having trouble breathing 0 1 2 3

40. Sexual feelings when you shouldn't have them 0 1 2 3

Subscale composition and scoring for the TSC-40: The score for each subscale is the sum of the relevant items.

Dissociation – 7, 14, 16, 25, 31, 38

Anxiety – 1, 4, 10, 16, 21, 27, 32, 34, 39

Depression – 2, 3, 9, 15, 19, 20, 26, 33, 37

SATI (Sexual Abuse Trauma Index) – 5, 7, 13, 21, 25, 29, 31

Sleep Disturbance – 2, 8, 13, 19, 22, 28

Sexual Problems – 5, 9, 11, 17, 23, 29, 35, 40

TSC Total Score: 1-40

APPENDIX H

Workshop Evaluation Survey

5 point Likert scale from 1= not at all to 5=extremely

1) Were the workshop objectives clearly communicated?

1 2 3 4 5

2) To what extent did the workshop achieve its objectives?

1 2 3 4 5

3) Did you achieve the learning outcomes specified for the workshop?

1 2 3 4 5

4) Was the material on vicarious trauma and self-care presented clearly?

1 2 3 4 5

5) Were materials such as handouts and/or visuals helpful?

1 2 3 4 5

6) Were workshop evaluation techniques (such as tests and surveys), consistent with workshop objectives?

1 2 3 4 5

7) Did the instructor clearly communicate the material of the workshop?

1 2 3 4 5

8) Were workshop discussions and/or exercises effective in helping you learn?

1 2 3 4 5

9) Was the instructor's communication style clear and effective?

1 2 3 4 5

10) To what extent did you learn from this instructor/presenter?

1 2 3 4 5

11) To what extent did this workshop prepare you to work efficiently with trauma clients?

1 2 3 4 5

12) Was the instructor conscientious concerning duties and responsibilities to the class (e.g. preparedness, efficient use of time, being well-organized)?

1 2 3 4 5

13) Did the instructor behave in an appropriate and professional manner?

1 2 3 4 5

14) How would you rate the workshop taking into account the course objectives?
1 2 3 4 5

15) Overall, was the workshop helpful? (circle one) Yes No

a) If yes, what was helpful about it? _____

b) If no, why do you think was not helpful about it? _____

16) What is your feedback for improvements or changes in the workshop? _____

APPENDIX I

Interview Questions During Follow-Up Meeting

1) Did you incorporate self-care practices since the workshop? Yes_____ No _____
2) If yes, what did you do? Tell me all the self-care activities that you engaged in?

   _____
3) How often did you engage in self-care activities?_____
4) What motivated you to engage in self-care? _____
5) Was there a specific structure to your activities or was it more spontaneous? Please explain. _____
6) What was the experience of practicing self-care like for you? _____
7) What was the most important self-care activity to you and why? _____
8) What is your opinion about the impact that self-care activities have on vicarious trauma? _____ If no impact, why not? _____
9) What prevents or prevented you from engaging in self-care activities? _____
10) How likely is it that you are going to engage in self-care activities and why? ____
11) What types of self-care practices do you recommend for other practicum trainees who are working with trauma patients?

APPENDIX J

PowerPoint Presentation slides

Slide 1:

Self-care for Therapists in training: A developmental and Evaluation psychoeducational workshop for managing vicarious trauma

Dharna Patel

2016

Slide 2:

- ❖ Read and Sign Consent Form
- ❖ Complete Demographic Form
- ❖ Complete Pretest Quiz
- ❖ Complete STSS
- ❖ Complete TSC-40
- ❖ Complete Self-Care Assessment Sheet

Slide 3:

Workshop objectives

- Vicarious Trauma (VT)
- Constructivist Self Development Theory (CSDT)
- Risks and Resiliency Factors
- Symptoms and Contributing Factors of VT
- Difference between VT and Countertransference
- Difference between VT and Burnout
- Difference between VT and Compassion Fatigue
- Self care: A coping skill to manage VT

Slide 4:

Picture slide: You are so brave and quiet I forget you are suffering. –Ernest Hemingway

Slide 5:

What is Vicarious Traumatization?

- "The transformation of the therapist's or helper's inner experience as a result of empathic engagement with survivor clients and their trauma material" (Saakvitne & Pearlman, 1995, p. 31).
- Alter the meanings, beliefs, and schemas of a psychotherapist
- Begin to see the world from their client's viewpoint.

Slide 6:

Contributing factors towards Vicarious Trauma

- Situational
  - ➢ Type of work
  - ➢ Types of clientele
  - ➢ Organization fails to provide support to staff
- Individual
  - ➢ Personality traits
  - ➢ Personal history
  - ➢ Current situation in life

Slide 7:

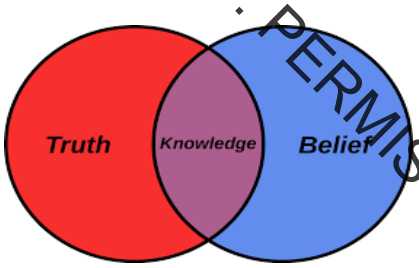
Symptoms of Vicarious Trauma

- Lack of energy for self
- Isolation
- Withdrawal from loved ones
- Sensitivity towards violence
- Feeling of despair and hopelessness
- Nightmares
- Change in identity and world view
- Decreased sense of self
- Disrupted cognitive schemas
- Deteriorating self-protective skills

Slide 8:

Constructivist Self Development Theory (CSDT)

- CSDT is built on the belief that people create their own truth based on their life experiences (Srdanovic, 2007).



Slide 9:

CSDT (continued)

- CSDT emphasizes 5 areas that can be affected through work with trauma clients
  - Frame of Reference (e.g. sense of personal identity, spirituality, world view, personal relationships, and experiences)
  - Self Capacities (e.g. Ability to self-soothe, inner capabilities, and sense of self)
  - Ego Resources (e.g. Self-awareness skills, interpersonal and self-protective skills)
  - Psychological Needs and Cognitive Schemas (e.g. Safety, esteem, trust, control, and intimacy)
  - Memory and Perception (e.g. visual images, behavior, emotions

Slide 10:

Cartoonstock.com Original Artist/Search ID: bron2520

Slide 11:

Risks and Resiliency Factors

- Defense mechanisms known as coping styles plays an vital role in how VT affects an individual.
- There are 2 types of defense mechanism:
  - Immature defense mechanism (e.g. isolating, splitting, repression, acting out behaviors)
  - Mature defense mechanism (e.g. rationalization, sublimation, suppression humor)
- Immature mechanisms = Risk of VT
- Mature mechanisms = Resiliency towards VT

Slide 12:

Difference between VT and Countertransference (CT)

- CT is defined as a psychotherapist's reaction to the client during session. (Freud, 1910).
- CT occurs in session in the presence of the client, whereas VT is the cumulative effect of performing trauma work with several clients.
- CT = direct engagement with client, while
  VT = enduring change to the therapists' worldview.
- CT can be experienced with or without trauma, whereas
  VT is a consequence of being exposed to traumatic material.
- CT is about how our clients affect our work, while
  VT is how our clients affect our lives.

Slide 13:

Difference between VT and Burnout

- Burnout is defined as a "feeling of emotional and physical exhaustion coupled with a deep sense of frustration" (Wolfe, 1981, p. 1046)
- Burnout can occur in any profession, however if the job is emotionally challenging the chance for burnout is higher.
- Burnout appears over time, conversely, VT can be sudden compared to burnout.
- Burnout occurs form an emotionally demanding job and with little to no support, while VT is the cause of being exposed to client's trauma.

Slide 14:

Difference between VT and Compassion Fatigue (CF)

- CF is defined as "emotional, physical, social and spiritual exhaustion that overtakes a person and causes a pervasive decline in his or her desire, ability and energy to feel and care for others." (Fran McHolm, 2006, p. 14).
- CF = emotional and physical erosion when one is unable to refuel and regenerate, while VT = change in one's own outlook on life due to trauma work.
- CF and VT are cumulative over time and can affect one's personal and professional life.

Slide 15:

Slide 16:

Self-Care

- "Ability to refill and refuel oneself in healthy ways" (Gentry, 2002, p. 48).
- Remaining aware of one's thoughts and feelings while being empathetic toward the client is considered an important form of self-care (Tartakovsky, 2013).
- Self-care is different from self-indulgence
- Self-care is comprised of three main activities:
  - Caring for self
  - Nurturing oneself
  - Coping with painful emotions

Slide 17:

Self-Care (continued)

- Caring for Self:
  - Incorporating healthy ways of living
  - Maintaining relations with family and friends
  - Understanding boundaries
  - Retaining balance
- Nurturing one self:
  - Treating oneself kindly by emphasizing relaxation and pampering
- Coping with painful emotions:
  - Shifting focus from painful thoughts towards pleasant activity

Slide 18:

Types of Self-Care

- Mindfulness/Meditation:
  - Mindfulness as a way of living in the present and being aware of our current surroundings (Kabat-Zinn (2012).
- Spirituality:
  - Getting in touch with the spiritual side makes one more self-aware and being self-aware is essential for self-care.
- Alteration in the professional sphere:
  - Attending training activities around trauma
  - Networking with fellow therapists to have a sense of community and support
  - Balancing one's caseload with trauma and non-trauma clients

Slide 19:

Types of Self-Care (continued)

- Exercising/Eating healthily/Hobbies:
  - Exercise as a daily routine
  - Eating healthily
  - Having a creative hobby

- Support system:
  - Staying in touch with family and friends
  - Accepting assistance when needed
  - Having open lines of communication
  - Maintaining boundaries and limitations
  - Volunteering

Slide 20:
Handouts of Testimonials from psychotherapists who have incorporated self-care successfully

Slide 21:
- Practicing 30- second quick relaxation
- Complete Posttest Quiz
- Complete Workshop Evaluation Survey

End of Workshop!

Slide 22:
References

- Pearlman, L. A., & Saakvitne, K. (1995). Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors. New York: W. W. Norton.
- Figley C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In: C. R. Figley (Ed.). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* (pp. 1–20). New York: Brunner/Mazel.
- Kassam-Adams, N. (1995). The risks of treating sexual trauma: Stress and secondary trauma in psychotherapists. In B. H, Stamm (Ed.), Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators (p. 37-48). Lutherville, MD: Sidran.
- McCann, L., & Pearlman, L. A. (1990). Vicarious Traumatization: A Framework for Understanding the Psychological Effects of Working with Victims. *Journal of Traumatic Stress, 3*(I).

- Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice, 26*, 558-565.
- Srdanovic, M. (2007). Vicarious traumatization: An occupational hazard for helping professionals. *Visions Journal, 3*(3), 15-16.
- Saakvitne, K. W., & Pearlman, L. A. (1996). *Transforming the pain.* New York: W.W. Norton.
- Freud, S. (1910). The future prospects of psycho-analytic therapy. *Collected Papers, 2*, London: Hogarth Press, 1946.
- Wolfe, G. A. (1981). Burnout of therapists: Inevitable or preventable? *Physical Therapy, 61*(7), 1046-1050.
- McHolm, F. (2006). Rx for compassion fatigue. Journal of Christian Nursing 23(4):12-21.
- Gentry, E. J. (2002). Compassion fatigue: A crucible of transformation. *Journal Of Trauma Practice. 1*(3/4), 37-61.
- Tartakovsky, M. (2013). Practicing Self-Care During Stressful Times. *Psych Central*. Retrieved from http://psychcentral.com/blog/archives/2013/11/24/practicing-self-care-during-stressful-times/
- Kabat-Zinn, J. (1994). *Wherever you go, there you are: Mindfulness meditation in everyday life.* New York, NY: Hyperion.

APPENDIX K

Outline of the Workshop

At the beginning of the workshop participants were given 20 minutes to read and sign the consent form and complete the demographic questionnaire, pretest quiz, and three questionnaires. This quiz was given to assess participants' knowledge of vicarious trauma and the two questionnaires STSS and TSC-40 were used to measure whether they were displaying symptoms of vicarious trauma, and one questionnaire Self-care assessment worksheet was to assess whether they practice any self-care techniques. This was followed by a 10-minute introduction of the presenter and the study. Following the introduction a hard copy of the PowerPoint presentation along with the workshop agenda was given to the participants. Following this phase of the workshop for approximately 30 minutes, I described to the group the definition of vicarious trauma and the difference between vicarious trauma and other common terms such as countertransference, burnout, compassion fatigue, shared vignettes that described each of these terms, talked about some facts about vicarious trauma and its effects, and explained the Constructivist Self Development Theory, and talked about the coping strategies, and risks and resiliency factors. After introducing these terms I asked the participants if they had any questions or thoughts. Following this phase of the workshop for approximately 30 minutes, I talked about self-care and the difference between self-care and self-indulgence, self-care as a technique to manage and/or reduce vicarious trauma. I described the five self-care methods from my dissertation; mindfulness, spirituality, professional support, leading a healthy lifestyle, and having a support system. I also handed out a compilation of articles on how psychotherapists have successfully incorporated self-care into their routine to manage vicarious trauma. Last, I lead the group in a 30-second quick relaxation as example of self-care, followed by question/answer session. The workshop ended with a period of 10 minutes to allow participants to answer the posttest quiz and the workshop evaluation survey.

APPENDIX L

Summary Of Results

This workshop included 20 participants who were graduate students working with traumatized clients at their practicum sites. Second, third, and fourth year doctoral students in the PsyD and PhD program in the Bay area were recruited to participate in this study. Quantitative outcomes from the pre and post Quiz, Self-Care Assessment Worksheet, Secondary Trauma Stress Scale, Trauma Symptom Checklist-40 and themes that were drawn from the qualitative analysis of the interview questions during follow-up meeting and the workshop evaluation survey is as follows.

Research question 1: Will participants gain a better understanding of vicarious traumatization after attending the workshop? It was hypothesized that after attending the workshop, participants will gain a better understanding of vicarious trauma and its effects. Results supported this hypothesis. Participants reported greater understanding of vicarious traumatization after attending the workshop and this was demonstrated by an increase in 19 participants' scores from pre-test to post-test. One participant maintained the same score during pre and post-test.

Research question 2: Did the workshop help participants increase self-care activities? It was hypothesized that due to attending the workshop participants' self-care practices will increase, as they understand the importance of self-care while working with trauma clients. Results partially supported this hypothesis. While participants' were motivated to integrate self-care in their weekly routine and had increased scores in the following areas of self-care; physical, psychological, emotional, spiritual, work balance, and overall balance they still struggled with managing professional self-care.

Research question 3: Did the workshop help reduce symptoms of vicarious trauma? It was hypothesized that due to attending the workshop participants' vicarious trauma symptoms will reduce as they learn better ways to take care of themselves while working with clients with trauma. Results partially supported this hypothesis. As self-care increased

symptoms of vicarious trauma reduced in subscales; STSS-intrusion, STSS-avoidance, and overall secondary trauma (STSS), except for STSS-arousal scale. Also, TSC-40 subscales; dissociation, anxiety, depression, sexual abuse trauma (SATI), sleep disturbance, sexual problems, and overall scores during post-meeting were inconsistent.

Vicarious Trauma: Overall, thirteen participant scores decreased, three participant scores stayed in the same range, three participant scores increased from baseline, and one participant was consistent and stayed below baseline.

Research question 4: What were the opinions and experiences of participants regarding the use of self-care techniques presented in the workshop? This was a structured interview as the focus was to gather qualitative data in order to understand if the participants' utilized the knowledge gained from the workshop during the two-week period before the follow-up. Themes that emerged were Importance of awareness towards this topic and the need to include this in graduate training, Increase in self-care practices due to awareness, Most participants reported not having enough time as the main Obstacles to self-care, Participants stated that Self-care had a positive impact on managing vicarious trauma, and participants mentioned feeling good and productive after doing self-care hence it was the main motivation to practice self-care.

Research question 5: What feedback will participants offer regarding areas of strength, weakness and ways to improve the workshop? The workshop evaluation survey inquired whether the participants learned new information, what they found most useful, what they found least useful, and any suggestions to improve the workshop. Question 11, "To what extent did this workshop prepare you to work efficiently with trauma clients?" had the least scores ($m = 4.30$). Overall mean scores of participants' ratings on the quality of the workshop were in the range of ($m = 4.65$ to $m = 5.00$). All participants said the workshop was helpful. Four participants mentioned the need for more group participation and interaction, three

participants stated that they would have liked to receive the examples and handouts of the vignettes shared during presentation, and one participant said, interactive activity and video clips would have been helpful.