INTERPERSONAL TRAUMA,

VICARIOUS TRAUMA AND PROTECTIVE MEASURES

by

Lori Sangha

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APPROVED BY

Karen Grant, Ph.D., Advisor, Counselling Psychology Faculty

Glen Grigg, Ph.D., Faculty Reader, Counselling Psychology Faculty

Division of Arts and Sciences

Abstract

The impact of interpersonal trauma can be devastating for survivors. Survivors who have directly experienced violence perpetrated against them may seek therapy for assistance with a wide range of negative consequences, challenges, and symptoms associated with the traumatic event(s). Trauma therapists who work with survivors and are vicariously exposed to their clients' trauma narratives, pain and suffering, are at risk of suffering consequences themselves due to the emotional stress and strain of the work. Some therapists will experience reactions and symptoms that are similar, yet not as severe as their clients'. The possibility for positive consequences, growth and resilience are also possible. Measures can be taken on a personal, professional and organizational level to counteract stress and promote therapists' resilience. Three essays are presented in this manuscript-based thesis which illustrate interconnected and key aspects of the central topic of the trauma therapist's experience.

Keywords: interpersonal trauma, survivors,trauma therapist, secondary exposure, vicarious trauma, protective measures

Dedication

To survivors and to those we have lost.

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CHAPTER ONE: INTRODUCTION

Problem Statement And Context

The field of traumatology is relatively new with continual developments in research and ongoing analyses by researchers and authors on the many aspects of psychological trauma, including the impact of vicarious trauma on therapists. Direct exposure to interpersonal traumatic events has multiple consequences for survivors. The definition of a traumatic event from the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM 5) (American Psychiatric Association, 2013; First & Tasman, 2006) is often utilized in the field of mental health and counselling psychology. Trauma is described in the DSM 5 as "exposure to actual or threatened death, serious injury, or sexual violence" (p. 271). Exposure to traumatic events is further defined in the DSM 5 as either "direct", "witnessing", "learning" about, or "experiencing repeated or extreme exposure to aversive details of the traumatic events" (p. 271). Clients may have been exposed directly to traumatic events, while therapists can be considered secondarily, or vicariously exposed by witnessing, learning about, and bearing witness to clients' narratives and experiences of trauma (Ford & Courtois, 2009; Pearlman & Caringi, 2009).

It is recognized by authors who take a broader perspective that trauma may be the result of a series of minor incidents over time, to a major crisis or catastrophe, and that it is the *perception* of threat which is a key consideration in defining trauma (Levine, 2005). A definition of trauma that informs the basis of understanding for this paper is provided by Briere & Scott (2015). They conclude "…an event is traumatic if it is extremely upsetting [and] at least temporarily overwhelms the individual's internal resources, and

produces lasting psychological symptoms" (p. 10). My focus in this manuscript-based thesis is on complex forms of interpersonal trauma which therapists encounter in their work with adults. These forms of trauma typically involve acts of abuse and violence towards individuals in relationships that cause overwhelming stress, betrayal and a shock to the survivor's psychological system (Briere, 2015; Van der Kolk, 2001). The impact of interpersonal trauma can involve "a cascade of biobehavioral changes" (Van der Kolk, 2001, p. S50) and is further exacerbated by developmental, historical or intergenerational traumatic experiences (Ford & Courtois, 2009).

Therapists who work with individuals who have experienced complex forms of trauma are exposed to traumatic experiences indirectly by learning about it, and being exposed to details through client narratives, disclosures and expressions of pain and suffering. Supporting clients effectively through their healing and recovery requires the essential elements of a strong, safe, therapeutic alliance, empathic engagement and attunement on the part of the therapist, regardless of the modality or techniques utilized (Briere, 2015; Herman, 1992; Miller, Duncan & Hubble, 1997). Posttraumatic therapy can be an emotionally intense and intimate process, and one that can present unique challenges and risks for the therapist (Harvey, 2007; Pearlman & Caringi, 2009).

Human beings, whether in the role of therapist or client, are not invincible or invulnerable to the consequences of stress and trauma. Given this realization, trauma therapists may be considered a "high risk population" for conditions such as secondary traumatic stress (STS) , compassion fatigue, vicarious trauma , and eventual burnout, which is considered a more progressively occurring condition (Figley, 2005). As Cerney notes, (as cited in Figley, 1995), trauma therapists "are especially vulnerable to STS…as

the assault on their sense of personal integrity and belief in humanity can be so shattering that it places them in a special group of traumatized individuals….similar in many ways to the individuals they treat" (p.4). The negative effects of trauma work may not always be obvious, may be obscured, or occurring at an unconscious level for therapists even though they may be natural and expected (Pearlman & Caringi, 2009; Rothschild, 2006).

Interpersonal trauma most often involves threats and acts of violence perpetrated against women (Province of BC, 2010). There are many types of violence and therapists are likely to encounter the complexities of clients' problems and challenges associated with childhood abuse, sexual violence, loss and violence in relationships, and domestic violence. In addition to the devastating physical and psychological harm incurred by trauma, interpersonal violence is also a public, social and health issue that should not be ignored.

These are considered gender and power-based acts and crimes. In British Columbia (BC), public policy and initiatives have been developed due to an ongoing and urgent need to address the dangers for women and children in particular. In 2010 the Ministry of Justice updated the "Wife Assault" policy to the "Violence Against Women in Relationships" policy. In 2012 a Provincial Office of Domestic Violence was established in BC with a mandate to coordinate resources, reduce and respond to domestic violence (Province of BC, 2012).

In addition to the negative consequences associated with trauma, clinicians and researchers are recognizing the potential for positive transformations that can develop in the aftermath of trauma and during the therapeutic process for both clients and therapists (Arnold, Calhoun, Tedeschi & Cann, 2005; Cann, Calhoun & Tedeschi, 2010; Hunter,

2012; Lindstrom & Triplett, 2010; Mancini & Bonanno, 2010; Tedeschi & Calhoun, 2000). This orientation is grounded in the principles of positive psychology with a focus on capacities, strengths, success, resilience and growth rather than a focus on pathology and dysfunction (Csikszentmihalyi & Csikszentmihaly, 2004; Hunter, 2012) as well as in relational healing (Dalenberg, 2004; Ford & Courtois, 2009). These are consequences that are often overlooked and understated in the literature and in practice (Lindstrom & Triplett, 2010; Ungar, 2010).

Whether therapists are new to the profession or seasoned, there are strategies that assist and support them in maintaining their capacity to remain empathetic, effective, and sustain hope in their work with traumatized individuals. There are measures that can be taken to prepare, prevent, reduce, buffer and ameliorate the harmful effects and adverse reactions associated with secondary exposure to trauma (Meichenbaum, 2007; Rothschild, 2006; Saakvitne &Pearlman, 1996). A multidimensional approach promotes proactive measures and shared responsibility beyond individual coping and self-care strategies. As Herman states, "There are no personal attributes of the individual sufficient in itself to offer reliable protection against the negative effects of trauma" (Herman, 1992, p. 57).

Purpose and Objectives

This manuscript style thesis includes a collection of three essays which I have written that provide an overview and broad perspective on the central topic of the impact of secondary traumatic exposure on the trauma therapist. Each essay represents a key and interrelated area of the central topic. The first essay addresses the scope and nature of interpersonal trauma in British Columbia. The impact of interpersonal violence, risk

factors, and other special considerations are included in this essay. The subject of the second essay is the experience of trauma therapists who work with trauma survivors. I describe both negative and positive consequences of the work, as well as several of the risk and contributing factors. In the third essay I illustrate preventative and protective measures that are recommended in the literature, that can assist therapists with the negative effects of their work, and promote resilience and growth. In the final concluding chapter I summarize and highlight key points from the three essays.

There are several objectives for this undertaking. The overriding goal is to offer a holistic and well balanced view of the issues. The objectives are related to gaining a greater understanding and raise awareness of the following:

- the nature and scope of the problem of interpersonal violence in British Columbia

- that in addition to the psychological issues, there are significant social, cultural and environmental factors related to interpersonal violence

- literature and research from key sources in the field on the impact of secondary traumatic exposure on therapists

- the potential impact of vicarious trauma on the therapist's role, functioning and the therapeutic process

- the constructs and models that have been developed and applied in the literature in relation to the impact of trauma work on the therapist, and those that are emerging, such as posttraumatic growth

- how constructs are defined and distinguished from one another and where there is overlap

- factors and variables that contribute to different outcomes for trauma therapists

- strategies that have been traditionally recommended to promote trauma therapists' health and psychological well being and, and those that are not as commonly known

- the importance of self-reflection and assessment of individual, professional and organizational realms in order to ensure actions that promote well being and counteract vicarious trauma for trauma therapists

Use of Language

The term secondary traumatic exposure, or secondary trauma is used interchangeably at times with the synonymous terms of vicarious traumatic exposure, indirect traumatic exposure, and the variations of secondary trauma, vicarious trauma, etc. I attempt to reserve the use of the term vicarious trauma or traumatization to refer to a specific, unique and serious hazard for trauma therapists. The term trauma therapist will be used for ease of understanding and to refer to both therapists that self-identify as trauma therapists and those who may not but who provide trauma specific therapy to clients. Other considerations around the use of language and interpretation of terms are addressed in each chapter.

Significance of Research

How therapists might be impacted by engaging in the treatment of trauma and some of the clinical implications are addressed in this thesis. It is vital that trauma therapists acknowledge and attend to the potential negative effects on their personal and professional lives. Although self-care strategies are essential measures in sustaining healthy functioning and effective therapeutic care, other actions can also be taken. The possibility of therapists engaging in social justice activities as a preventative and

proactive measure is proposed, for example, and this could serve multiple purposes (Harvey, 2007; Rothschild, 2006; Saakvitne & Pearlman, 2006). In addition to the personal and societal value, this fulfills the ethical obligations of the profession, particularly connected to the principles of "Responsible Caring" and "Responsibility to Society" (BC Association of Clinical Counsellors, 2008). There are several topics outlined in relation to trauma, recovery, healing, and therapeutic practice that can be applied in the areas of education, training, professional development and program development. The essays provide information that may be relevant not only to trauma therapists, but also in related areas of work, such as health, justice, child welfare, family services, anti-violence and victims' services.

Limitations

This thesis represents an overview of some of the key areas related to therapeutic practice with trauma survivors, the psychological impact of trauma on clients, and the effects of secondary trauma on therapists. The scope of literature is wide, and continues to expand and diversify on these topics. The understanding of the impact of secondary trauma exposure has developed from research with family members, caregivers, medical personnel, and first responders (Figley, 1995; Pearlman & Mac Ian, 1995). I have sought out sources of data and research that are most closely related to the topics of interpersonal trauma, and the work of trauma therapists with survivors of interpersonal violence for these essays . Although these variables are emerging topics of interest in the field of research, there are still few available studies that target the population of trauma therapists exclusively, and even fewer that are specific to Canadian communities. Therefore, research that has been conducted with other subjects such as graduate students

of psychology, interns, clinicians and psychologists, and other helping professionals are also presented to reflect the current trends in research. Whenever possible, research and data pertaining to interpersonal trauma that involves violence in relationships is drawn upon, rather than other forms of interpersonal trauma. Sources of information that pertain to the helping profession or provision of therapy in general are utilized, as these are considered significant foundational pieces of work in the field of traumatology.

A matter that I do not directly address in this paper is the notion that trauma, resilience and psychology in general, are culture bound constructs (Ungar, 2010). Western values of autonomy and self-reliance for example, do not match the ideals or needs of individuals across all populations and cultures. Applying a broader multicultural lens to the topics represented in this thesis would help reflect other aspects that would bring a more inclusive and comprehensive perspective on the subjects.

CHAPTER TWO: INTERPERSONAL TRAUMATIC STRESS

The topic of psychological trauma and its impact on adults is of primary importance in the field of counselling psychology and mental health. Therapists in a variety of settings provide counselling services for individuals impacted by the effects of trauma and stressors of an interpersonal nature. A greater understanding of the scope and sequelae of interpersonal trauma can strengthen the foundation for providing effective services, and help to promote a well-informed and compassionate response to individuals suffering from trauma related stress.

In this chapter I begin with a review of the posttraumatic stress disorder construct. I then introduce the topic of interpersonal trauma with a focus on interpersonal violence against women. Next, I present data on the prevalence of interpersonal violence, drawing mainly from local provincial and national sources. In the final section I discuss the impact, risks and consequences for survivors of interpersonal violence.

There are terms used in this paper to refer to the same or related concepts, and similar terms that describe distinctly different ones. A brief explanation may help to preempt any confusion while reading. I will use the abbreviated form, "IPV", to refer to intimate partner violence, and "IPT" for interpersonal trauma. Instead of shortening it, I will use the term "interpersonal violence" in its long form, for clarity. I will use the terms "victim" and "survivor" at different times in the paper only to match the language used in the sources and contexts which I am drawing from. From the perspective of a counsellor, I prefer to use the more empowering and strengths-based term "survivor", to refer to those who have experienced traumatic events.

Attention to this crucial topic has grown since the 1980's following the formal establishment of posttraumatic stress disorder (PTSD) in the Diagnostic and Statistical

Manual of Mental Disorders III (DSM-III) (American Psychiatric Association, 2013; First & Tasman, 2006). The DSM classification for PTSD has been revised over time and in the current fifth edition includes a total of twenty criteria, grouped into four symptom clusters, which are briefly described as follows:

1. Intrusion/re-experiencing which includes intense psychological or physical distress in reaction to trauma reminders, nightmares and dissociative reactions such as flashbacks.

2. Persistent avoidance of people, places, activities, or of distressing memories, thoughts or feelings associated with the traumatic event/s.

3. Negative alterations in mood and cognitions such as loss of memory, exaggerated negative beliefs about oneself, others, or the world, persistent feelings of fear, horror, anger guilt, or shame.

4. Alterations in arousal and reactivity, including hypervigilance, self-destructive behavior, or feelings of detachment.

Specifiers to capture possible features of dissociative symptoms and delayed expression of PTSD symptoms have been incorporated into the diagnostic criteria , as well as a subtype of PTSD for "Children 6 Years and Younger" (American Psychiatric Association, 2013).

PTSD was previously classified as an anxiety disorder in the DSM and now falls under the category of "Trauma and Stressor-Related Disorders". It is distinct from other disorders in that it requires an external experience in the form of a traumatic event (Briere, 2015; First and Tasman, 2006). The definition of a traumatic event is defined in the DSM-5 as "…exposure to actual or threatened death, serious injury, or sexual

violence". There are four criterion listed regarding the way in which an individual may be exposed to a traumatic event:

- Directly experiencing the traumatic event

- Witnessing the traumatic event in person

- Learning that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental)

- Experiencing repeated or extreme exposure to aversive details of the traumatic events (not through media, pictures, television or movies unless work-related)

(American Psychiatric Association, 2013)

There is controversy over the DSM-5 definition of a traumatic event as it omits incidents that may not be life threatening, but constitute a severe threat to psychological integrity and cause an equal degree of suffering (Briere, 2015). As research has continued to expand in the field of traumatology, more extreme and distinct forms of the disorder, known as "complex posttraumatic stress disorder" (Complex PTSD) (Herman, 1992), or "complex traumatic stress disorders" (Ford & Courtois, 2009) have become associated with interpersonal traumatic events that are particularly severe, prolonged and repeated. Although these disorders are not listed in the DSM, survivors of these more complex traumatic events are considered to experience an overall impact beyond the symptoms of PTSD, with primary features being somatization, dissociation, and affect dysregulation (Ford & Courtois, 2009; Herman, 1992).

Interpersonal trauma (IPT) typically involves more than a single incident, unlike traumatic events such as a natural disaster or a life threatening car accident (Astin, Ogland-Hand, Coleman & Foy, 1995). IPT includes abuse and violence against children,

women, men, older adults, a group or culture. Types of IPT include, but are not limited to, childhood abuse and neglect, incest, war, torture, community violence, racism, hate crimes, kidnapping, hostage-taking, and other crimes against the person (Justice Institute of British Columbia, 2011). Interpersonal traumatic stressors may be recurring, prolonged or continuous, and vary in their magnitude and subsequent harm . IPT may be transmitted across generations such as in the case of Canada's aboriginal population, with historical atrocities which involved forced isolation, discrimination and widespread abuse in the residential schools (Camfield, 2013).

Intimate partner violence (IPV) comprises the largest category of interpersonal trauma. This term is used interchangeably with several others in the literature, for instance, spousal assault, wife abuse, battered women, relationship violence, and domestic violence (Government of Canada, n.d.). Domestic violence usually refers to acts which occur within a family setting or household. As acts and crimes of IPV are most often committed by men towards women, the language and research associated with this topic tends to reflect this gender disparity (Province of BC, 2010). The vast majority of literature on interpersonal violence focuses on violence perpetrated against women in heterosexual relationships. This excludes populations of individuals in the lesbian, gay bisexual, transgender, queer and two spirited (LGBTQ2S) communities. Ristock (2005) reports there are specific behaviors around violence associated with the larger contexts of homophobia, biphobia, transphobia and heterosexism. Specific issues of exclusion and domination affect responses to trauma and recovery for these individuals.

The term "Violence Against Women in Relationships" (VAWIR) has been adopted by policy makers in British Columbia's (BC) public safety and child welfare

systems to signify IPV consisting of the range of physical and sexual violations that might occur against women in domestic, spousal, or other relationship types in which the perpetrator is a person known to the victim (Justice Institute of BC, 2011; Province of BC 2010). However, the VAWIR policies and associated sections of the law are also meant to be applied to any victim of violence in relationships, regardless of gender.

The prevalence of IPV/domestic violence is so vast that it has been referred to as "a public health issue that has reached epidemic proportions globally" (Wortham, 2014, p. 7). While women in heterosexual relationships are affected more often and more severely by IPV, victims can also include males. IPV occurs in same-sex relationships as well as heterosexual relationships. It occurs across cultures, ethnic groups, socioeconomic levels, ages, genders, gender identities, and sexual orientations (Ending Violence Association of BC, 2013). IPV consists of behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, shame, hurt, injure, or wound the other partner.(Johnson & Dawson as cited in Jackson, 2011; The United States Department of Justice, n.d.,). These abusive behaviors are considered power based acts and crimes, with women being affected more often than men (Hoff, 2010; Humphreys, 2008; Province of BC, 2010; Kendall-Tackett, 2005).

Patterns of violence in relationships can vary from being gradual and coercive, cyclical, constant, or less predictable. Violence may also be situational or an act of self-defense in an attempt to stop aggression against oneself (Jackson, 2011). Types of violence include coercion, intimidation, threats or acts of physical and sexual assault, the threat or use of weapons, financial/economic abuse, psychological and verbal abuse, deprivation of liberty, stalking, harassment, forced isolation, destruction of

objects/property, threats to harm pets or others close to the victim (Bryant-Davis & Wong, 2013; Johnson & Dawson as cited in Jackson, 2011; Province of BC, 2010).

There are many forms of sexual violence including sexual exploitation, sexual harassment, voyeurism, unwanted sexual touching, and sexual attacks. Acts of sexual violence include both physical and non-contact forms of sexual abuse. IPV can take place in present or former common-law, same-sex, friendship, or dating relationships (Basile, 2005; Jackson, 2011). Violence against women also occurs in non-spousal relationships, with a range of abusive acts and crimes perpetrated by associates, or strangers.

Although some acts of sexual violence involve physical contact and others do not, the common determinant is that "the survivor is unable to consent, or unable to refuse the sexual activity" (Kendall-Tackett, 2005, p. 101).   The use of the word "rape" was removed from the Canadian Criminal Code in 1983 and reclassified as an assault, in an attempt to reduce the stigma towards women that stemmed from sexism in both social and legal realms. Other changes in the law included recognition that sexual offences do occur within marital relationships and women's' testimony could be admissable. Maximum penalties for sexual assaults range from ten years to life sentences for the most serious "aggravated sexual assault" offences in Canada, which cause extensive physical and psychological damage (Tang, 1998).

The word rape is still used as a criminal definition in the United States as well as in local Canadian social discourse, certain literature and community service agencies. The terms "date rape" and "marital rape", for example, are familiar terms which are used to

refer to violent assaults against women, consisting of forced sexual intercourse (Basile, 2005).

The Prevalence and Impact of Interpersonal Violence

The fact that IPV is a gender-based crime is supported by the data on victimization, evident in national and provincial statistics, which points to an alarming and ongoing serious threat to the safety and well-being of large proportions of women in Canadian communities. In Canada, statistics on physical and sexual violence are based mainly on crimes which appear in the Criminal Code of Canada. Data that is based on police reports excludes the majority of violent acts against persons actually committed due to underreporting, and the focus on acts that constitute criminal offences. Crime statistics are compared and considered with self-reports gleaned from national General Social Surveys (GSS) on victimization which are conducted every five years (Sinha, 2013a). The GSS examines victimization in relation to offences of physical and sexual assault, stalking and harassment, robbery, as well as specific information on spousal assault (p. 10). What follows is a compilation of selected results from the collection of data on interpersonal violence, which helps to illuminate the nature and scope of this critical issue. The limitations and absence of other sources of available data raises questions and draws attention to outstanding issues surrounding this subject.

Given that, according to the Canadian Justice Department, nine in ten sexual assaults are never reported to police, that leaves the vast majority of these crimes, approximately 90%, unaccounted for in the figures (Sinha, 2013a). As well, fewer than one in four, or less than 25% of all incidents of IPV are reported to police, (Province of BC, 2015; Sinha, 2013a; Statistics Canada, 2009). This points to the significant issues of

underreporting by victims of abuse in relationships, and to the fact that published data is only revealing a fraction of the actual picture. It also raises questions about victims' levels of fear and distrust of justice systems, of powerlessness, whether minimization is a factor, and to what degree societal attitudes are factors.

Even with these limitations, and narrow view, it is, unquestionably, an extremely dire situation for women. Women are more likely to experience more severe forms, multiple types and repeated incidents of victimization (Astin et al., 1995; Basile, 2005; Goodman & Epstein, 2008). The rates of reported IPV overall is four times higher for women than men (Sinha, 2013a; Statistics Canada, 2009). In addition, women are six times more likely to report being victimized by a previous spouse than a current one (Sinha, 2013a). Common incidents of IPV involve women being beaten, choked, or threatened with a gun or a knife by a partner or ex-partner (p 10).

Women comprise 83% of all victims of spousal violence and men are the perpetrators in at least 81% of cases of violence against women (Sinha, 2013a). Women are eleven times more likely than men to be victims of sexual offences and in 84% of cases the abuser was known to the woman (Sinha, 2013a, p.14). It is estimated that thirty-two women each day are fleeing abuse and seeking shelter in transition homes across B.C. (Sinha, 2013a, p. 10). Women report being physically injured in approximately 40% of all assaults compared to 13% of male victims (Sinha, 2013a p. 8). The national survey from 2009 indicated the rate of dating violence was 60% higher than the spousal violence rate (Sinha, 2013a, p. 19). Although traditionally men are more likely to become victims of violence at the hands of strangers than women, the most recent national survey

result points to a significant increase in self-reported sexual abuse against men, however data on the the gender of the perpetrator is not provided. (Harvey, 2007; Sinha, 2013a).

Females ages fifteen through thirty-four are at higher risk for violence than older women, with rates that are three times higher for all forms of victimization (Sinha, 2013a, p. 11). Of all ten provinces in Canada, BC, (along with Alberta), has the highest rates of self-reported sexual assaults against women at more than double that of the other provinces (p. 31). In one year in the city of Vancouver alone, approximately 11,500 reports of violent crimes against women are made to the police, and of those, almost 5,000 fall under the category of intimate partner or domestic violence (p.44). Violent crimes are categorized as physical and sexual assault, attempted murder and homicide (p.39).

The rates for spousal assaults among lesbian and bisexual women are reportedly four times higher than for heterosexual females and for non spousal violence rates were five times higher, however gender of the perpetrator is not specified in this data (Sinha 2013a, p.59). Aboriginal women are disproportionately represented in the data, with rates 2.5 to 3 times higher for violent victimization than non-Aboriginal women (Sinha, 2013a).

It is estimated that children are present in a large proportion of spousal assault/domestic violence incidents (Wortham, 2014). In BC there has reportedly been a 43% increase in recent years of children being exposed to or witnessing domestic violence and a recent report indicates exposure to domestic violence occurred in 34% of substantiated child welfare cases in BC (Province of BC, 2012, p. 7).   According to the General Social Survey results from 2009, 64 % of those with children who experienced

violence by an ex-spouse indicated that a child had seen or heard the violence

(Government of Canada, n.d.). Pond & Spinazzola (2013) suggest that up to 97% of

child maltreatment cases occur in the context of family violence (p. 2).

The consequences of IPV can escalate and become lethal, with domestic homicide

rates for female victims being 4.5 times higher than for male victims (BC Coroner's

Service, 2012; Sinha, 2013b p. 4). Women consistently constitute close to three quarters

of all homicide victims as a result of IPV, annually, in Canada. In BC, there are, on

average, 13.9 reported deaths of women killed as a result of IPV per year (BC Coroner's

service as cited in Province of BC, 2015). A history of physical assaults, choking or

attempted strangulation, threats of suicide by the abuser, access to weapons, stalking and

harassment are all, among other factors, strongly linked to lethal violence (Campbell &

Kendall-Tackett, 2005; Government of Canada, n.d.).

The level of harm is compounded for certain populations of women due to a variety

of physical, social and contextual disadvantages that contribute to additional and greater

negative impacts, including revictimization. This includes women from aboriginal,

refugee, immigrant, and visible minority populations, women with disabilities, and

women from LGBTQ2S populations. Marginalization, due to language and cultural

barriers, substance use and misuse, and mental health, is an issue which compounds the

negative impact of violence against women (Ending Violence Association of BC, 2013;

Hoff, 2010; Province of BC, 2010; Ristock, 2005).

In cases of relationship and domestic violence, the risk for women is often higher

during certain times and events. Danger may escalate immediately after disclosing the

abuse to someone, when she makes attempts to leave, upon separation, when legal actions

are pursued via the justice system or family court system, or when entering a new relationship (Ending Violence Association of BC, 2013).

The Impact

The impact of IPT is distinct from noninterpersonal types of trauma, and can result in women experiencing a wide range of trauma-related symptoms and PTSD effects. It is important to consider that there is great diversity in how people respond to trauma, as well as how they may define and make meaning of trauma, and in the way they may experience symptoms and recovery (Harvey, 2007; Lepore & Revenson, 2006). The lifetime prevalence rate for PTSD in the the general population is approximately 8.7%, and for depression it is 10 % (American Psychiatric Association, 2013). PTSD rates for women who have experienced physical and sexual violence range from 33% to 83% (American Psychiatric Association, 2013; Campbell & Kendall-Tackett, 2005; Humphreys, 2008; Jackson,2011; Scott & Eliav. 2005). A variety of studies indicate anywhere from 45% to 84% of women in transition homes meet the criteria for PTSD (Astin et al., 1995). According to the American Psychiatric Association (2013), the highest rates of PTSD overall are found among survivors of rape (p. 276).

The risk of suffering the effects of PTSD can be substantially greater and more severe for women facing interpersonal violence who also experienced childhood abuse (Astin et al., 1995; Minshew & D'Andrea, 2015; Schumm, 2006; Seng, D'Andrea & Ford, 2014). If abuse occurs while a woman is pregnant, combined with a prior history of childhood abuse, the risk for suffering PTSD can be up to twelve times higher than for women who are not pregnant (Seng et al., 2014). In a study with women examining the

variables of child abuse and adult rape, researchers found women to be seventeen times more likely to suffer symptoms of PTSD and depression (Schumm, 2006).

There is a close link between mental health, substance use and IPT for women.   In a collection of data from across Canada, 90% of women in substance treatment centres indicated abuse-related trauma as children or adults and 60% indicated other forms of trauma (BC Provincial Mental Health and Substance Abuse Planning Council, 2013 ; Campbell & Kendall-Tackett, 2005).   It is difficult to determine a causal link, however, and it may be that exposure to trauma in the form of abuse increases the likelihood of these issues arising for women, and for others substance use and mental health issues increase their vulnerability of being exposed to traumatic events (Campbell & Kendall-Tackett, 2005).

Given that IPT is typically violent, intentional, and may occur repetitively or multiple times over the course of a woman's lifetime, the impact can be far reaching, virtually negatively affecting all aspects of her development, life, and capacities.

The surfacing of trauma effects and symptoms may be delayed for weeks, months or years after a traumatic event(s).   A major stressor or incident may trigger any number of trauma symptoms (Ford & Courtois, 2009; Herman, 1992; Levine, 1997). Symptoms may abate, then recur and intensify during particularly stressful times in one's life. Difficulties associated with the effects of trauma can be transient, or persist for months, years, decades, or a lifetime (Basile, 2005; Forbes , Fletcher, Parslow, Phelps, O'Donnell, Bryant & Creamer 2012). It is estimated that 25% of those who suffer psychological trauma seek help, and these are also the ones who have experienced the most severe types

of violent abuse (Ford & Courtois, 2009). It also follows that women tend to seek counselling services more often than men (Cox, 2014).

Consequences of IPT are felt in both the body and the mind with a broad range of complex and interconnecting symptoms (Beck, Grant, Clapp & Palyo, 2009; Herman, 1992; van der Kolk, 2001). Complex PTSD is described by Briere (2015) as a "disturbance of self", with relational and identity problems being predominant. Disturbing and profound changes can occur in personality, self worth, self-concept, and emotional regulation.   An overall sense of disconnection with oneself, others, and the world is a common experience among survivors and points to alterations in physiology and the nervous system as well (Briere, 2015; Levine, 2005; van der Kolk, 2001).

Problematic changes in multiple areas of functioning can develop for survivors. A sense of disorganization in areas of cognition, arousal, attention, perception, memory, knowledge and emotion can occur. The dynamics of power and control involved in violence can cause a profound sense of helplessness and loss of control for the survivor (Ford & Courtois, 2009; Herman, 1992).   The emotional toll can be debilitating, with intense fear, anguish, confusion, shock, disbelief, anger, shame, and anxiety being common experiences among survivors. Depression/sadness, guilt and self-blame or perceptions of over-responsibility for the violence are frequent consequences as well. (Beck et al., 2009; Beck et al., 2015; Briere, 2015). The survivor may suffer physical injuries in addition to profound psychological suffering. Emotional horror and "the terror of being confronted by their own vulnerability" are prominent aspects of the survivor's suffering in the aftermath of trauma (Janoff-Bulman, 1992, p. 60).

One's fundamental core beliefs and assumptions about themselves and the world are shattered for those who suffer the most from the effects of trauma (Janoff-Bulman, 1992; Levine, 1997). A basic trust in what was known and believed prior to the trauma can virtually disintegrate afterwards. This can signal profound distress and an existential crisis of meaning for the individual. Interpersonal trauma represents a threat to one's life, bodily integrity, and sense of safety and security. When the threat overwhelms the survivor's capacity to adapt, trauma effects and PTSD symptoms develop (Herman, 1992; Levine, 1997; Levine, 2005; van der Kolk, 2012). Leaders in the field of trauma describe symptoms of PTSD as normal, adaptive and automatic responses and defenses. These are attempts by the body's "survival system" to protect oneself from even greater pain, terror, and damage (Briere, 2015; Ford & Courtois, 2009; Herman, 1992; Janoff-Bulman, 1992; Levine, 1997) . The body's automatic survival mechanisms kick-in "when action, resistance nor escape are viable options" (Herman, 1992, p.34) against a threat, yet the body and nervous system stay in a constant "state of alarm" even when the actual threat has passed (Herman, 1992; Minshew and D'Andrea, 2015). This illustrates the hyperarousal and reactivity symptoms which are commonly experienced among survivors of trauma.

Distorted perceptions of reality, emotional "numbing", and intrusive memories are also common features of traumatic stress reactions (van der Kolk, 2012). Avoidance, either internally, with thoughts and emotions, or externally, in behavior, may be unconscious and automatic stress responses to trauma (Janoff-Bulman, 1992). Individuals may find themselves unpredictably vascillating between experiencing these different sets of contradictory and perplexing symptoms. Somatic distress in the form of

chronic pain or ailments may arise. For some individuals, dissociative episodes, or altered states of consciousness may come and go, with the most severe state being one of total amnesia (Briere, 2015; Herman, 1992; Janoff-Bulman, 1992).

If violence occurs in relationships or families, there are additional psychological ramifications due to the experience of betrayal and complexities of relational and family dynamics. Sexual abuse, in particular, which exacts suffering due to the physical, moral and psychological violations involved, is compounded by the breach of attachments in these relationships (Basile, 2005; Herman, 1993). Psychological damage can be even more severe for women if victim blaming occurs, which can result in revictimization and retraumatization   (Humphreys, 2008).

The impact of interpersonal violence often produces effects and symptoms beyond the construct of PTSD sequelae, and van der Kolk (2001) and others claim that "pure" PTSD may be the exception more than the norm . It is estimated by the American Psychiatric Association (2013) that 80% of those suffering with PTSD likely have symptoms of at least one other mental health disorder ,and these are usually depressive, bipolar, anxiety or substance use type disorders (p. 280) . Other posttraumatic clinical outcomes include acute stress disorder, brief psychotic disorder, and dissociative disorder, among others (Briere, 2015).

There are a range of behaviors that may be demonstrated by persons suffering from the effects of interpersonal trauma that negatively affect multiple aspects of their lives, including their social, occupational, and physical functioning. Being overwhelmed by the horror of violence in its many forms, may leave many women "imprisoned by their fear and unable to engage in life" (Levine, 1997, p.28). Risky behaviors such as substance

misuse, binge/purge eating, self-mutilation, and compulsive sexual behavior may occur, and yet paradoxically may be attempts at controlling one's pain and fear. A survivor may seem inattentive or appear to be in a hypnotic trance. Other outcomes may be expressed as a preoccupation with danger, social alienation, isolation, aggressive behaviors, and suicidal tendencies (Briere, 2015; Ford & Courtois, 2009; Herman, 1992). Disruptions in relationships are often primary consequences. As illustrated by Johnson & Whiffen (2001), "those who have been violated in close relationships simultaneously desperately need and seek, and fear and avoid closeness".

Conclusion

Interpersonal violence of many forms affects a large proportion of women across this province, and nation. Violent acts against women occur in cultures and societies across the globe and has been described by the World Health Organization (2012) as "the most widespread and socially tolerated of all human rights violations". National and provincial sources of data help to shed light on the the broad scope and nature of interpersonal violence and the clear gender disparity of physical and sexual violence. However, information is limited to those acts which are reported and also fit the criteria for criminal offences, which results in a gross underestimation. Although this information benefits our understanding, it is the missing data, on violence and abusive acts that are not reported or do not meet the criminal threshold, that gives us greater clarity on the profound gravity of this issue. This also leads to the conclusion that the number of women experiencing any form of an entire range of interpersonal abuse and violent actions against them, on any given day, in this province alone, is staggering.

The risk of danger to women from acts of violence and abuse remains steadily high and this includes the risk of lethal harm (Sinha, 2013a). The preponderance of interpersonal violence against women occurs in the domain of established relationships. Sexual violence affects women almost exclusively. There is also an indication of a changing trend with increased reports of victimization of men. Shifts in reporting may reflect changes in societal attitudes which promote greater acceptance and safety around acknowledgement of harm for men, and for women. Women in marginalized populations are over represented in the victimization statistics and the negative consequences of abuse and violence for these individuals can be exacerbated due to a number of psychosocial and historical issues .

The research on the prevalence and risk for PTSD and the impact of interpersonal trauma on female survivors illustrates the depth and breadth of this troubling phenomenon. Many leaders in the field of traumatology utilize a broader definition of trauma than what is published in the most recent and fifth revised edition of the DSM. As well, the psychological distress and suffering in reaction to horrific threats and acts of abuse against women, can be so devastating that all aspects of her inner and outer world are affected, and can, at its worse, result in catastrophic and long lasting changes beyond the symptoms of PTSD (Bryant-Davis & Wong, 2005; Forbes et al., 2012; Goodman & Epstein, 2008; Herman, 1992; Janoff-Bulman, 1992).   The four hallmark trauma symptom categories of PTSD, intrusion/re-experiencing, avoidance, mood and cognition, and arousal may only describe part of the impact on women. Intimate partner violence against women often involves multiple incidents and may be experienced over prolonged periods of time. If a woman also suffered childhood abuse or neglect this can lead to

more complex and severe trauma reactions. Consequences in addition to the symptoms of PTSD have been captured in the literature on complex PTSD and complex traumatic stress disorders (Ford & Courtois, 2009; Herman, 1992). There are a vast array of potential negative effects and consequences individuals may experience, and how this occurs will vary from one person to the next. They range from acute fear and threat responses to lasting changes in mood and cognition (Lepore & Revenson, 2006). The level of despair can be so great, and the disturbances so deep, that every aspect of ones' life are affected, particularly in relational domains. Devastating changes can occur which alter both the body and mind of the survivor (American Psychiatric Association, 2013; Forbes et al., 2012; Herman, 1992; Lepore & Revenson, 2006). Acts of interpersonal violence against women signify violations of safety and betrayals of trust. Many women who have suffered the atrocities of abuse and violence will seek therapy. This may be the key to helping regain a sense of stability, safety, trust and connection with themselves, others and the world.

In the next chapter I will focus on the experience of the trauma therapist. I highlight aspects of the therapist's role in posttraumatic therapy, and the potential impact of secondary exposure to clients' traumatic experiences. The negative impact of vicarious exposure to clients' pain and suffering as well as the possible positive consequences, including growth and resilience, are discussed.

CHAPTER THREE: POSTTRAUMATIC THERAPY AND

THERAPIST OUTCOMES

Much of the literature in the field of traumatology focuses on the impact of traumatic events on survivors, and on treatment and therapeutic outcomes for these clients. In this chapter I will focus on the possible consequences for the therapists who provide treatment services to trauma survivors. I begin with describing the key elements of the therapeutic relationship and general processes in posttrauma therapy. Challenges for therapists who work with survivors of interpersonal trauma (IPT) are then highlighted. Following this, I illustrate the possible trauma responses and negative consequences that trauma therapists may experience as a result of empathic engagement and secondary stress exposure.

I discuss a variety of specific constructs that are found in the literature and how therapists may be affected personally and professionally. Certain related risk factors and contributing factors are highlighted. I then present an overview of the potential rewards and gains for trauma therapists, highlighting the concepts of vicarious posttraumatic growth and vicarious resilience. Variables that are associated with growth and resilience are discussed, and a review of the research in this area is presented. I conclude with a discussion and summary of the material covered in this chapter.

"Traumatic experiences are the ultimate confrontation with human vulnerability" (Smith Kleijn, Trijsburg, & Hutschemaekers, 2007, p. 203). For individuals who are commencing therapy to assist with their recovery and healing from trauma, the process can be a long, deeply personal, and, at times, daunting one. Safety in the setting, as well as in the connection with her/his therapist is important in order to effectively work

towards goals, through challenges and to resolve issues. This is particularly crucial for people who have suffered the pain, terror, horror and betrayal of interpersonal acts of violence. (Herman, 1992; Teyber & Teyber, 2014).

There are a range of settings where posttraumatic psychotherapy may be offered, including community social service agencies, rape crisis centres, anti-violence services, government based outpatient or inpatient mental health centres, private practice offices, or other clinical settings. Therapy may be brief or long term and a wide range of models and interventions may be offered, however, the quality of the therapeutic relationship is paramount in all forms of trauma therapy, and can account for a large portion of the outcome for the client (Herman, 1997; Kinsler, Courtois and Frankel, 2009; Teyber & Teyber, 2014).

The Therapeutic Relationship

"Psychotherapy is a relational and interactive process" (Arnold, Calhoun, Tedeschi & Cann, 2005, p. 240). Developing and maintaining a working alliance depends on gaining trust with the client, and consistently providing dependable care within a context of safety and understanding (Lawson, Davis & Brandon, 2013). According to Kinsler et al., (2009), an effective therapeutic relationship in trauma therapy "models secure attachment, provides containment of anxiety,…a context within which to work out relational issues, and a basic valuing of or validation" of the client's message (p. 187). Not only is the working alliance central, the relationship between the client and the therapist is considered a "vehicle of change" in posttrauma therapy (Kinsler et al., p. 187).

As a primary tool of the therapist, empathy is the "unifying factor" across all modes of therapy (Teyber & Teyber, 2014). The capacity to engage effectively with clients depends largely on the therapist's ability to create and sustain an atmosphere of empathic attunement with the client. (Kinsler et al., 2009; Lindy & Wilson, 1994; Wilson, 2004). Wilson (2004) describes the "continuum of empathic functioning" from minimal and least effective on one end, to "therapeutic empathic congruency" on the other (p. 296). Empathy is more than just understanding, it involves a skill and ability which enables the therapist to accurately receive and understand the client's thoughts and feelings (Wilson, 2004). Kinsler et al., (2009) identify therapist qualities of being present, mindful, warm, kind, calm and gentle as essential to empathic attunement. They emphasize the importance of balancing clear boundaries with an open and honest engagement with the client.

In addition to the necessary element of empathy in providing posttraumatic therapy, is the use of compassion. Compassion applies to that which moves people from feeling for others towards actions that will help relieve the pain and suffering of others (Koerner as cited in Salston & Figley, 2003). Compassion is described by Stamm (2002) as "feeling and acting with deep empathy and sorrow for those who suffer" (p. 107). The degree to which empathy and compassion are utilized and expressed may vary from one therapist to another, across modes and interventions. These variations will also affect the quality of the therapeutic alliance, processes and outcomes (Figley, 1995). Scales used to measure empathy include *the Jefferson Physician Empathy Scale* (Hojat, Gonnella, Nasca, Mangione, Vergare & Magee as cited in Brockhouse, 2011), as well as the *Interpersonal Reactivity Index* (Davis as cited in Devilly, Wright & Varker, 2009).

Challenges and Stressors for the Therapist

For therapists working with survivors of IPT, there may be particular challenges to forming and maintaining a therapeutic relationship, due to the client's "survival responses" and associated relational distress. As Ford & Courtois (2009) state, "the therapist [may be] constantly tested in this domain" (p. 188). Clients who are suffering from the effects of severe and/or chronic forms of violence perpetrated against them may present with behaviors consistent with multiple, complex and profound negative effects. As Kasl (2002) explains, some responses that often occur for survivors include "difficulty giving and receiving comfort and care from others and fear in relationships, difficulty setting limits, affect dysregulation….low frustration tolerance, [and] lack of self-care". Survivors of IPT may have difficulty forming attachments, experience intense feelings of helplessness, fear, terror, severe anxiety, and anger (Dalenberg, 2004; Lawson, Davis & Brandon, 2013; Trippany, 2004). Trauma survivors are also likely to present with feeling powerless, demoralized, and depressed, and, possibly suicidal (Farber & Heifetz, 1982).

Ruptures to the therapeutic alliance are a particular risk in post-trauma therapy, as well as re-enactments of interpersonal difficulties (Farber & Heifetz, 1982; Teyber & Teyber, 2014). Kinsler,et al., (2009, p.193) and Herman (1992, p. 140) refer to "traumatic transference" which can occur when the therapist least expects it, often as the therapeutic relationship deepens. The client's fears and expectations of betrayal and abuse may be projected onto the therapist, with the risk of the reenactment of victim - perpetrator dynamics (Herman, 1992, p. 147). Therapists may find the relational challenges frustrating, or have difficulty managing the intense emotions that arise. In their analysis of therapists' descriptions of difficult situations with traumatized clients,

Smith et al. (2007) categorized their responses into three types: traumatic, interactional and existential. Their report illustrated the associated corresponding reactions from therapists as shock and anxiety, helpless reactions, and feeling responsible and ruminating, respectively. The specific difficulties related to the therapeutic alliance that were identified included failing to establish a working alliance, the client's anxiety to talk about past traumatic events, and insufficient progress in therapy. Therapists also identified client-related stressors such as post-traumatic symptoms, and psychosocial dilemmas such as ongoing violence in clients' lives.

Therapist Vulnerability

The topic of "therapist vulnerability" is a common one in the literature and related to negative outcomes for trauma therapists. This perspective usually refers to the therapist's own personal trauma history, and, specifically, of childhood sexual abuse (Benatar, 2000; Jenkins, Mitchell, Baird, Whitfield, & Meyer, 2011). Researchers have found prevalence rates for personal physical and sexual abuse histories among sampled psychotherapists of 33.1% (Feldman-Summers as cited in Benatar 2000) and reports of up to 81% for therapists who report having experienced one traumatic event in their past (Arnold, Calhoun, Tedeschi & Cann, 2005). Therapist vulnerability is also linked to the risk of empathic engagement with clients, and the overall "cost of caring" (Figley in Figley, 1995). These "costs" refer to psychological harm and adverse reactions for the trauma therapist, and subsequently, the potential negative impact on the therapeutic process and outcomes.

Exposure to a client's trauma narrative, pain and suffering, combined with empathic engagement, which reduces the psychological distance between therapist and

client (Brockhouse, 2011), may lead to any number of negative effects and trauma responses for the therapist. As Rothschild (2006) notes, "all emotions are contagious" (p.9).   Authors Figley (1995) and Wilson (2004) attempt to explain the processes involved in how the client's verbal and nonverbal "trauma transmission" occurs in the interactions with the therapist. Their models involve a dynamic sequence of intersecting elements and variables. Figley (1995) refers to "compassion stress" (p. 253) as being directly related to a therapist's level of satisfaction and sense of achievement in relieving the suffering of their client. If this sense of competency is not strong, then ongoing exposure to a client's traumatic material compounds this stress. Wilson (2004) uses the term "empathic strain" to illustrate the range of adverse reactions that may develop for therapists treating clients with posttraumatic stress disorder (PTSD). Rothschild (2006) claims it is the "unconscious empathy" that is most attributable to therapists' suffering (p.10).

Trauma Responses and Negative Consequences

The list of terms and concepts associated with the negative consequences for trauma therapists is lengthy, with many overlapping definitions and interpretations. A brief description of countertransference, and the syndromes of compassion fatigue/secondary traumatic stress, vicarious trauma and burnout follows. These concepts continue to be utilized, researched, and redeveloped or expanded upon in the literature. One of the common features among the terms, is the acknowledgement of the emotional burden for therapists. As Herman (1992) notes, therapists can become overwhelmed "[sharing] in the client's experience of helplessness" (p. 140). Figley (2002b) cites a wide range of negative effects on the therapist noted in the literature including psychological,

physiological, social, moral, philosophical, existential and spiritual ones. At least one study has concluded that there is "a higher mortality rate among helper professionals than among controls" (Beaton & Murphy as cited in Figley, 2002b, p. 18).

Countertransference

This concept has traditionally been used to refer to therapists' reactive feelings that arise with clients, rooted in the therapist's personal life experience, and not considered appropriate to the therapeutic process (Rothschild, 2006). It is a process that occurs in session and is usually linked to a particular client (Saakvitne & Pearlman, 1996). Countertransference (CT) is difficult to determine and difficult to measure (Figley, 2002a). There is a distinction made by some researchers between classical CT and traumatic CT (Herman, 1992; Salston & Figley, 2003;). Rothschild (2006) states CT is "a highly debatable concept" (p. 16) and that therapeutic practice has moved towards greater transparency, acknowledging, valuing and making use of the therapist's personal reactions as a tool in the therapeutic process.

Compassion Fatigue and Secondary Traumatic Stress

These two terms are sometimes used interchangeably in the literature, and at other times differentiated from one another. There is contradictory information regarding whether compassion fatigue (CF) is a trauma-specific process, and if secondary traumatic stress (STS) ought to be reserved for those situations in which a therapist is secondarily traumatized by the client's primary traumatic experiences. STS was originally intended as an explanation for the trauma reactions felt by family members and caregivers of individuals with PTSD. It was later applied to mental health therapists. (Jenkins & Baird, 2002). Then in 1995 Figley coined the term "compassion fatigue" to

refer to the stress, exhaustion and trauma responses which therapists who help the traumatized may experience (p.xiv). It may be that CF is best understood as being made up of two components, STS and burnout (Stamm as cited in Froman, 2014). As well, "STS" can refer to the collection of symptoms, or process, while "secondary traumatic stress disorder" (STSD) is also used, to specify the condition that may develop as a result of the process (Figley, 1995).

In his 1995 publication, *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those who Treat the Traumatized,* Figley professed that compassion fatigue was "…identical to secondary traumatic stress disorder (STSD) and is the equivalent of PTSD" (p. *xv*). It is proposed that CF may develop quite suddenly through identification with the trauma response of the client (Figley, 2002b). He also referred to CF as a form of "caregiver burnout" and stated it was a more "user friendly" term than secondary traumatic stress (Figley, 2002b, p. 3). Figley also contended that CF "could replace other concepts or may have been masked by other related concepts of burnout, countertransference, worker dissatisfaction and others" (Figley, 2002b, p. 3).

Some of the more popular measurements that are used to capture these processes, outcomes and symptoms, include the *Compassion Fatigue Self Test for Psychotherapists (CFST),* (Figley, 1995; Figley and Stamm in Jenkins et al., 2011), the *Compassion Satisfaction and Fatigue Test and Subscales (CSFT)* (Stamm & Figley in Figley 2002b),the *Secondary Traumatic Stress Scale* (STSS), (Bride, Robinson, Yegodis & Figley 2003 in Craun & Bourke, 2014) and the most recent revision, *the Professional Quality of Life Scale: Compassion Satisfaction and Fatigue Subscales – Revision IV* (ProQOL-R-IV), (Stamm, 1997-2005 in Rothschild, 2006). Also, the *Impact of Event*

Scale (IES) which specifically measures trauma symptoms of intrusion and avoidance is applied to practice and research in this area (Zilberg, Weiss & Horowitz as cited in Bobber & Regher, 2005).

Vicarious Trauma

Vicarious trauma (VT) is a construct identified by McCann & Pearlman in 1990 that depicts the disruptive and cumulative effects of empathic bonding with traumatized clients and can lead to changes in virtually all aspects of the therapist's functioning (Kadambi & Ennis, 2004). The foundation of VT, the constructivist self-development theory (CSDT), defines core beliefs, or schemas, in five main areas which can be negatively affected: "safety, esteem, trust, control and intimacy" (Jenkins & Baird, 2002; Saakvitne & Pearlman, 1996, p. 30). VT is considered an expected and normative consequence of trauma work, rather than a reflection of one's competence, and most likely to be a consequence in relation to interpersonal forms of secondary trauma exposure (Adams & Riggs, 2008; Benatar, 2000; Neumann & Gamble, 1995).

According to Pearlman and Mac Ian (1995) VT has the potential to profoundly and permanently affect one's world view, sense of identity and spirituality (p. 29). VT can also manifest as imagery intrusions, sensory reactions (Meichenbaum, 2007), and cause difficulties with memory and perception. Bober & Regehr (2005) point to the importance of distinguishing between short term and long term symptoms of trauma and VT. The distorted beliefs that can develop are viewed as "attempts to protect oneself, one's meaning system from the harm that trauma threatens" (Saakvitne & Pearlman, 1996, p. 27).

Herman (1992, p. 140) refers to VT as "traumatic countertransference", and as an inevitable occurrence for the trauma therapist. VT is often measured utilizing the *Traumatic Stress Institute Belief Scale* (TSI) which is based on the CSDT of disrupted cognitive schemas (Pearlman and Mac Ian, 1995).

Burnout

As likely the most widely recognized term and used as a "catch-all" phrase, burnout traditionally refers to the impact of chronic work-related stressors, rather than being a trauma-related response. Maslach & Leiter describe burnout as stemming from "a conflict between the values of the individual and organizational goals and demands" (in Salston & Figley, 2003, p. 168). Burnout is often related to the amount and type of work, and "a sense of having no control over the quality of services being provided" (Salston & Figley, 2003, p. 168). Since its inception in 1975, this stress-response model has expanded. The additional characteristic of cynicism was added to the original list of defining features which included exhaustion and inefficacy (Maslach, Leiter & Jackson, 2011). The tool most often relied upon to measure burnout is the Maslach Burnout Inventory (MBI) (Maslach, Leiter, & Jackson, 2012).

Making Distinctions. It is implied in the literature that VT involves a more insidious and deeper type of negative inner change, that CF/STS is a more temporary set of responses, and that burnout may be exacerbated by VT (Meichenbaum, 2007). It can be difficult to distinguish between all of the constructs and terms due to conflicting definitions in the literature, similarities and overlaps among concepts, personal preferences, and popularity of certain terms. It is possible, according to various authors, that combinations of these effects and syndromes can occur simultaneously as well as

independently.   For example CF and burnout without VT, or burnout and VT concurrently (Cieslak, Shoji, Douglas, Melville, Luszczynska & Benight, 2014; Rothschild, 2006; Trippany 2004). STS is often applied to circumstances in which a combination of PTSD symptoms and burnout are present.   The constructs that are generally understood to be the most specific and relevant to counselling traumatized clients are STS/CF, and VT. It is important to note that not all therapist reactions are necessarily part of a particular construct, or signs of a disorder.

Impact on the Therapist

There are a number of challenges and potential problem areas for therapists who are negatively affected by exposure to their clients' trauma narratives, pain and suffering. The impact can affect their personal and professional realms in multiple ways. It is difficult to draw a clear line between personal and professional effects given the profession involves an extensive "use of the self". Signs and symptoms may differ from one therapist to another, both in the subjective experience as well as in outward appearance.

Collectively, all of these effects, reactions and constructs represent the potential for negative alterations on the physical, cognitive, behavioral, emotional, psychological and spiritual aspects of a therapists' life.   It seems possible that any one of these constructs may manifest in a therapist to varying degrees along a continuum ranging from milder to more extreme signs and symptoms (Rothschild, 2006). The severity of the impact of any of these conditions may depend upon the nature and degree of the therapist's stress and trauma response (Figley, 2002b) as well as other factors, unique to each persons' circumstances, history and personality.

The energy depletion, emotional numbing, loss of ability to feel and care for others, trouble sleeping and with concentration, and being jumpy/easily startled are all consequences associated with burnout which are also similar to aspects of CF and VT. These and other effects such as detachment/depersonalization, general disillusionment, cynicism and negativity can drastically change how an individual functions in daily life, in the workplace, in practice, and socially (Meichenbaum, 2007; Maslach & Jackson as cited in Meldrum, King & Spooner, 2002). Experiences of fear and anxiety are frequently linked to CT/STS as well as VT and CT (Hernandez-Wolfe, Killian, Engstrom & Gangsei, 2015). Existential despair, anxiety, and reduced frustration tolerance are common with VT (Saakvitne & Pearlman, 1996, p. 34).

Alterations in meaning and beliefs in the five areas of psychological needs, of safety, esteem, trust, control and intimacy, are associated with VT processes, and can transform the therapist's life, capacity and interactions negatively. Changes in personality, beliefs and meaning are all possible consequences of VT (Wilson, 2004). Impairments in personal and familial relationships can occur, including conflicts and problems with trust and intimacy. Reductions and changes in morale and self-worth can contribute to difficulties in caring and connecting with oneself and with others, as well as with motivation (Figley, 2002b; Saakvitne & Pearlman, 1996). Beliefs about oneself and others may undergo negative transformations that result in self-doubt, fear and a sense of powerlessness. Expectations about oneself and others can become distorted, and the individual may turn to coping strategies that are ineffective or harmful. A sense of a loss of control which is often associated with the distress associated with trauma may result in compensating behaviors, or in "giving up" (Figley, 2002b).

Problematic memory and sensory effects can interfere with day to day life. States of numbness alternating with intense and overwhelming feelings which are similar to but may be less intense as PTSD symptoms can occur. Intrusion is a symptom that has received a great deal of attention in the literature on stress responses (Bober & Regehr, 2005), and for the trauma therapist this may include intrusive images of the client's experience with violence (Clemans, 2004). Somatic symptoms such as body tension or physical ailments, as well as anxiety and depression can be related to VT as well (Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995).

Impact on Therapist's Role

According to Rothschild (2006), the negative changes in empathic abilities and arousal regulation may not be conscious to the therapist. A decreased level of insight and self-awareness as a result of STS or VT lowers the therapist's ability to recognize and gauge his/her own reactions. Given that the therapist may also experience distress related to contact with the traumatized client, the clinical implications are significant (Meldrum et al., 2002). Strong affective reactions may include intense anguish, despair, horror, shock, and alienation which Valent (2002) refers to as "helper dysfunction" (p. 23). According to Herman (1992), extreme anger may manifest for the trauma therapist as a result of over identifying with the client's rage over violations and abuses. Hernandez-Wolfe et al. (2015) suggest that experiencing VT can lead to the therapist having stronger countertransference reactions in sessions. CT reactions may result in the therapist taking on roles of "rescuer" or "champion" with the client (Meichenbaum, 2007, p. 3) who has been victimized.

Alternately, the therapist's range of emotion may be lowered or restricted. This may be related to shifts in cognition and worldview associated with VT, and a loss of a sense of meaning (Trippany, 2004) or symptoms associated with STSD/CF that mimic PTSD. Whether one or the other, with the therapist's internal resources compromised, even the ability to listen to the client may become difficult (Baranowsky, 2002). Maintaining objectivity, and setting and maintaining healthy boundaries may be more challenging or not possible (Saakvitne & Pearlman, 1996). If the therapist is struggling to empathize, the entire therapeutic alliance and process can be jeopardized.

As a result of STS/CF or VT, professional errors can occur in the areas of assessment, diagnosis or conceptualization, and treatment planning. Important information about the client, and her/his traumatic experience/s may be missed, avoided, misunderstood or overlooked if the therapist is overwhelmed or distracted by negative consequences or symptoms (Baranowsky, 2002; Figley, 2002b; Iqbal, 2015; Pearlman & Saakvitne, 1995). The therapist may not be able to be present with the client, grounded in the session, or mindful of the process (Pearlman & Saakvitne, 1995; Salston & Figley, 2003). Damage to the therapists' sense of self-efficacy and confidence in the therapeutic alliance and process is likely to affect goal achievement and lead to unsuccessful outcomes. In their description of the consequences of unaddressed VT, Neumann and Gamble (1995) list nonempathic distancing from clients, victim blaming, and thoughts of leaving the profession as possible outcomes. Signs of facing difficulty may include overextending or overindulging oneself in the work, and intellectualizing issues (Pearlman and Saakvitne, 1996). Pearlman and Saakvitne (1995) describe how VT

"challenges [the therapist's] identity" and that it may be difficult to recognize as "adaptations can disguise the pain" (p.161).

If the therapist experiences a diminishment of hope due to negative changes in perceptions, affect or beliefs, this factor alone, may, arguably, place the therapeutic process and outcome in the most peril. Without a belief in healing and change, possibilities and direction cannot exist, or be offered, for the client (Saakvitne & Pearlman, 1996).

There is a risk of professional and ethical problems arising if a therapist is practising while suffering with such negative effects or consequences. Issues around the principle of "responsible caring" may come into question, for example, specifically around competence, modeling effective boundaries, minimizing harm, and managing risk (BC Association of Clinical Counsellors, 2008, p. 4; Iqbal, 2015).

Literature Review

Risk Factors and Contributing Factors

Saakvitne and Pearlman (1996) define risk factors for VT under the four categories workplace, client, therapist and context. More specifically, these encompass the nature of the work, the nature of the clientele, the degree of cumulative exposure to trauma material, and organizational, social and cultural contexts. Individual factors pertaining to the therapist include "personal history", "personality and defensive style", "coping style"," current life context", "training and professional history", "supervision", and "personal therapy" (p. 40).

Therapist-related variables have been the focus of most of the research on the topics of STS and VT. The factor that has garnered the most attention in the research is

the personal trauma history of the therapist, or "survivor therapists" (Pearlman & Mac

Ian, 1995; Salston & Figley, 2003). Pearlman and Mac Ian (1995) reported there is a

wide variance in findings across studies on the variable of therapists' personal trauma

history. In their study with 188 self-identified trauma therapists, "survivor therapists"

experienced more psychological difficulties than therapists without a personal trauma

history. In their study with 131 mental health practitioners, Williams, Helm and Clemens

(2012) reported that the practitioners with more frequent experiences of childhood trauma

had higher rates of VT. However, several researchers have found no relationship

between VT and childhood trauma (Benatar, 2000; Dunkley & Whelan, 2006; Schauben

& Frazier, 1995 as cited in Williams, 2012).

In a study published in 2006, Hargrave, Scott & McDowall examined therapists'

personal trauma history from a different perspective. They investigated whether the

resolution of past trauma was significant in relation to STS scores, compared to the

results of therapists who had non-resolved trauma histories and found it was of key

significance. Therapists with non-resolved trauma histories had higher STS scores.

Williams, (2012) also confirmed other factors that contribute to negative effects for

therapists. Their results indicated having a greater number of trauma clients correlated

with disruptions in core beliefs (VT), and exposure to sexually traumatized clients was

directly related to PTSD symptoms. Bober & Regehr (2005) found that hours per week

spent working with traumatized clients was a primary predictor of trauma scores. They

measured trauma and stress symptoms with 259 clinicians who work with trauma

survivors. The highest rates of VT according to the TSI scores were for therapists who

treated clients with childhood abuse, sexual violence and wife assault.

In an exploratory study with therapist trainees, Adams & Riggs (2008) found that a maladaptive coping style, termed self-sacrificing, was associated with significantly higher levels of VT than for subjects who demonstrated more mature coping styles. This immature coping style is characterized by "reaction formation and pseudoaltruism" (p. 31).

Sanness (2012) studied the relational traits of expert level trauma therapists, with a focus on attachment styles. This researcher took a broader view of the impact on therapists, and defined negative reactions of therapists as "difficulties and coping", rather than traumatization. Characteristics of the therapists who reported the most difficulty were avoidant coping styles, higher attachment anxiety, low levels of self-differentiation, and less experience with clients exposed to repeated incidents of trauma rather than single incidents.

Results from the Pearlman & Mac Ian (1995) study also indicated that younger, less experienced trauma therapists are at particular risk of experiencing negative consequences of the work due to having a more vulnerable sense of professional identity.

In an Australian study, Devilly, Wright and Varker (2009) assessed 152 mental health professionals in both private and community based service provision, for STS, VT, and BO. Their results point to work related stressors and being new to the profession as predictors of distress for practitioners.

Baranowsky (2002) points to skill level and competency as factors in the development of CF. She states "there are times when client stories are overwhelming, beyond our scope of comprehension and desire to know, or simply spiraling past our sense of competency" (p.156).

In their study of CF and BO with 532 self-identified trauma therapists drawn from a national sample, Craig and Sprang (2010) found lower levels of trauma-specific training predicted higher levels of burnout.

Practitioners in community agencies, rather than private practice, are more likely to develop VT because of the lack of control with organizational factors, workloads, and the lack of opportunity to screen cases, according to Saakvitne and Pearlman (1996). As well, whether the work is short term or long term in nature may affect the degree to which the therapist is affected by VT (Saakvitne & Pearlman, 1996, p. 42). In a study with 500 crime task force personnel (Craun & Bourke, 2014) higher STS scores were related to lower job satisfaction and more distrust of the outside world.

In an exploration of factors that contribute to burnout, Farber & Heifetz (1982) studied 60 psychotherapists in major treatment facilities. The primary source of stress in their work, cited by 73% of the subjects, was a "lack of therapeutic success" (p. 297). Other relevant factors included the nature of their role, working conditions/organizational issues such as politics and workload.

Researchers Jenkins et al., 2011, took a novel approach and examined the motivation to do trauma counselling work, with a sample of 101 domestic violence and sexual assault counsellors. Of the portion of counsellors who reported subjective negative changes corresponding to STS, VT and BO, most were motivated by "personal meaning" and "higher purpose" rather than the third type of motivation they defined as "altruism". This result raised the question of whether the negative effects may be linked to those counsellors being overly optimistic and facing the subsequent disillusionment of trauma work.

Prevalence

It is difficult to report on definitive figures or estimates of prevalence rates for specific effects and constructs for trauma therapists, due to inconsistencies across studies, and the diverse nature of empirical data. In an Australian study with 300 mental health professionals in forty-one mental health facilities, approximately 36% of all therapists reported experiencing symptoms of secondary traumatic stress/distress as a result of their work with traumatized counsellors. This was attributed to the trauma effect of their work as well as perceptions of stress related to their work (Meldrum et al., 2002, p. 91).   In a 1996 study, 14% of trauma counsellors were found to have experienced traumatic stress levels similar to PTSD (Arvay & Uhlemann as cited in Meldrum et al., 2002, p. 95). Meichenbaum (2007) reports that "50% of professionals who work with trauma patients report feeling distressed", and "30% report experiencing 'extreme distress' (p. 2).

The Positive Outcomes for the Trauma Therapist

The proposition that suffering might result in growth is not a new notion, however, it is gaining attention in the field of traumatology. A focus on the transmission of trauma and negative consequences for the trauma therapist represents an incomplete picture. Vicarious exposure to trauma may also result in positive sequelae for therapists which involve processes of transformation, growth, and increased resilience. The role of empathy, and specifically the empathic connection between therapists and traumatized clients is of benefit not only to the client, but also has positive ramifications both personally and professionally for the therapist (Brockhouse, 2011; Harrison & Westwood, 2009). Some of these are considered experiences beyond simply adjusting

well, are distinct from subjective well-being, and pointing to a higher level of psychological well-being (Brockhouse, 2011; Cann, Calhoun & Tedeschi, 2010; Joseph, Murphy & Regel, 2012; Tedeschi & Calhoun, 2006). Therapists and authors McCann & Pearlman (as cited in Silveira, 2013) reported that in addition to vicarious trauma, there were rewarding aspects of trauma work for themselves, which included being more empathic, less judgmental, more spiritually involved, and experiencing positive shifts in perspective.

The rewards and experiences of pleasure gained from doing the work of trauma therapy are not often acknowledged in the literature. There are few studies on the subject that focus primarily/solely on the benefits or rewards for trauma therapists. An early study on VT with female counsellors working with sexualized violence survivors also included data on the positive aspects of their work. Some of the benefits that counsellors reported included "an appreciation for the resilience of survivors and their capacity to grow despite adversity, feeling gratified that they are working to help heal both individual clients and society as whole, and that they also grow and change as a result of their work with survivors" (Schauben & Frazier, p. 62 as cited in Silveira, 2013, p. 40).

Benatar (2000) describes" enduring changes in the inner experience and behaviors of the trauma therapist" (p. 19) as positive self-transformation (PST). Five interrelated themes associated with PST are identified as: self esteem/empowerment, mind expansion/wisdom, work with other clients, validation/healing, and activism (Benatar, 2000). Compassion satisfaction (CS) which is derived from emotional engagement and a compassionate helping relationship with the client, encompasses a sense of fulfillment, balance and wellness for the therapist (Larsen & Stamm as cited in Froman, 2014). CS

can be viewed both as a benefit in the form of wellness, and as a buffer for the negative

effects of CF, VT and BO (Abel, Walker, Samios & Morozow, 2014).

Vicarious Posttraumatic Growth

Higher levels of growth are associated with people exposed to trauma more than

negative changes (Cann, Calhoun & Tedeschi, 2010; Cobb, 2006; Tedeschi & Calhoun,

2006). The construct most widely recognized to describe the positive changes that can

occur following trauma exposure is posttraumatic growth (PTG). Utilizing this model,

positive change can enhance a person's life in areas of relationships, self-perceptions,

and life philosophy (Joseph et al., 2012). The development of PTG is not a

straightforward or linear process; it is a complex and transformative one that "may be

wrought with distress, struggle, and difficulties with adjustment" (Tedeschi & Calhoun,

2006, p. 29). The "struggle" is considered a necessary and key element of this model.

Many clients likely experience PTG in therapy as they work through and overcome the

primary issues associated with traumatic experiences (Cann,Calhoun & Tedeschi, 2010;

Tedeschi & Calhoun, 2006). The development of PTG is related to the disruption of

core beliefs/schema as a result of traumatic stress, as is VT, combined with "a deliberate

and constructive rumination" of the stressful or traumatic event (Lindstrom, Cann,

Calhoun & Tedeschi, 2013 p. 51 ; Cann, Calhoun & Tedeschi, 2010; Lindstrom &

Triplett, 2010).

Social and cultural factors, as well as personal characteristics of the survivor are

also considered significant in the PTG model. The type of event, level of distress, and

role and response of reference groups such as family and friends, are known to affect

survivors' experiences with growth. In addition, the larger community and environment

are influential variables. As Lindstrom and Triplett (2010) state, "if a model of growth is present in society…..a survivor will be more likely to find growth" (p.577).

The growth experienced by trauma therapists may be very similar to that of trauma survivors. The PTG model inspired the development of vicarious posttraumatic growth (VPTG) theory. The PTG model can be applied to the process of positive transformation that can occur for trauma therapists, as a possible outcome of indirect exposure to clients' trauma. VPTG is understood to be a gradual and progressive phenomenon, and therapists who work with longer term clients may have greater opportunities for VPTG (Cohen & Collens, 2013). Disruptions to the clinician's world view, with affective and cognitive processes such as the role of meaning-making are involved in facilitating VPTG (Abel et al., 2014; Cann et al., 2010; Joseph et al., 2012). Brockhouse (2011) refers to the complexity of how VPTG develops in therapists through "accommodation processes" which can be either negative as in VT or positive as in VPTG (p. 740).

In the original study on VPTG, Arnold et al. (2005) report the benefits for therapists "may be much greater than any previous estimates" (p. 240). Elements of PTG were reported by 76 percent of the clinicians in their study, and attributed to the direct work with traumatized clients. However, many of these therapists may also have experienced their own PTG related to personal trauma histories and this is difficult to distinguish in the study. The researchers describe permanent positive changes that are possible in the domains of the therapist's world view, beliefs, compassion and sensitivity, and spirituality and faith. Of particular interest, 90 percent of the clinicians stated that their clients experienced PTG, characterized by gains in self-confidence, sensitivity and compassion, enhanced appreciation for what is important in life, among other changes.

This highlights the significance of observing and encouraging PTG in clients (Arnold et al., 2005; Howard, 2010).

The tool most often used in the research on PTG as well as VPTG is the PTGI (Posttraumatic Growth Inventory), a 21-item scale that measures the five factors most indicative of PTG: new possibilities, relating to others, personal strength, spiritual change, and appreciation of life (Tedeschi & Calhoun as cited in Cann et al., 2010). The PTGI was revised in 2008 and renamed the PTGI-42, which incorporates pairings of negative changes, or posttraumatic depreciation (PTD), that correspond to the same five domains (Cann et al., 2010).

It is understood by several authors and researchers that both positive and negative effects of trauma work can co-exist for therapists. Both distress or loss and growth may occur simultaneously. In their 2010 study with 118 first year psychology students, Cann et al. (2010) concluded that "quality of life and presence of meaning in one's life depend on having both PTG and PTD" (p.164).

Downey (2013) explored the positive effects of trauma therapy in a study with 116 psychologists and students utilizing the IES and the PTGI measures. The results demonstrated that the clinicians' work with traumatic stress patients was associated with greater levels of perceived PTG, as well as the negative effects of intrusion, avoidance and arousal.

Cohen and Collens (2013) conducted a metasynthesis of twenty qualitative journal articles on the impact of trauma work and VPTG. Four themes emerged in their research: both positive and negative changes in counsellors' and workers' worldviews occurred,

perceptions of self and day to day living changed, and that PTG and VPTG are similar but not exact. Their results indicated support for the theory of VPTG in the literature.

In a study utilizing the PTGI with 118 registered therapists from a national recruitment in the United Kingdom, Brockhouse (2011) examined three moderator variables of VPTG, empathy, sense of coherence, and perceived organizational support. The *cumulative* amount of vicarious exposure for each therapist was calculated, and identified as a key component necessary for growth for therapists. Empathy was seen as a positive predictor of growth, and therapists who previously had personal therapy had significantly higher levels of growth. Sense of coherence, which is theoretically linked to positive responses to stress, (Antonovsky as cited in Brockhouse, 2011) did not predict growth, nor did organizational support.

Vicarious Resilience

Another possible positive outcome, stemming from the empathic engagement with traumatized clients, for therapists, is vicarious resilience (VR). VR is similar to PTG in outcome dimensions, but with a different underlying theoretical framework and process. Positive transformations, growth and even personal healing for the therapist can occur by bearing witness to the client's process of resilience (Hernandez, Engstrom & Gangsei, 2010; Hunter, 2012). In this context and application, resilience is viewed as an outcome rather than a process of endurance (Zautra, Hall & Murray, 2010). VR is a more recent construct which continues to be under development built upon the basic premise that for survivors, "resilience is forged through adversity….not despite it" (Walsh, 2006, p. 7).

As Saakvitne and Pearlman (1996) state,*" witnessing pain brings with it the possibility of witnessing healing" (p. 141). Qualitative studies have illustrated the

positive effects of witnessing how clients cope with adversity (Hernandez-Wolfe et al., 2015; Silveira, 2013) as well as the "powerful satisfaction, and sense of privilege stemming from being trusted by the client" that trauma therapists may experience (Hunter, 2012, p. 187) . VR and compassion satisfaction (CS) are seen as conditions which can counterbalance the risks of bearing witness to trauma narratives for therapists. Although not fully understood or empirically investigated, VR is not considered a spontaneous process but one which requires conscious self-reflection (Hernandez et al., 2010). As well, the development of VR is not necessarily a "pain free" process, however the rewards are what can sustain and enhance the work of trauma therapists (Hernandez-Wolfe et al., 2015; Saakvitne & Pearlman, 1996; Silveira, 2013; Reynolds, 2009) Empathy is seen as a necessary element and catalyst in the development of vicarious resilience, along with an appreciation of the resilience trauma survivors bring to the treatment process (Tummula-Narra, Liang & Harvey, 2007). Resilience and VR develop via a reciprocal and shared processes in the therapeutic relationship which benefits both the client and the therapist, in what Silveira (2013) describes as the activation of "a resilience feedback loop"(p. 150).

Four qualitative studies have examined the unique positive effects described by trauma therapists as a result of their interactions with trauma survivor clients (Hernandez, Engstrom & Gangsei, 2007; Engstrom, Hernandez & Gangsei, 2008; Engstrom, Gangsei, & Hernandez, 2010 as cited in Hernandez et al., 2010; Silveira, 2013). Combined results from these studies illustrate the potentially extraordinary positive changes in attitudes, emotions and behavior that can affect therapists' personal and professional lives, and that are often understated in the literature. These include: increased confidence and efficacy,

becoming a stronger advocate, reflecting and reframing one's own coping and humans'

capacity to heal in general, motivation to incorporate similar strategies and approaches

into their own lives, development of personality traits (that may have been previously

innate) and attitudes that are congruent with resilience such as hope and optimism,

reaffirming the value of therapy, and discovering the power of community healing

(Hernandez et al., 2010; Silveira, 2013).

Discussion

Providing therapy for survivors of trauma can be an extremely challenging

endeavour with powerful emotional and psychological effects and consequences for the

therapist. The empathic connection is seen as a necessary and key ingredient in building

the therapeutic relationship which is central to many forms of trauma therapy, as well as

in the potentially transformative processes for the therapist. The empathic bond carries

with it a risk and vulnerability for therapists in their work with traumatized clients, as

well as benefits and rewards. In this chapter I provided an overview of both the negative

and positive outcomes for therapists who are indirectly exposed to their clients' traumatic

experiences. The focus in the literature tends to be on the negative consequences and

difficulties for therapists. There is also a growing body of work on the transformative

processes related to growth and resilience, which was presented.

The potential psychological, emotional and behavioral changes that can occur for

therapists as a result of indirect exposure to clients' traumatic experiences were

illustrated. Several of the terms and constructs that are used to describe the potential

effects on therapists were defined, with the acknowledgement that they tend to overlap

and distinctions can be ambiguous. The effects range from emotional stress and strain to

distress and trauma responses. Over time, a host of devastating and lasting internal

changes can profoundly impact the therapist's world view, sense of self and behavior.

The potential impact on a therapist's personal and professional life were described.

The potential deleterious effects on the therapist's role and the therapeutic process

were given particular attention. Many of the variables associated with negative

consequences have been clearly determined . These were presented and a review of

empirical evidence and theoretical foundations were provided. Some of the contributing

and risk factors that have been investigated were highlighted. Variables that have been

studied and associated with negative consequences of trauma work tend to be those

related to therapists' vulnerabilities. Results from studies show correlations but causality

is not always clearly understood between variables. It is difficult to make comparisons

due to a lack of normative data in relation to types of therapists, work settings and

contexts, levels of experience, client populations and other variables.

The more recent concepts of VPTG and VR are grounded in theory and clinical

observation, with research just beginning to emerge in these areas. There is research and

data available which clearly indicate a great prevalence in the experience of PTG

reported by trauma therapists. It is also understood from the research that positive and

negative effects likely co-exist for therapists although the exact processes of transmission

between secondary traumatic stress and the outcomes are not fully understood or

explainable.

Developing a comprehensive understanding of the range of possible consequences

for therapists who are exposed secondarily to traumatic experiences of their clients

requires a review of both the costs and rewards. Examining ways to prevent harm and

promote positive outcomes for trauma therapists is a natural next step. In the next chapter

I review this topic, which includes strategies that are recommended by experts in the

field of traumatology.

CHAPTER FOUR: PROTECTIVE MEASURES, INTERVENTIONS AND FACTORS

THAT PROMOTE RESILIENCE AND GROWTH FOR THERAPISTS

Along with the rewards of the work, the impact of providing trauma therapy to clients can result in a variety of negative outcomes for the therapist, from emotional strain and stress, to debilitating psychological distress. Terms that describe the range of negative effects and responses include empathic strain, countertransference (CT), secondary traumatic stress (STS), compassion fatigue (CF), vicarious trauma (VT) and burnout (BO). In the previous chapter descriptions of these constructs were provided, as well as possible positive transformations therapists might experience reflected in concepts such as compassion satisfaction (CS), vicarious resilience (VR) and vicarious posttraumatic growth (VPTG).

In this chapter, I begin with introducing the topic of resilience as an overriding concept which can affect all realms of a therapist's experience and is a major factor in preventing, managing and overcoming adversity. Strategies and approaches that mitigate the risk of VT, assist with healing from adversity and can transform therapists' experience are presented. Specific interventions and models are described, as well as resources for future reference. Relevant areas of research , including empirical evidence, are highlighted in different throughout this chapter. I end the chapter with considerations for future research and concluding remarks.

Measures that can be taken to address VT are grouped under three broad categories: personal, professional and organizational (Saakvitne & Pearlman, 1996). In practice there are many overlaps between these areas in a therapists' life, with elements from one area both influencing, and being affected by, elements from other areas.

Similarly, strategies that are illustrated may serve multiple purposes in a therapists' life. Factors that are protective are also often preventative, and interventions meant to ameliorate or treat negative effects may also serve to promote resilience and growth, which in turn provide additional safeguards for the therapist. Although most of the information offered in the organizational category appears to pertain to therapists who work in community agencies or other group settings, I propose that many of the underlying concepts are relevant and applicable to therapists in private practice as well.

The term VT is used extensively in this chapter to refer to both the syndrome and process of vicarious trauma. There is an assumption that a broad range of effects are possible in reference to any of the constructs, and it is not an easy task to distinguish between them. Burnout is used to signify a more progressively occurring condition from any combination of syndromes (Figley, 1995), and in this chapter is used interchangeably with CF at times, based on the references utilized, and is often used as a "catch-all" to reflect the potential "final stages" of a therapists' professional life.

The foundation of the counselling profession is built upon wellness, along with growth and development (Myers, as cited in Jarnagin & Woodside, 2012). The majority of therapists are resilient, and trauma survivors also bring resilience to the therapeutic process (Walsh, 2006; Tummula-Nara, Liang, & Harvey, 2007). However, therapist resilience does not equal invulnerability (Walsh, 2006). A strengths-based perspective takes into account the factors that promote positive developmental outcomes, as well as risks and deficits. As Joseph (2012) states, "adversity does not always lead to a damaged dysfunctional life….[but] can be a springboard for posttraumatic growth and higher levels of psychological well-being" (p. 816).

The risk of harm to trauma therapists as well as clients may be exacerbated if problems such as VT are left unaddressed. The recommendations for attending to VT from experts on the subject encompass the three dimensions of awareness, balance and connection in personal, professional and organizational realms This "formula" is known as "the ABC's of addressing VT". (Saakvitne and Pearlman, 1996, p. 76). More specifically, they advocate tuning in to personal needs, limits, emotions and resources, creating a balance in work, play and rest, attending to meaning-making, and connecting to oneself and to others to combat isolation (Saakvitne and Pearlman, 1996, p. 76). This formula can be modified and applied to all types of therapist distress, whether considered VT or otherwise. It is used as a guideline in this chapter to illustrate protective and preventative measures that can be taken, and interventions that can be considered to facilitate the health, wellness, recovery, and growth of trauma therapists.

Resilience

Resilience is a multidimensional and dynamic phenomenon that comprises qualities of the person and the person's environment, both past and present. It is a complex interactional process involving risk factors plus multiple internal and external protective factors over time (Harvey, 2007; Lepore & Revenson, 2006; Ungar, 2010: Walsh, 2006). Resilience can be learned, cultivated, and can change over time. It is influenced by many factors. An ecological framework of resilience takes into account culture, context and community influences (Harvey, 2007; Walsh, 2006; Ungar, 2010). In relation to personal characteristics, Zautra, Hall & Murray (2010) list predictive factors for resilience as coping, flexibility, personal agency, sense of purpose, positive emotional engagement, physiological indicators and emotional regulation. Maddi & Khoshaba (as cited in Hoge

et al., 2006) describe resilience as a "pattern of hardiness" and suggest three key characteristics which help people thrive amid disruptive changes and stress. These are attitudes which they define as commitment, control and challenge.   Resilience is also closely related to the qualities of hope and optimism (Silveira, 2013). According to Walsh (2006, p. 7), the basic premise of resilience is that it is "forged through adversity", rather than in spite of it.

Protective Measures

Personal Realm

Self-Care. A dominant theme in the literature and in the field of counselling psychology is on the value of self-care as a protective measure against work-related stress and a buffer for VT (Howard, 2010; O'Halloran & O'Halloran, 2001; Saakvitne & Pearlman, 1996). This is closely related to the concept of wellness which typically incorporates the triad of body, mind and spirit (Myers, Luecht & Sweeney, 2004). Self-care encompasses these elements, and entails a wide range of responsibilities and actions on the part of the individual in order to balance the physical, emotional, relational, psychological, spiritual, creative and sensual aspects of ones' life (Saakvitne & Pearlman, 1996). Some of these include effective use of leisure time for rest, relaxation and exercise, taking on roles other than "caretaker" such as gardener or painter, utilizing support of family, friends and community, seeking out healing and spiritual activities, and taking vacations. Another form of self-care is personal therapy which can assist with managing or treating the effects of stress and secondary trauma. According to MacRan Stiles, & Smith (1999), personal therapy also provides a form of experiential learning for therapists, and an adjunct to academic studies.

Coping. The topic of coping is frequently associated with, or conflated with self-care for therapists. Meichenbaum (2007) suggests attending to cognitive processes as part of a self-care program to manage distress stemming from trauma work. Recommended strategies include "developing realistic expectations, understanding the limitations of one's role and responsibility, adopting a philosophical outlook, and challenging negativity" (p. 15). Hunter (2012) discusses the importance of developing belief systems that help make meaning of adversity. Saakvitne & Pearlman (1996) suggest challenging negative beliefs and assumptions. Developing a capacity for humour is recommended and endorsed by several authors as a valuable tool in lowering STS and preparing for adversity (Craun & Bourke, 2014; Figley, 2002; Saakvitne & Pearlman, 1996). Particular adaptive "coping styles characterized by active problem-focused strategies" have been associated with fewer PTSD and VT symptoms and burnout among therapists (Adams & Riggs, 2008, p. 27). A strong social support network is known to contribute to coping and resilience (Saakvitne & Pearlman, 1996; Trippany, 2004; Walsh, 2006). A study with eighty trauma therapists found that even perceived social support, not actual, had a significant effect on lowering STS symptoms (Rzeszutek, Partyka & Golab, 2015).

Mind and Body Awareness. Mindfulness and acceptance are considered vital intervention strategies for addressing and transforming VT (Meichenbaum, 2007; Saakvitne & Pearlman, 1996). Mindfulness is cultivated through a purposeful practice of moment-to-moment observation of the mind-body process in which one "assume[s] a stance of impartial witness to [their] own experience" (Kabat-Zinn, 1990 p. 33.). Acceptance and recognition are important tasks in managing the changes associated with VT (Saakvitne & Pearlman, 1996; Salston & Figley, 2003). Mindfulness can be viewed

as a self-care and preventative measure for trauma therapists, as well as a tool that can be employed in professional practice. Meditation, mindfulness practice, yoga, spiritual or religious activities are all avenues that can assist with raising awareness, provide a sense of meaning, lower stress and promote greater inner balance (Rothschild, 2006; Saakvitne & Pearlman, 1996; Stahl & Goldstein, 2010, Walsh, 2006).

Results from a recent study on mindfulness (Keane, 2014) with forty psychotherapists highlights many possible benefits, among them an "…improved ability to be present and to attune to clients", "increased awareness of self-care needs and ..support in meeting them" (p. 689), and greater clarity of purpose. Therapists who practiced mindfulness regularly scored lower on perceived stress measures (p. 689). Mindfulness practice has been shown to foster relational qualities of empathy, openness, acceptance and compassion (Bruce, Shapiro, Constantino, & Manber, as cited in Keane, 2010; Keane, 2014). Therapists in a qualitative study (Ciggola & Brown as cited in Keane 2014) described changes from mindfulness practice as "greater affect tolerance, metacognitive insight, …qualities such as non-judgmental acceptance, openness, curiosity and compassion" (p. 690).

Rothschild (2006) describes the importance of therapists tuning in to their own mind and body signals and using "common sense" strategies such as taking breaks, connecting with others, and having a cry, to help prevent CF and VT . This author advocates "mindfulness through arousal awareness" (p. 95) which is particularly helpful in reducing PTSD type symptoms associated with VT and CF. This practice of "somatic empathy" (p. 49) involves developing the skills to discover one's own somatic cues such as tension, breathing patterns, skin temperature and heart rate, and learning to

differentiate between states that represent safety or danger. As Rothschild notes, "calm and relaxed are not necessarily the same thing" (p. 117).

Professional Realm

Professional development is identified in the literature as a significant buffer for adverse reactions, as it contributes to improving practice and a sense of effectiveness (Miller, Hubble & Mathieu, 2015; Saakvitne & Pearlman, 1996). Maintaining professional connections by attending workshops and forums, and seeking out colleagues and supervisors for consultations are also recommended as ways to reduce isolation, and obtain support.

Hernandez et al. (2010) suggest supervision and peer support can also be used to discuss "organizational issues that [help] or hinder the work… [and]… the social contexts which frame the client's trauma experiences" (p. 68) as well as self-care. Becoming aware of one's own vulnerabilities, reflecting on personal experiences such as the impact of childhood trauma and one's motivation for the work can be protective measures explored during graduate training (Brockhouse, 2011; Trippany, 2004).

Several authors promote the importance of trauma awareness courses for graduate students (Iqbal, 2015; Pearlman and Mac Ian, 1995; Saakvitne & Pearlman, 1996; Trippany, 2005) and learning about VT signs and symptoms as well as the potential for PTG (Silveira, 2013). Yassen (1995) states it is vital for graduate students to be trained in addressing how to prevent CF, VT and BO. Training in mindfulness can promote stress reduction, and also may provide a way to develop empathic qualities (Keane, 2014) which are difficult to teach. Recognizing empathy as a protective tool with secondary

trauma and one that promotes growth can encourage therapists to "move in" with clients (Harrison & Westwood, 2009).

Understanding concepts of VT and VPTG can be empowering for the therapist and can influence the work in many ways. Specific training such as in PTG, and ways to increase compassion satisfaction have been proposed by researchers to help counteract distress for therapists (Arnold et al., 2005; Craig & Sprang, 2010; Downey, 2013;). An orientation towards resilience in practice incorporates reframing, noticing and appreciating resilient traits in clients, as well as the potential for PTG. In these ways therapists' well being can be strengthened and resilience can be harnessed in the process (Hernandez et al., 2010). Researchers Smith, Kleijn, and Hutschemaekers (2007) identify two main attitudes, or styles, demonstrated by therapists in their work, which may affect coping with secondary stress. One is characterized by helpfulness and closeness, the other is described as an "actively intervening" approach (p. 211).

Miller, Hubble & Mathieu, (2015) emphasize the importance of focusing on treatment outcomes as a primary factor in the prevention of CF and BO. As they wrote, burnout "doesn't begin with caring or even caring too much, but continuing to care ineffectively" (p. 142).

A treatment approach proposed by Joseph (2012) that helps to promote resilience and PTG can be considered for clinical work with trauma survivors. The "THRIVE" model consists of six components:" taking stock, harvesting hope, re-authoring, identifying change, valuing change, and expressing change in action"(p. 818).

Other recommendations for the prevention of STS include assertiveness skills/training, setting and maintaining clear boundaries/limit setting, gaining/maintaining

social support, and creating balance by involvement in social activism (Yassen, 1995).

Reynolds (2011; 2014) strongly advocates addressing values and ethics in supervision,

consultations and self-reflection as a way to address burnout, redefined as "spiritual

pain" (Reynolds, 2011, p. 30). Working in line with ethics, and keeping "the spirit of

collective ethics alive" (Reynolds, 2014, p. 6) by participating in community social

justice work are key considerations in promoting sustainability. Engaging in other types

of work such as policy development, informal training, or pursuing educational

endeavours, along with clinical practice, are recommended strategies for counteracting

stress for workers.

Organizational Realm

Several authors suggest that workplace and organizational factors are more

pertinent to buffering stress, traumatization, and reducing negative consequences for

therapists than individual ones such as self-care (Bober & Regehr, 2005; Cohen &

Collens, 2013; Iqbal, 2015; Miller et al., 2015). Safer working conditions,

psychologically healthy work cultures, and a positive supervisory working alliance are all

factors predicted to prevent, identify and reduce vicarious trauma responses, and combat

burnout (Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995; Williams, 2012).

According to Miller et al.'s (2015) review of the research, a key ingredient in preventing

burnout for counsellors is having more control in the workplace, and not about promoting

self-care initiatives and creating work-life balance. Involving employees in decision-

making to enhance control , and actions that facilitate increasing a sense of achievement

are recommended to combat BO in particular (Meichenbaum, 2007; Miller et al., 2015).

Agencies that are proactive in providing supervision, education and training, promote professional connections and support altruistic activities help to reduce vulnerability and mitigate risks of secondary traumatic stress for clinicians. Other factors that strengthen and support clinicians include the provision of benefits, paid vacations, and Employee Assistance Benefits to cover psychological services (Meichenbaum, 2007). Additional measures include managing and limiting caseloads, flexible work schedules and additional support for novices, such as mentoring. Decisions around whether newer therapists are prepared and equipped to work with a caseload of trauma survivors are important considerations (Iqbal, 2015). Positive results are also expected in organizations where training is provided on the impact of stress and VT, and where administrators take part in VT focused exercises (Meichenbaum, 2007; Saakvitne & Pearlman, 1996).

Supervision and support. Effective clinical supervision, and peer supervision or consultations that are most supportive have the aim of normalizing experiences and reducing isolation for therapists associated with VT (Trippany, 2004). Trauma sensitive supervision can support the growth, resilience and healing of therapists by addressing both the positive and negative ways individuals are affected by the work (Williams, 2012). Mailloux (2014) underscores the importance of adopting ethics as a priority in supervision to safeguard therapists and clients. Hernandez et al., (2010) recommend clinical supervision practices and consultations that emphasize "… developing and amplifying meaning that strengthens hope and reciprocity" as promoting VR (p. 75), as well as acknowledging and recognizing [therapists'] place of privilege and power in society, and in the therapeutic process.

Workplace culture. An important consideration in assessing workplace culture includes how trauma is addressed and acknowledged, including critical incidents. Although every therapist is subject to VT, there may be barriers, including stigma that exist, with admitting inadequacies and vulnerabilities for clinicians. This can interfere with clinicians attaining the necessary support and assistance. Sharing vulnerabilities with others may be particularly challenging for novice therapists and more of an issue in certain workplace settings. If a therapist wishes to discuss their personal trauma history, fears and worries around confidentiality, shame and discomfort may be obstacles. Therefore, an environment that allows openness and supports sharing feelings of distress is beneficial to clinicians (Howlett & Collins, 2014; Pearlman & Saakvitne, 1995). An attitude of respect and acknowledgment of the impact of traumatic stress is conducive to creating a healthy workplace environment.

O'Brien (2000) writes about the importance of intentionally creating compassion and connection in workplace environments as a valuable means of counteracting the potential negative effects of CF, VT and other stress responses for therapists who work with traumatized populations. The two guiding principles of this endeavour include enhancing a sense of shared goals and community and "acknowledging and honouring therapists' contributions more formally and routinely" (p. 29). Several steps that can be taken by individuals and organizations are offered by O'Brien to achieve these. One such measure is the deliberate sharing of values, purpose and objectives of the work, and discussions among all clinicians and supervisors centering on mission statements.

Interventions

Bercier and Maynard (2015) conducted a systematic review with the aim of examining interventions to reduce STS, CT and VT and their endeavour came up "empty" due to a dearth of evaluative studies. This does not imply that methods do not exist. A selection of programs and interventions are offered in the following examples. Although they are not all necessarily specifically designed for trauma therapists, they support principles and concepts that are recommended in the literature around education, support and self-reflection. Interventions and models can be modified to suit the needs of individuals, groups, and for different settings.

The "VT Seed group", a psychoeducational mutual aid group, was developed and facilitated by Clemans (2004) with the aim of destigmatizing VT with social workers in New York. Goals of the group were to help address the emotional, physical and spiritual transformations of VT, to share and discuss "taboo areas", and to generate effective strategies (p. 61). Hernandez et al. (2010) offer guidelines for supervision comprising a set of relevant questions that can be posed to elicit dialogue with therapists on the positive and negative effects of trauma work.

Gentry, Baranowsky, & Dunning (2002) developed the Accelerated Recovery Program for Compassion Fatigue (ARP) (p. 123) for professionals. This began as an individual model then grew into a multi-session group design with standardized sessions. The treatment model has the aim of resolving the distress of trauma exposure, reducing symptoms associated with CF, and promoting empowerment and resilience-building. Various components cover areas including a therapeutic alliance assessment, with steps

that determine changes over time, anxiety management, healthy lifestyles, and conflict resolution. Training for "certified CF specialists" has subsequently been developed.

There are several scales that can be used as a guideline to help therapists self-evaluate their level of comfort, distress and symptoms. The Life Status Review covers eight categories of functioning including medical, health/wellness, financial, housing/transportation, employment/school, legal, alcohol/substance use, self/social, and interpersonal (Stamm & Rudolph, 1996 as cited in Rothschild, 2006, p. 223). The 17 point PTSD checklist – Civilian Version (Weathers, Huska, & Keane 1991 as cited in Rothschild, 2011, p. 221) rates one's level of VT symptoms. The ProQol-R IV 30 point Compassion Satisfaction & Compassion Fatigue subscales (Stamm & Hudnall, 1997-2005 as cited in Rothschild, 2011) offers questions about both the positive and negative experiences of "helpers"(p. 213). The Compassion Satisfaction and Fatigue test is comprised of 66 questions that facilitate a more extensive personal exploration of positive and negative aspects of helping (Stamm & Figley, 1996, in Stamm, 2002, p. 113). A clear assessment can be the starting point in determining the areas that may benefit from greater attention.

Saakvitne and Pearlman (1996) provide a selection of creative and experiential exercises in their book, Transforming the Pain: A Workbook on Vicarious Traumatization. Strategies that are applicable to personal, professional and organizational domains are offered. These include techniques that can be practiced individually, in pairs, or in groups.

In Rothschild's 2006 book, Help for the Helper: Self-Care Strategies for Managing Burnout and Stress, extensive research based information and skill building exercises are

provided, to enhance understanding and awareness for therapists on the impact of secondary trauma. Information on neurobiology is offered, as well as a model of "structured self-care" (p. 190). Additional recommended strategies include conducting a personal inventory of life stressors, body awareness, attending to personal history and listening to feedback from others (p. 212). Rothschild's suggestion that "experimentation and evaluation are the keys to helping each therapist discover which interventions are most effective for keeping her in her own chair" (p. 207) is, perhaps, one of the most significant considerations and ideals in helping to prevent and heal from the impact of vicarious trauma.

Conclusion

Although distress, negative effects , and consequences such as VT may be considered inevitable for trauma therapists, they may also be preventable or at least mitigated through preparation, training, early intervention and recovery strategies. In addition to the therapists' actions, educators, trainers, supervisors and organizations have important roles and responsibilities in mitigating harm for trauma therapists. Strategies that empower, protect and transform can be implemented in many ways by individuals, in groups, and within organizations (Saakvitne & Pearlman, 1996). The potential for adversity to generate growth and resilience is a possibility for both clients and therapists.

As the phenomena of VR and VPTG are more recent ideas in the field of counselling psychology, there is much to be learned, and a need for further research to increase understanding on the specific factors that contribute to the occurrence and improvement of these processes. Studies that analyze and compare different interventions or models of treating and reducing VT are lacking and could be beneficial.

Further investigations into the clinical and personal benefits of therapists' own mindfulness practice could help inform practice and training. Projects which test out innovative measures such as mentoring, group sessions, or supervisory techniques that address negative effects and promote sustainability for trauma therapists in different work settings could illuminate areas of need and lead to effective actions and improvements.   Qualitative studies with trauma therapists from different populations, experience levels, orientations, and work settings, can bring life to the experience of secondary traumatic stress, distress, and also growth and resilience, and offer valuable contributions to the field.

CHAPTER FIVE: CONCLUSION

The prevalence of intimate partner violence, the relational context of therapeutic work, and limited supportive measures can all lead to higher risk of vicarious trauma (VT) effects for therapists. Due to the large scale prevalence of interpersonal violence in British Columbia (BC), the phenomenon of complex psychological trauma is also widespread. Spousal/domestic and intimate partner violence rates are elevated in BC, and this represents a social and health issue of great magnitude (Sinha, 2013b). In addition to psychological consequences, social problems prevail that contribute to inequities of power and support beliefs and attitudes of tolerance for violence in BC communities. Psychological treatment and care is needed for survivors as well as social action and advocacy.

Trauma therapists encounter individuals in their practice who are suffering from complex psychological trauma symptoms, intertwined with social problems that affect children, families and communities. These may be related to perplexing legal systems, criminal and court proceedings, obstacles and barriers in obtaining resources, or poverty. Inequities related to gender, ethnicity, economics, and immigration also exist as contributing factors to violence. Related issues of stigmatizing individuals with mental illness and/or substance misuse issues and victim blaming represent additional sources of grief and distress for survivors.

For survivors of interpersonal violence, the intensity of suffering and distress often results in a distorted sense of safety and security in relationships (Briere & Scott, 2015) that affects the establishment of a working alliance with the therapist. Complex trauma is a unique stressor that can cause deep reactions for the therapist. The feelings of rage,

grief, loss and despair that are part of the client's experience may also eventually become signs of VT for the therapist (Pearlman & Caringi, 2009). The challenge of building and maintaining a therapeutic relationship with clients whose worldview is marked by mistrust and foreboding (Lawson, Davis & Brandon, 2013) can be taxing and lead to negative effects of VT. The therapist's use of empathy while bearing witness to the client's traumatic experiences are additional causes of strain and increased vulnerability for cumulative internal changes. Changes associated with VT can negatively affect a therapist's sense of identity and worldview, beliefs and expectations (Pearlman & Caringi, 2009; Pearlman & Mac Ian, 1995). If negative effects become severe or remain unchecked, this can lead to professional errors, personal difficulties, burn out and potentially end a therapist's career.

Expecting and preparing for VT reactions may also be preventative. A multidimensional approach that incorporates a wide range of measures and strategies may be the most effective in counteracting negative consequences and promoting therapists' psychological well being. Raising awareness through education and a safe and open culture of support can help reduce the effects of VT for therapists (Hernandez, et al., 2010; Silveira, 2013). Attending to the many facets of personal care are the usual strategies recommended and assist with managing negative internal states, self-regulation and reducing stress. The framework of awareness, balance and connection can be applied to strategies that attend to the mind, body and spirit of the therapist as well as to professional and organizational realms (Saakvitne & Pearlman, 1996) . There is a need to look beyond traditionally recommended self-care measures and attend to the importance of workplace and organizational measures and support. For therapists in private practice,

working in isolation can diminish the provision of immediate support and consultation. Supervision practises and peer support that specifically address and normalize VT experiences openly and without judgment can help reduce the stigma and impact of VT (Hernandez et al., 2010; Meichenbaum, 2007; Silveira, 2013). Connection with others is a key to trauma recovery as well as for therapists to combat and manage VT reactions. Maintaining connection through professional associations, training forums, participating in conferences, can help fortify therapists' sense of competency, identity and purpose in the work (Harvey, 2007; Saakvitne & Pearlman, 1996; Trippany, 2004).

Incorporating social justice work, advocacy and community involvement can fuel resilience for therapists. Engaging in efforts and causes that promote empowerment for survivors, and prevention of IPV, can foster a sense of collective ethics and care among professionals, and is sustaining (Harvey, 2007; Hernandez et al., 2010; Reynolds, 2009; Reynolds, 2011; Silveira, 2013). Increasing compassion satisfaction is a buffer for VT and proactive measures that help counteract the costs of caring and hazards of the profession can help trauma therapists to sustain hope and optimism (Arnold et al., 2005; Craig & Sprang, 2010; Downey, 2013). Addressing the topic of VT through self-reflection, with peers, in educational and professional settings, can, in itself, strengthen trauma therapists' resilience and ultimately, positively impact the recovery and healing process for survivors of interpersonal trauma.

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