Vicarious trauma in helping professionals: How can a counsellor help?

by

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Abstract

Vicarious trauma occurs in helping professionals that are exposed to the trauma of others. It can occur by seeing, hearing or being in the presence of others trauma which produces symptoms or changes in ways of thinking in the helping professional. Counsellors are in a professional position that may encounter clients or organizations affected by vicarious trauma. The goal of this capstone is to uncover effective ways a counsellor can reduce the impacts of vicarious trauma. This literature review will discuss past and current literature relating to vicarious trauma in helping professionals and the treatment approaches that a counsellor can engage in when working with vicarious trauma. The ways in which a counsellor can help with VT in individuals and at a societal or organization level is compiled in this capstone to help a counsellor access VT related approach information in one space. In conclusion, this capstone has recommendations for further research ideas that could contribute a counsellor VT treatment toolbox.

Keywords: vicarious trauma, helping professionals, treatment approaches, counsellor

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Chapter 1

Humans that devote their work life helping other humans in times of illness, crisis or trauma are exposed to the feelings, emotions, and nervous systems of those they are working with. This can elicit changes in the helper's mental and physical health (Hallinan et al., 2021). Helping professionals considered in this capstone are those that work in healthcare, first response, police and social work. Vicarious most simply defined as the exposure to the trauma experience of others (Molnar et al., 2017). Pearlman and Saakvine (1995) defined vicarious traumatization as a profound change in a helper that occurs due to empathetic engagement with a subject's experience or story of trauma and this definition continues to be used today.

The concept of vicarious trauma dates back to Freudian theory in which a client's unconscious feelings or thoughts are projected onto the therapist (Newell et al., 2016). The inability for the therapist to stop these projections and in turn activate the therapist's unresolved or unconscious issues (Freud, 1923/1964; Hacker, 1957 as cited in Newell et al., 2016) could be said to be the first description of countertransference, possibly the first characteristics of vicarious trauma. In the 1980's and 90's studies by Charles Figley (1983), Irene McCann and Laurie Anne Pearlman (1990), and Pearlman and Paula MacIan (1995), determined that helping professionals who were exposed to client's trauma on an extended basis may start to develop maladaptive behaviours and emotions, however, it was not seen as countertransference or burnout and further terms were developed to describe the phenomenon. The more recent terms used are vicarious trauma (VT), secondary traumatic stress (STS), or compassion fatigue (Newell et al., 2016). McCann and Pearlman (1990) coined the term vicarious trauma and defined it as the transformation that occurs within a therapist (or helping professional) due to their empathetic engagement with a clients'

trauma. This could include changes in worldview for the helping professional and affect how they experience themselves and the world (Pearlman & Mac Ian, 1995). The evolution of acknowledgement of VT is noted in the latest DSM-5-TR as it newly recognizes trauma that can be experienced by an individual that was not at the traumatic event can occur from a medical perspective (Morrison & Morrison, 2024).

More recently, the effects of vicarious trauma (VT) were studied during the Covid 19 crisis as helping professionals were managing their own stressors related to the pandemic as well as the trauma of their clients (Aafjes-van Doorn et al., 2020). The media's coverage of the people who contracted Covid 19 and the strain this put on the frontline workers own health increased the exposure to, and interest in vicarious trauma. Workers experienced health changes that challenged their abilities to stay at work due to VT, contributing to staffing shortages. This supports prior studies where workers' departure from their work was contributed to VT (Perez et al., 2010), turnover of workers increased (Middleton & Potter, 2015), and lowered morale and efficiency was noted when workers experience VT (O'Connell & Kung, 2007).

Although Covid 19 may have increased the interest in this area as it increased mental health concerns in general exacerbating VT in helping professionals (Lodha, 2021), vicarious trauma has occurred and been an issue in helping professional workplaces for many years. Tsouvelas et al. (2019) report they found that 6-26 % of therapists that worked with individuals experiencing trauma and up to 50 % of workers in the child welfare system were at high risk for experiencing VT (Tsouvelas, et al., 2019). Contrary to the possible expectation that the number of helping professionals experiencing VT increased, a survey done in 2020 of therapists working during Covid 19 showed results that VT levels experienced were the same during the pandemic as previous studies had shown,

approximately 15% experienced high levels of VT (Aafjes-van Doorn et al., 2020). Of note, that study showed there was an association that younger or less experienced therapists accounted for a higher number of therapists experiencing VT, also in line with prior studies involving helping professionals (Aafjes-van Doorn et al., 2020; Devilly et al., 2009).

Although, that study did not show an increase in the percentage of therapists experiencing VT during Covid 19, Chira et al. (2024) suggest that it is important to research interventions for helping professional experiencing VT as their symptoms relating to trauma exposure could be increased due to their work on the front lines of the Covid 19 pandemic. Also noteworthy is that it is not known if the overall number of helping professionals increased during the pandemic, which if there was, the same percentage of those individuals dealing with VT would equate to a higher number of helpers experiencing VT. The need for implementing strategies due to possible increase of VT symptoms was heightened during this time (Jimenez et al., 2021). It is possible that if further study results from Covid 19, pandemics or and or other global health crises and their aftermath come forward, incidence rates and severity of VT experienced by helping professions can be further understood. Knowing that 15% of therapists experience high levels of VT (Aafjes-van Doorn et al., 2020), and there is a possibility for that number to increase due to global health crises, supports the need for counsellors to understand VT and how to approach it.

Vicarious trauma can present numerous ways in the helping professional. Some of the reported symptoms include negative coping skills, hyperarousal to personal safety, nightmares, unwelcome thoughts, social isolation, and avoidance of intimacy (Branson, 2019). Changes in worldviews, queries about spiritual beliefs, and changes in attendance or motivation for work or work ethics can also occur (Branson, 2019). Cognitive schema (cognitive structures that represent a human's knowledge of a situation or entity) changes are

a symptom of VT. The main categories of schemas relating to both self and others that can be affected are safety, control, trust, esteem and intimacy (Pearlman and Saakvitne (1995) as cited in (Jenkins & Baird, 2002). When these symptoms, thoughts or behaviours contribute to a decrease in wellbeing, support for the helper outside of the workplace is indicated (Bride et al., 2024). This may lead a helping professional to seek support for themselves, solidifying the need for therapists to know the most effective approaches to assist these individuals.

Research Problem

How VT can be addressed is an important question not just for individual sufferers but for society due to its effects on healthcare systems with respect to availability and quality of care for patients. Helping professionals experiencing vicarious traumatization can experience symptoms of VT that contribute negative outcomes to their quality of life (Torres et al., 2023). For society, the loss of helping professionals in the workplace due to the effects of VT trickles down to decreased health support for society in general as it contributes to the shortage of helping professionals able to work (Perez et al., 2010). Determining effective treatments and approaches to VT will contribute to the individual's wellness and society, as the helping professional may be able to continue or return to their important work. The possibility of positive growth outcomes of VT, such as Post Traumatic Growth (PTG) (Deaton et al., 2023), warrants review as well to ensure a counsellor is informed of all possible effects of vicarious trauma both positive and negative so appropriate treatment strategies can be applied. Counsellors can be related to VT in several ways. They can treat helping professionals experiencing VT, they can be involved in promoting or facilitating VT prevention programs or strategies or they may need to manage their own personal experience of VT. In existing

literature, the writer was unable to find a toolkit that informed counsellors how they can help with vicarious trauma experienced in helping professionals, exposing the rationale and goal of this paper.

Research Justification

Exploring effective treatments for vicarious trauma symptoms experienced by helping professionals can provide counsellors with VT informed approaches in the counselling room. VT appears to present in many helping professionals that work with all populations. Sprang et al. (2019), concluded that further investigation into how many helping providers were affected by VT and to what extent (personal and occupational) is needed. Scientific treatment development was stated to be at early stages at that time and a gap in literature that focused on specific effects of secondary trauma or VT was noted (Sprang et al, 2019). A need for further understanding for evidence-based treatments in the area of the effects of indirect exposure to others trauma was noted (Sprang et al., 2019).

Since the research by Sprang et al (2019) was conducted, the Covid 19 pandemic occurred, which highlighted the need for further exploration of VT treatments for counsellors. Mental health workers that were treating folks affected by Covid19 experienced significant burnout and negative mental and physical health outcomes due to Covid 19 (Mittal et al., 2023). Trauma experiences in general increased, worsening VT in helping professionals (Lodha, 2021). Not only were frontline workers affected by the circumstances of Covid 19 but helping professionals providing support to the frontline also experienced symptoms of trauma, and burnout, warranting sharing interventions that will assist helping professionals recover or maintain their health when dealing with secondary trauma (Mittal et al., 2023).

There is significant literature regarding effective approaches and treatments for direct trauma, however, there are 4 treatments that the writer found that had specific mention for treating vicarious trauma. Treatment protocols CBT (Graham, 2012) and EMDR (Tarquinio et al., 2021a) have been studied in relation to working with helping professionals experiencing VT. Art therapy is referenced as an approach to use with VT (Gibson, 2018; Neswald-Potter & Simmons, 2016; Ortner, 2024) , but studies showing a direct link to effectiveness in treating VT were not found. Somatic therapy has been more recently used when working with symptoms of VT (Thiessen, 2024). Determining which protocol has shown positive effects for treating VT and under what circumstances would be useful for a counsellor.

Besides working with symptoms that are negatively affecting a person due to VT, another phenomenon that is being studied is vicarious post traumatic growth (VPTG). VPTG is positive growth that can occur in a helping professional as a result of being exposed to indirect trauma (Deaton et al., 2023). Understanding that VPTG can happen alongside the negative symptoms of VT (Deaton et al., 2023) and how it may enter or could be integrated into the counselling room may add another layer in addressing VT.

Along with post symptom treatment options, preventative strategies that counsellors can educate in or advocate for would be helpful for the counsellor to know, such as systemic or environmental influences which could contribute to VT. Systemic issues would include an employer or organizations policies and procedures. Environmental influences could be related to the helpers' support, training and personal factors. These influences on VT have been researched very little in professions that provide human services (Strolin-Goltzman et al., 2024).

Providing counsellors with all avenues that can be used to address VT is discussed in this capstone to provide a balanced view of how a counsellor can help with VT. This includes treatment approaches of VT in the counselling room, systemic strategies and prevention protocols. All VT knowledge will help a counsellor themselves manage their own risk or occurrence of VT.

Contributions to the Field of Counselling

Researching effective treatments of vicarious traumatization is directly linked to the practice of counselling psychology as helping professionals experiencing VT may seek assistance from a counsellor. Knowledge of informed approaches and interventions will provide a counsellor with tools and confidence for working with such clients. Counsellors are also called upon in times of mass trauma or healthcare crisis to support those working in the field. Recent examples in Western Canada would be Covid19, the opioid crisis, and wildfire responders. In addition to understanding different treatment approaches that may assist helping professionals experiencing VT, such as CBT, EMDR, Art or Somatic therapies, knowing other factors that contribute to VT, such as systemic or organizational structures or environments will also add to a counsellors proficiency in working with VT. Understanding if there are preventative treatments or circumstances that reduce the effects of VT can provide a counsellor with knowledge to advocate for programs and changes in process or environments for helping professionals, perhaps providing preventative guidance. Staying current with evidenced-based research, new theories or approaches for VT, such as the concept of vicarious post traumatic growth is also important for counsellors to inform their ongoing practice in the area of VT.

I believe it is important to have a scholarly-practitioner model supported in order to support the practical application of academic research. This model suggests that practitioners act

as researchers as well to guide their work and progress in their fields with evidence-based research. This capstone will prioritize that model when presenting information so a practitioner can inform their practice and professional guidance in the area of VT.

Theoretical Framework

Researching effective interventions for a variety of situations or symptoms that a therapist may encounter with a pragmatic approach will allow for a systematic review of the literature available in the area of VT and organize summary or the results. This approach aligns with my own beliefs in problem solving and scientific theory. The quest to have clearly presented evidence-based solutions to a problem is what guides my research interests and goals. That said, a postmodern perspective is necessary for literature reviews such as this one. Rossman & Rallis (2012) as cited in (Creswell, J.W. & Creswell, J.D., 2023) describe this perspective as knowing that research involves issues of power, is not transparent due to being written by raced, classed, gendered, or political people, needs to include representation of all people for a full understanding, and has commonly left out voices of marginalized groups. As trauma, and therefore VT, can be viewed, experienced and treated differently among varying groups of people, it is important to understand that all voices may not be present in literature to date, leaving out data that may be helpful.

Psychological theories that have led to the concept of vicarious traumatization and its effects are psychoanalytic theory (Newell, 2016) and constructivist self-development theory (Pearlman & Mac Ian, 1995) . Freudian psychoanalysis was based on the idea that a client's emotions can be absorbed by a therapist. Transference neurosis which is described as the when the client's information is taken in by the therapist during psychoanalysis and triggers

the therapist's own unresolved conflicts and issues (Hayes et al., 2011). The current term used for this concept is countertransference.

Pearlman and McCann (Pearlman & Mac Ian, 1995) used the framework of constructivist self-development theory which suggests that people make their reality from cognitive schemas that provide their reality with subjective meaning to inform VT. Changes to the cognitive schema of the helper can occur when the helper is exposed to the trauma of the client (Halevi & Idisis, 2018).

This capstone will utilize a pragmatic orientation that will integrate qualitative and quantitative research to construct practical application of results. This approach allows for exploration of different approaches that address the research question of how counsellors can effectively reduce the impacts of vicarious trauma. Limitations of using a pragmatic orientation can be less emphasis placed on theoretical frameworks or critical analysis of assumptions in the literature. So as not to overlook limitations within the research reviewed, a postmodern perspective will be considered to recognize and acknowledge limitations within the research.

Positioning Statement

The topic of vicarious trauma is of interest to me as I work in the field of supporting healthcare professionals that are struggling in the workplace. Some of these folks are suffering from symptoms of VT or compassion fatigue. Given that I only work with helping professionals that are unwell, and not all helping professionals, this may contribute to a bias of thinking the prevalence of VT experienced in helping professionals is higher than it is. I may also look for research supporting the negative effects of VT and post symptom treatment effectiveness more intentionally. Focus on preventative treatments as well as positive outcomes of vicarious trauma

will be considered along with my preconceived thoughts about the negative symptoms of VT and their effective interventions.

Definition of Key Terms

There are a number of terms that are related to or used interchangeably with vicarious trauma (VT) in some literature. These definitions will note the differences and similarities of the key terms for referencing.

Burnout is a term used to describe feelings relating to the workplace where a helping professional may feel apathetic or exhausted physically or emotionally, may get a depersonalized feeling and not have the desire or ability to be productive at work (Branson, 2019). This is similar to VT in that both can be a result of repeated or accumulated stress. According to Branson (2019), burnout differs from VT in its treatment protocol, which can include changes such as a rest, change in job, boss, or responsibilities. VT has more noticeable changes in the helper that are likely to last longer.

Compassion fatigue is similar to secondary traumatic stress (STS), and both terms were coined by Figley in 1995, (Branson, 2019). They are often used interchangeably and are characterized by a helpless feeling due to being overwhelmed by the needs of those suffering and difficulty in accessing assistance for them.

Secondary traumatic stress (STS) can be defined similarly to VT as reactions due to indirect exposure to the trauma of another person. Some symptoms may be similar to Post Traumatic Stress Disorder (PTSD) but will not meet the DSM V criteria (Sprang et al., 2019). The most recent DSM-5-TR (2022) recognizes STS as a stressor for PTSD so is included as criteria for a PTSD diagnosis when symptoms of PTSD follow.

Vicarious trauma can be defined as the cumulative impact on a helper due to learning about a clients' trauma. VT can be differentiated from burnout, compassion fatigue and STS,

due to its inclusion changes in cognitive schemas and belief systems of the helper (Pearlman & Saakvine, 1995 as cited in Sprang et al., 2019).

Vicarious post traumatic growth (VPTG) is growth that occurs due to exposure to the trauma of others. The concept that positive outcomes for the helping professional such as increased resiliency, development of personal growth, life meaning and work satisfaction are considered in this area of study (Deaton et al., 2023; Michalchuk & Martin, 2019). VPTG can occur alongside the negative symptoms of VT (Deaton et al., 2023).

This capstone will focus on and use the term vicarious trauma (VT), however, as the purpose of this capstone is to explore effective approaches for VT, an awareness of terminology that may be related and used in relation to VT should be considered. Overlapping symptoms or client description of VT, compassion fatigue or burnout will present in the counselling room, so having an awareness of those connections is relevant for the purpose of this paper.

Summary Conclusion

A therapist may work in a field or a counselling room where they are presented with symptoms indicative of or related to vicarious trauma. There is benefit to individuals, organizations and society to help alleviate or prevent these negative effects of these symptoms (Perez et al., 2010). Several terms are used in reference to the experience of helping professionals' exposure to the trauma of their clients including secondary traumatic stress, burnout, compassion fatigue and vicarious trauma (Branson, 2019). These terms have overlapping symptoms. Although this capstone is focused on the term vicarious trauma (VT), which has a distinguishing symptom of changes to cognitive schemas and core beliefs of the client (Branson, 2019; Jimenez et al., 2021; Pearlman & Mac Ian, 1995), the writer

feels it is important for a therapist to have knowledge of appropriate treatment for all symptoms that the client may relate to VT.

Although using evidence-based treatments has shown decreases in secondary traumatic stress and burnout, there is little research on particular treatment approaches (Craig & Sprang, 2010). This literature review revealed EMDR (Tarquinio et al., 2021a; Torres et al., 2023), CBT (Graham, 2012; Torres et al., 2023), ~~and~~ Art Therapy (Ortner, 2024) and Somatic Therapy (Thiessen, 2024) as possible treatments for VT. As well, preventative and organizational/systemic strategies have been shown to improve symptoms of VT. A review of these strategies will be presented in this capstone~~.~~

A complete review of VT includes exploring positive symptoms that can occur in a helping professional exposed to VT. A counsellor may witness post traumatic growth with a client that has experienced VT, therefore the concept of VPTG as a treatment or informed approach in the counselling room will be explored. The purpose of this capstone is to review current literature on effective approaches counsellors may engage in when working with helping professionals that may or are experiencing VT symptoms. Strategies outside of the counselling room, such as systemic or organizational issues in the workplace and prevention measures enacted by both employer and helper themselves will be explored. Understanding one's own relationship to VT as a counsellor (helping professional) is reviewed given its importance to the health of the counsellor and as a strategy when working with others experiencing VT. The intent is to provide a complete overview of how counsellors are associated with and can help with vicarious trauma. The importance of cultural concerns and research limitations is acknowledged in this capstone, and they have

been embedded within the sections they are most relevant to be stated in for ease of reference.

Chapter 2: Literature Review

Chapter one explained vicarious trauma (VT), its potential relation to helping professionals, and various ways a counsellor may encounter VT in their professional work. Literature to date relating to treatment protocols, preventative measures and advocacy opportunities which a counsellor may engage in when working with vicarious trauma in helping professionals was reviewed. Therefore, the balance of this capstone is an attempt to consolidate information that has been produced to date regarding VT treatments and approaches that have been discussed by psychology professionals with special interest in VT. Although there are several counselling approaches to treating trauma experienced directly, only CBT (Graham, 2012; Torres et al., 2023), EMDR (Tarquinio et al., 2021; Torres et al., 2023), Art Therapy (Ortner, 2024) and Somatic Therapy (Thiessen, 2024) will be considered in this paper as they were specifically studied in the reviewed literature in relation to addressing VT symptoms. Post traumatic growth (PTG) will be reviewed as both an approach and a result of VT. Preventive strategies employed by the helping professionals themselves such as self-care and self-awareness will be explored. The systems helping professionals practice within will be discussed considering VT from both the organizations and the helping professional's perspective, as a counsellor may be able to advocate or support in this regard. And finally, workplace structure and practices within organizations that can influence helping professional experiences of VT will be discussed given that counsellors can be consulted by organizations requesting assistance in mitigating the effects of VT on their employees and organizations. The varying ways in which a counsellor can encounter and help with the management of VT will be addressed in this capstone.

Treatment Approaches

Cognitive Behavioural Therapy (CBT)

CBT is a currently widely used counselling approach that's development began by Aaron Beck in the1960's. The relationship between a person's feelings, thoughts and behaviours are explored and challenged (Dewan et al., 2018) in this approach. CBT can include psychoeducation, mindfulness, challenges of negative thoughts, all or nothing thinking or thought distortions. It is a goal oriented, present focused approach that has a strong evidence base in psychotherapy treatment (Dewan et al., 2018).

CBT and VT

Several references suggest that CBT is an effective treatment for vicarious trauma (Deblinger et al., 2020, Morrison & Morrison, 2024, Sprang et al., 2019). Some research did not directly link CBT as a treatment for VT, however a link may be drawn in other research due to the use of multiple terms for the symptoms of VT such as burnout, secondary traumatic stress (STS), compassion fatigue and PTSD (Branson, 2019, Craig & Sprang, 2010).

CBT is indicated as one of several appropriate approaches to VT by people working in the field of VT (Sprang et al., 2019). While researching interventions for STS which were reviewed experts in field of STS, Sprang et al. (2019) identified best practice approaches for symptoms which could be described by a person experiencing VT depending on presenting symptoms. CBT was suggested for irritability, hypervigilance, concentration problems, exaggerated startle response and sleep disturbances. Psychoeducation and mindfulness, which can both be considered parts of CBT, were identified as best practice approaches for not only those symptoms, but also distressing memories of client encounters, distressing dreams, physical or psychological distress of reminders and avoidance of reminders. While

all those symptoms may be described by a client experiencing VT, a defining characteristic of VT which differentiates it from similar conditions such as secondary traumatic stress and compassion fatigue, are changes in the client's worldview and cognitive schemas (Pearlman & Saakvine, 1995 as cited in Sprang et al., 2019). An approach within the CBT framework that may help in this area is challenging thought distortion. Thought distortions can be questioned as being factual or supported by evidence, followed by trying to facilitate a reframe or more balanced thought (Dewan et al., 2018).

Trauma focused CBT (TF-CBT), an adapted form of CBT which is an evidenced based treatment most often used with children or adolescence that have experienced trauma, has shown promise in managing VT for the helping professional themselves when they engage in the TF-CBT (Deblinger et al., 2020). TF-CBT's structure when used with this client group can be described by the acronym PRACTICE, Psychoeducation, Parenting skills, Relaxation skills, Affective expression and modulation skills, Cognitive coping skills, Trauma narration and processing, Invivo master, Conjoint child-parent session and Enhancing safety and development (Deblinger et al., 2020). Deblinger et al., 2020, studied 115 clinicians/supervisors before and after they participated in training for PWYP (Practice what you preach) TF-CBT. When the counsellors themselves participated or practiced those steps that were relevant for them such as psychoeducation, being trained in trauma informed practice which increased their competency and confidence, relaxation techniques (self-care), cognitive coping skills and enhanced development through supervision, they reported decreased levels of VT (Deblinger et al., 2020). This PWYP method supports that TF-CBT could be effective in treating VT.

Eye Movement Desensitization and Reprocessing (EMDR)

EMDR is a relatively newer approach for treating trauma which was first conceptualized by Francis Shapiro in the 1980's (Shapiro & Brown, 2019). It is an eight-stage model using bilateral stimulation to assist the processing of trauma, which has developed over time to its current status as an innovative trauma treatment (Shapiro & Brown, 2019). EMDR was found to have positive results in reducing VT symptoms (Morris et al., 2023; Tarquinio et al., 2016, 2021b).

EMDR and VT

As mentioned, a feature of VT that separates its definition from compassion fatigue and secondary traumatic stress is the change in cognitive schema that the person may feel. In a review done of a first responder that was seeking treatment for VT, EMDR was chosen by the therapist as the most effective way to deal with "shattered schemas" (Keenan & Royle, 2007). This case study chronicled one helping professionals' journey through treatment for VT with eventual elimination of disabling symptoms including intrusive images and disrupted cognitive schemas relating to his work identity. He had described himself as useless, worthless and vulnerable with regard to work. Prior counseling, including CBT, had not been helpful for them, but after 8 EMDR sessions, he was able to return to base level life function including work (Keenan & Royle, 2007).

As PTSD has a crossover of symptoms of VT, such as anxiety, irritability, hypervigilance, intrusive thoughts, and avoidance (McCann & Pearlman, 1990), studies where EMDR was used to treat PTSD may provide transferable information for treating VT. Tarquinio et al. (2021) posited that EMDR treatment may be a helpful approach to healthcare workers that were experiencing the cumulative psychological and emotional stress (VT) from caring for Covid 19 patients. Since 1989, EMDR had been reported to be

effective in treating PTSD (Tarquinio et al., 2021b) which led to their curiosity of its effectiveness for VT. EMDR protocol applied via phone (due to pandemic limitations) found that the participants' anxiety and depression scores had decreased after one session with continued reduction after one week (Tarquinio et al., 2021).

Furthermore, an adapted EMDR approach called EMDR (G-TEP), which is EMDR Group Traumatic Episode Protocol used in a group application has been applied with therapists that had experienced VT (Simmons, n.d.; Tsouvelas, et al., 2019). This protocol included all aspects of early interventions that may help with VT including working with thought distortions, hypervigilance and flooding reduction, return to regular functioning and production of further feeling of safety. Results supported that the therapist's distress regarding the stressful workplace events was reduced after the EMDR protocol (Tsouvelas, et al., 2019).

EMDR as a treatment protocol has an evidence base for treating trauma such as PTSD, and complex trauma (Shapiro & Brown, 2019). These types of traumas appear to have been researched more than VT, however, with the increase in popularity in disseminating information by media such as podcasts or webinars by experts in a field, the use of EMDR to treat trauma, including VT, is being discussed currently (Parnell, 2024; Simmons, n.d.). The positive effects of using EMDR interventions for recent trauma recovery in an effort to reduce the effects of VT in areas of disaster or war trauma are presented from firsthand experiences (Parnell, 2024; Simmons, n.d.). Potential for expanding the use of EMDR for VT is supported.

Art Therapy

Art therapy is another approach that has been documented as a treatment for VT symptoms. Art therapy includes the use of any creative, artistic behaviour to assist an

individual improve their wellness. Popular forms include painting, drawing, journaling, sandtray, ecograms, dance, sculpturing, poetry and singing, however any method of expressing one's thoughts or feelings in a creative manner could be considered art therapy (American Art Therapy Association, 2017).

Art Therapy and VT

Art therapy can be used as a form of self-care, which is a suggested strategy to combat VT, as well as if done in a group, it has been reported to help normalize the experience of VT (Drapeau et al., 2022).

Case studies involving personal accounts of helping professionals that accessed art therapy to treat the symptoms of VT supported Art Therapy as a VT treatment protocol. A chronicle of how visual journaling assisted a child trauma therapist through his vicarious trauma experiences and symptoms is presented by Gibson (2018). The therapist concludes that the amount and frequency of VT symptoms he encountered carrying into his homelife "dramatically" changed as the visual journaling therapy progressed. Symptoms including depression, anxiety, hypervigilance and nightmares decrease. He described the visual journal as a "container for thoughts and emotions related to his patients" and reported better sleep quality and a renewed interest in work with increased resilience (Gibson, 2018).

An expressive arts model that was studied when used with supervision of counsellors experiencing VT is called the Regenerative Model (Neswald-Potter & Simmons, 2016). Case studies by Neswald-Potter & Simmons, 2016, recount the effects of using expressive arts during supervision. There was increased focus from the client on themselves as opposed to their client's trauma, reduced anxiety, changes in cognitive schemas and increased confidence in their professional abilities. Expressive art modalities used within the supervision sessions included story writing (journalling), reflective processing, clay

sculpture work, horticulture work and collaging. This model has also been studied due to its possible relation to vicarious post traumatic growth (VPTG), which is positive outcomes or positive psychological change that occurs when a helping professional processes the trauma experienced by their clients (Neswald-Potter & Simmons, 2016). VPTG will be discussed further in the next section. Employing expressive arts in supervision, as well as any other intervention that may produce VPTG, is worthy for a counsellor to be aware of.

Ortner (2024), a trainee art therapist herself, described her own experience personally using art therapy as a method to mitigate the symptoms that may have been related to VT. She concluded that her participation in art therapy reduced stress, hypervigilance, and negative physical symptoms. She also suggested that art therapy may help with an overall improved sense of well-being and post traumatic growth (Ortner, 2024).

Art therapies characteristic of personal choice in type and presentation of the art form, as well as the regenerative model itself include space for cultural and spiritual expression and awareness (Neswald-Potter & Simmons, 2016). This attribute makes art therapy attractive to many clients due to its flexibility and connection to all cultures in a way the client wishes.

Somatic Therapies

Somatic therapies focus on the mind-body connection. They are based on the concept that trauma is stored in one's body. Peter Levine, PhD, first developed the idea that the body responds to trauma through nervous system pathways about 40 years ago. Levine (1997) used the term somatic experiencing to describe the approach of using body focused attention and movement primarily (as opposed to a cognitive forward approach) to process symptoms of trauma (Levine, P.,1997; Senreich et al., 2025). Using somatic experiencing

treatment with helping professionals working with disaster victims has shown a reduction in VT symptoms (Leitch et al., 2009).

Amanda Thiessen (2024) provides somatic therapy practical approaches a counsellor can consider when working with a client experience VT. Given that empathy is shown by mirroring a client while listening to them, which can start to build VT, the following somatic therapy ideas for unmirroring (the opposite of mirroring) in the moment can be provided to the client. Peripheral vision exercise can be done while looking at a client. This is done by keeping peripheral vision intact (as opposed to tunnelling) which will physiologically give the body a message of safety. Grounding exercises such as feeling into your feet can help unmirror, as well as imagining the story/incident is happening to your client and not yourself.

To move towards unmirroring long term, a counsellor can work on the following with the client. Building body awareness through somatic work and educating or suggesting clients use their body to try to process stored trauma (walk, run, dance, yoga, etc.) can be beneficial. As well as developing ongoing visualization and transitioning rituals, such as “shaking it off” or lighting a candle at the end of a shift to recognize, feel, and in an attempt to contain or let go of emotions or feelings connected though vicarious trauma exposure (Thiessen, 2024). Somatic techniques are an area that warrants further research given the qualitative accounts of those working in the field of VT.

Cultural Considerations and Limitations with Treatment Approach Research

Cultural considerations and limitations of the studies reviewed relating to the direct treatment techniques in this capstone will be noted here. Lack of control groups (Deblinger et al., 2020; Morrison & Morrison, 2024), and questionable baselines due to recruitment methods were noted. Surveys were only offered in the English language, and would limit

data returned (Morrison & Morrison, 2024). Population size for studies were noted to be small and therefore not representative of diverse populations. Case studies involving only one subject are open to researcher bias as in the case study by Janoff-Bulman (1985).

EMDR protocol for VT studies noted sample size was small, and the group of subjects studied were in one particular area of helping people, either health care workers or therapists. Sample size and cultural, social, or professional diversity of subjects would allow for more diverse evidence for EMDR treatment across populations. In the EMDR (G-TEP) study, the results were limited as a control group was not used and effectiveness of the treatment after the initial assessment was not done to determine continued effectiveness after a period of time such as 3 months (Tsouvelas, et al., 2019).

As for Art Therapy, although it is considered appropriate for cultural and spiritual expression (Neswald-Potter & Simmons, 2016), it should be noted that the individual case studies would not have cross cultural considerations embedded or qualify as evidence based. Individual case studies are subjective observations in which reliability and objectivity may be affected.

Other sources of information in this review were webinars and podcasts (Parnell, 2024; Simmons, n.d.; Thiessen, 2024) so the current discussions in the field of VT were included. These may have validity, reliability and bias concerns and may not be considered as evidence based given the lack of referencing within the presentations.

Beyond the limitations of the studies reviewed, a possible unique practical limitation for helping professionals engaging with VT affected helping professionals was noted. Working with these helping professionals experiencing VT (such as counsellors) can be challenging no matter what treatment protocol is followed. Helping professionals that are aware of how CBT, EMDR, Art Therapy or Somatic approaches are undertaken may have a

difficult time taking their professional hat off or analyzing how treatment is being performed. Being unable to fully engage in the treatment due to this distraction may make treating certain individuals with these approaches difficult (Simmons, n.d.).

Overall, a main theme noted as a limitation in this literature review was that further exploration and studies are needed in the area of VT to provide evidence-based information on using CBT, EMDR, Art and Somatic Therapy (Graham, 2012). Increasing evidence-based research on the treatment and approaches for VT would further knowledge and provide support for actions counsellors could take when working with VT. Moving past direct treatment approaches, a phenomenon that can occur within any treatment approach, VPTG, will now be discussed.

Vicarious Post Traumatic Growth

As described in the previous sections, post traumatic growth is positive psychological shifts post trauma. Although not termed VPTG, McCann and Pearlman (1990) discuss the importance of a helping professional maintaining hope and optimism while working with the trauma of others. Positive effects they personally experienced included a deeper sense of connection with others, greater self-esteem, intensified hope for the human ability to endure and overcome trauma or adversity, and a more realistic world view (McCann & Pearlman, 1990). Perhaps these ideas were the first unacknowledged description of VPTG. Vicarious post traumatic growth (VPTG) is a relatively newer area in relation to VT that is being studied as helping professionals reported not only negative symptoms of VT, but favorable changes in personal growth such as positive change in world view, increased emotional expressiveness in personal relationships, and renewed or new meaning developments in their work (Bartoskova, 2017). These positive growth changes can occur within the helping professional while they are being exposed to others trauma

vicariously (McNeillie & Rose, 2021). Understanding how to promote or access VPTG with clients experiencing VT is an area counsellors may find helpful in their practice, despite the lack of research on the subject.

Understanding of VPTG in helping professionals is limited (Deaton et al., 2023). The experience of VPTG has been described by many folks that experience VT, however, few studies involving what predicts, precipitates, facilitates or enhances VPTG have been done on a level to support an evidence base. Lived experiences of 6 psychologists that worked with clients dealing with trauma suggested the finding that the participants maintained resiliency in regards to VT by acknowledging and believing in the privilege of witness or sharing the clients narrative and cultivating positive meanings of purpose through serving humanity (Michalchuk & Martin, 2019).

In meta-analysis by Melinte et al. (2023), a positive relationship was found between secondary traumatic stress (STS) and VPTG which those researchers believed was the first study of its kind (Melinte et al., 2023). A positive relationship was found between STS and positive psychological thoughts such as life appreciation, existential and spiritual change and belief in new possibilities.

Melinte et al., 2023 suggested that identifying factors that can be modified to reduce STS and promote VPTG would be useful, such as practical designs within an organization. Training programs, organizational support, supervision, group support, self-care promotion and leader modelling were some suggestions (Melinte et al., 2023). Although this would not take place in the counselling room, a counsellor may be part of an organization's team in which they may be able to influence support to minimize VT and maximize VPTG.

Cultural Considerations and Limitations - VPTG

VT and therefore VPTG may be viewed differently between cultures. A collectivist versus individualistic view of trauma itself influences how trauma is described, perceived and treated. This will contribute to a lack of consistency in a universal understanding of VPTG, what it means and how it is achieved (Melinte et al., 2023). Small subject groups, subjective information as data and lack of cultural or professional intersectionality in the helping professionals providing information for these studies of VPTG also needs to be noted (McNeillie & Rose, 2021).

System Support

When researching effective approaches for VT, there was not only support for individual therapy reviewed, but the part that systems can play in the effects of VT was a popular discourse. The systems within which helping professionals live, work, study and socialize can play a role in how they cope, manage or heal from vicarious trauma. Organizational approaches have had the largest impact on preventing and dealing with VT (Bober & Regehr, 2006; Thiessen, 2024). The ethical responsibility of organizations to provide support to their members or employees that may experience VT is outlined by Sutton et al. (2022). The effectiveness of organizational support follows in the next sections.

Workplace

A workplace affected by vicarious trauma may have the following characteristics show up in their worker's experience. Lack of emotional containment, lack of trust, cycles of hope and discouragement, regularity of retraumatizing triggers, inadequate or unsafe organizational process, anxiety-based interactions and shame or guilt felt by workers may be described or witnessed (Thiessen, 2024). Some employers have focused on providing self-

care wellness programs, however some experts in the field of employee wellness propose that employee distress should be viewed as a collective requiring organizational approaches to tackle this distress (Barton et al., 2022).

Sutton et al. (2022) reviewed literature on the contribution of organizational factors to VT in mental health professionals. They found some factors such as, number of administrative tasks required by the professional, having access to resources or space, or perceived support from administrators did not correlate with a decrease in VT. Support was found for integrating regular supervision with supportive relationships with supervisors, healthy peer support networks, education on VT to be aware how it can present, and providing a variety in caseloads (Sutton et al., 2022).

Employers' approach to dealing with VT amongst their employed helping professionals will affect the well-being of their employees, their financial bottom line and overall morale in the workplace (O'Connell & Kung, 2007). Areas of interest that can relate to VT that an employer can influence include workload or trauma exposure amounts, supervision, education and workplace culture (Hallinan et al., 2021). Promoting change in a workplace's approach to VT may be something a counselling professional can be involved in. Challenges that can be expected for those trying to invoke changes in workplaces/organizations include motivating administrators, obtaining employee commitment to making changes and finding evidence-based support for the improvements needed to address VT (Hallinan et al., 2021).

VT therapist experiences during Covid19 were studied and it was found that younger, less experienced therapists experienced higher levels of VT (Aafjes-van Doorn et al., 2020), confirming prior suggestions of the same (Pearlman & Mac Ian, 1995). Support in the form

of mentors or supervision, colleagues and training were indicated as options to reduce the effects of VT (Aafjes-van Doorn et al., 2020; Pearlman & Mac Ian, 1995).

Workload distribution as a method to reduce trauma exposure to a single helping professional has been suggested to be more effective than individual treatment or selfcare for VT, as correlation between hours spent working with clients sharing their trauma and trauma scores for the helper has been shown (Bober & Regehr, 2006). Contrary to that evidence, Foreman (2018) found that counsellors' increased exposure to trauma did not influence wellness, but counsellors with a higher level of wellness experiences less VT.

The type of intervention a counsellor uses while working with trauma clients may influence the risk of the counsellor experiencing VT. Practicing EMDR was shown to have a lower risk of producing VT symptoms than trauma focused - CBT or prolonged exposure (Torres et al., 2023). This was attributed to the development of EMDR in which the client does not need to narrate or describe their trauma for the EMDR process to occur.

Principles for organizations wanting to address VT (or STS as termed in the study) were provided recently by Bride et al. (2024). They could not deem their results as evidence-based but called them consensus based as a field of experts in the STS (or VT) field were consulted. The principles that a counsellor working within an organization to address VT could strive for were provided as a result of the consensus-based approach. Providing ongoing evidence-based, culturally responsive STS (VT) training to help supervisors support the helping professionals was noted. An organization can cultivate a psychologically safe work culture involving personal boundaries and team support while naming possible effects of working with trauma. Workloads can be structured in a way that will decrease the likelihood of VT, such as maintaining a manageable caseload number with a variety of trauma versus non trauma cases (Bride et al.,

2024; Folland, 2021). Commitment to helping professionals' wellness is shown by having policies and practices to respond to STS (VT). Having qualified support through supervision and well as leaders that model trauma-responsive behaviour with active involvement in resilience is the workplace is important when working with VT. And the final suggested guideline is recognizing the wellness of the workers (helping professionals) as a top priority by measuring and monitoring it while maintaining privacy for the worker (Bride et al., 2024).

Thiessen (2024) emphasized the importance of organizations having a collaborative approach to VT with a work culture that supports the structure, processes and people of the organization to address VT. As mentioned above, building a safety culture with trust should be the foundation and this can be done by management being able to anticipate and respond to staff needs, management having their own support system (colleagues or mentors) as staff VT can shift to management, having structured protocols in place to debrief, normalizing and naming VT experience and language, ensuring staff access to counselling services, managing workloads and difficult cases, and offering resiliency training courses (Thiessen, 2024).

Cultural Considerations and Limitations - Workplace

The subjects in the studies are usually from one helping profession or just one organization is studied, limiting the extrapolation of the results into general guidelines organizational support. Varying cultures within the workers themselves and the organization need to be considered when developing organizational strategies for addressing VT.

Professional Associations

Helping professional associations can include groups formed due to a shared profession such as nurses, health support workers, mental health professional, home care worker or social workers, shared employers, or shared union memberships.

McCann and Pearlman (1990) discuss the positive effects their own profession group had on mitigating the experiences of VT. They found that meeting with a group of others engaging in similar work involving the trauma of others assisted them in developing coping strategies. Sharing ideas about balancing caseloads, varying caseloads to include not only trauma or victim cases, work hour limitations, personal boundaries, and realistic expectations for trauma work produced strategies individuals could adopt. Social activism and engagement in non-work (trauma or victim) related activities was also discussed and supported in these professional groups in an effort to promote hope and optimism (McCann & Pearlman, 1990).

Cultural Considerations and Limitations - Professional Associations

Professional organization members are connected through the commonality of their work. Other factors that may contribute to VT such as a member's professional background, personal history with trauma (Saakvine & Pearlman, 1990 as cited in Leung et al., 2023), cultural beliefs, worldviews and family or social support will differ in the members. Awareness of these personal differences should be considered when offering support in group settings such as debriefing groups. As with group therapy, sharing of one's own experiences related to VT may trigger more VT or negative symptoms for an individual given their unique history and relation to trauma personally or culturally.

Prevention

Prevention is an important aspect of addressing VT and is something counsellors may be involved in if working in the health and wellness area of an organization. Recognition of VT signs, leading to timely interventions may reduce long term negative effects for the helping professional and the organization by supporting the helping professional to continue working (Jimenez et al., 2021). Two areas of prevention that were regularly discussed in the literature reviewed for this paper were supervision, both during the helping professionals training, and on a regular basis once the worker is fully engaged in the work, and self-care management or principles.

Supervision

Supervision's relation to addressing or mitigating VT in helping professionals is supported (McNeillie & Rose, 2021; Neswald-Potter & Simmons, 2016; Pathan et al., 2023). The range of depth extends from suggestions of supervision in general to more specific supervisory approaches such as relational-oriented or reflective supervision (Howarth, 2021). Supervisors that are trauma informed and work outside of the helping professionals' organization may provide better support for VT (Folland, 2021).

Strategies that a supervisor can employ which have been suggested to be helpful for addressing the impact of trauma work on helping professionals include education and open dialogue about VT, facilitating an exchange of experiences, and aiding in the development of reflective processes with the helper (Neswald-Potter & Simmons, 2016). Using expressive modalities such as art or journaling within supervision can assist with meaning making, cognitive schema changes, anxiety reduction and increased confidence in work (Neswald-Potter & Simmons, 2016).

Approaching supervision from a strength-based approach by exploring trauma work as "a calling" has been suggested as a possible way to increase meaning and satisfaction of work and therefore improved feelings of wellness and client success (Michalchuk & Martin, 2019). Education about VPTG and support for the development of resilience and strength along with discussions of what is working well with clients may also benefit the helping professional (McNeillie & Rose, 2021; Michalchuk & Martin, 2019). In general, supervision to address VT by regenerating the helping professional is most beneficial when it is undertaken intentionally with authentic and reflective processing (Neswald-Potter & Simmons, 2016).

Cultural Considerations and Limitations - Supervision

Whether supervision is a voluntary or mandatory support that a helping professional engages in may factor into its effectiveness. Cultural backgrounds or personal history of the supervisor or supervisee should be considered regarding power imbalance or cultural behaviours or practices. Mandatory supervision may not be accepted as openly as voluntary. The option to choose a supervisor that the helping professional resonates with and respects, could influence the effectiveness of the supervisor and therefore management of VT.

Self-care

Self-care as a practice to mitigate mental health concerns of all types, for all people has been widely recommended for several decades. It is described as a preventative approach to VT to lessen the effect empathetic engagement has on the helping professional (Lodha, 2021). Perhaps its applicability to all cultures and intersectionality's makes it the most universal form of prevention or treatment for mental health issues. It is a topic that counsellors can approach with any client with justification and supporting evidence. When

working with a client experiencing VT symptoms, while still important for the client to access, the type of self-care that may be useful may differ from the dominant narrative of self-care strategies (ie- meditation, yoga, exercise, reading, nature walks), other self-care strategies such as complete rest, cessation of work, self-reflection or personal trauma therapy may be helpful

Tamarine Foreman (2018) studied the effects of helping professional (counsellors in this case) wellness and levels of VT. A correlation was found supportive of counsellor wellness as a protective factor for VT. Counsellors that reported higher wellness scores experienced less VT (Foreman, 2018).

Contrary to the dominant discourse that self-care is an effective prevention and treatment for VT, Hallinan et al. (2021) concluded in their study on organizational change to address VT, that self-care can place a burden on individuals that may experience VT which would further contribute to the stress. Hallinan et al., (2021) suggested that self-care be woven into the organization's efforts to address VT. This can be interpreted that self-care in itself was not found to be ineffective, but putting the responsibility of accessing self-care solely on the individual outside of time or support within their organization/employer can add to their distress.

Principles for an individual that is or may face VT were outlined by Bride et al. (2024) in their consensus-based study from experts in the STS (VT) field. These principles are described more as responsibilities of the helping professional, as opposed to direct self-care approaches. A counsellor could psychoeducate and support a client experiencing or working on preventing VT with these principles as guidance (Bride et al., 2024). A counsellor could facilitate self-awareness of risks for experiencing VT and approaches for mitigating it. Helping a client foster

and exercise beliefs that build their feelings of well-being in their work can support resilience to VT. A client may benefit from being aware of their personal strengths and weaknesses for developing VT, as well as knowing their own health and when to employ strategies to improve it. Counsellors can educate helping professionals of their own tolerance zone for trauma and develop strategies with the client that can help regulate the client to stay within that zone. Connecting with peers, other professionals and colleagues can be discussed and determined if appropriate for the helping professionals' needs for managing VT. And finally assisting the helping professional with information to help them know when further support or professional guidance is needed in their journey with VT, as well as how to access it is useful (Bride et al, 2024).

Cultural Considerations and Limitations – Self-care

As with most studies reviewed for this paper, cultural differences may not have been considered. Views of and what constitutes self-care practices may differ between cultures as well as differences in how a helping professional may be viewed or view themselves within an organization. Applying self-care practices or principles may not be considered acceptable in all cultures or work environments. The crossover of organizational principles possibly affecting the ability for an individual to apply personal principles to address VT should also be considered (Bride et al., 2024). For example, the availability of prayer rooms and time to access them built into the work environment could be a self-care option for some people. Understanding the helping professionals differing needs for self-care will benefit both the helping professional themselves and the organization they work within.

Summary of Findings

There seems to be interest in the community of those that support mental health to find the most effective ways to prevent, address or treat VT experienced by helping

professionals that are at risk of experiencing it. Although the evidence base for VT interventions is limited (Lodha, 2021), a reasonable amount of literature was found that provided recommendations from quantitative studies, albeit with generally low numbers of participants and cultural variation, and qualitative studies which reviewed case studies and self-reports of VT, that suggestions for how a counsellor may be able to respond to a client experiencing VT can be provided in this capstone. The goal of this capstone is to give counsellors a current summary of information which they can draw from to inform their approach with clients or organizations that want to address vicarious trauma. This information may also provide foundational information for counsellors to combat the effects of VT on themselves during their careers.

Therapeutic interventions that had some evidence bases were CBT, EMDR and Art therapy. Variations within those approaches will provide a more individualized treatment plan for a client, as can be derived from gathering information on the client's history, culture, social and family supports.

To facilitate this capstone's goal, current practical techniques as suggested by a therapist working in the VT field have been included. Somatic approaches to unmirror or disengage with empathetic connection to prevent or reduce current VT symptoms were presented (Thiessen, 2024). Although not evidence based as an intervention yet, this could be an area of further research.

VPTG, or the positive results helping professionals experience when working with trauma affected individuals, is a more recent field of interest as it relates to VT. The personal growth in world views, finding positive meaning, life appreciation, increased confidence and satisfaction in their work life of serving humanity can be indicative of VPTG

and has been shown to have potential to provide relief and maintain resilience for VT (Michalchuk & Martin, 2019).

Approaching VT through support from systems including the workplace, professional organizations and social networks has been outlined by professionals studying the field of VT. Qualitative and quantitative studies have discussed the relationship between these systems and their possible effects on instances and severity of VT experienced by helping professionals (Bride et al., 2024). Specific areas of focus are an organization's safety culture, training provided, supervision or mentorship framework, workload balance in terms of both caseload and case severity, and provision of support services such as counselling or debriefing programs.

VT prevention strategies including supervision and management of self have presented in VT literature. Supervision in general is recommended to support the well-being of helping professionals, and especially new trainees to the field as they are most likely to be affected by VT (Devilly et al., 2009; Pearlman & Mac Ian, 1995). Varying styles of supervision may impact the effectiveness of the supervisory practice with different groups of helping professionals. Self-care or self-management strategies may have an impact on the likelihood of experiencing VT or affect the severity of symptoms. The impact of self-care compared to organizational supports for VT and how they impact each other is important to consider for addressing VT.

Limitations in the information and literature that has been produced regarding VT should be noted (Michalchuk & Martin, 2019). A main theme listed as a limitation is the inconsistency or clarity of terminology used in relation to vicarious trauma (Howarth, 2021). The terms secondary traumatic stress, PTSD or compassion fatigue are used without specific definition at times, likely due to overlapping symptoms. Other common research limitations

acknowledged in the cited studies were low sample sizes, lack of control group comparison, and lack of cultural diversity in subject groups.

Despite the noted limitations in the information reviewed for VT, the need for further research is the field is noted in all studies. The existence of vicarious trauma symptoms does not seem to be debated in the literature, therefore confirming the need for counsellors to be provided with approaches to VT that they can employ with individual clients, workplaces or organizations they may work in.

Chapter 3: Discussion and Applied Practices

Vicarious trauma is experienced by up to 26 % of therapists (Tsouvelas et al.,2019). Given the risk of VT occurrence in any helping professional, strategies for working with or managing VT may be of interest to a counsellor. As a counsellor in training and an employee in healthcare myself, these perspectives include treatment of an individual experiencing VT, advocacy for systemic changes to reduce the incidence of VT and awareness or prevention or management of VT for self. Understanding how a counsellor can treat another helping professional experiencing VT may involve knowing what VT symptoms are, how they differ from direct trauma and approaches that may be applied with some effectiveness for VT symptoms. This literature review provided support for organizational or procedural strategies that may decrease the frequency of and overall organizational impact of VT for an employer employing helping professionals (Bride et al. 2024; Sutton et al., 2022; Thiessen, 2024). Counsellors could be situated in a consultant or advocate role in this area. Furthermore, counsellors themselves are particularly vulnerable to the effects of VT (Lodha, 2021; Trippany et al., 2004). Knowing and practicing prevention techniques and recognizing the symptoms of VT in ourselves is a necessary perspective when considering VT. This final chapter will reflect on the information from the literature review to provide counsellors with an overview of how vicarious trauma can be encountered and approached in clinical practice, as a consultant or advocate, and if in relation to oneself as a helping professional.

Vicarious Trauma Treatment- Practical Recommendations

Counsellor Approaches to VT in the Counselling Room

Knowing a client's history and current sociocultural atmosphere (what kind and how much trauma have they been exposed to) will assist a counsellor in understanding if VT could be occurring for the client. Helping professionals that may be engaged in empathetic relationships

for their work may be exposed to VT. Newer workers in helping professions are more likely to experience VT (Aafjes-van Doorn et al., 2020; Devilly et al., 2009), as well as those that have had a history of trauma themselves. Understanding these factors that can increase the likelihood of experiencing VT, as well as how VT can present in a counselling room is important for a counsellor to recognize. Once recognized, validation and educating the client about VT can be done. Providing the client space to explain and explore their experience of VT may not only be helpful, but unique as sometimes helping professionals will feel that sharing accounts of VT with others, such as colleagues or family, can spread the VT further. For this reason, group therapy may not be an effective approach for VT. However, there is a possibility that if a focus of the group was VPTG or Post Traumatic Growth, perhaps healing, positivity and reduced VT symptoms could result in the group (Rosen & Tsai, 2023).

Counselling room approaches that have shown improvement in VT symptoms include CBT, EMDR, Art Therapy and Somatic Therapy (Graham, 2012; Ortner, 2024; Tarquinio et al., 2021; Torres et al., 2023; Thiessen, 2024). Knowing these options, what symptoms of VT the approach may work best for and how to facilitate each approach will provide counsellors confidence in their abilities to work in VT. Integrating approaches may be more effective for some clients depending on their unique situation.

Through a client-centered view, a counsellor may be able to determine which technique may be more suitable for a client as the counsellor will obtain information about the clients beliefs, likes, dislikes, history of trauma and intersectionality. For example, it should be noted that homework can be a major part of CBT (Graham, 2012), and since fatigue can be a symptom of VT, requesting a client to engage in the additional tasks to help them recover may not be appropriate.

Following is a summary table of potential therapies for VT as discussed in this capstone.

Table 1 - Summary of Potential Therapies for VT Symptoms

(Drapeau et al., 2022; Gibson, 2018; Keenan & Royle, 2007; Neswald-Potter & Simmons, 2016; Parnell, 2024; Shapiro & Brown, 2019; Sprang et al., 2019; Thiessen, 2024; Tsouvelas, et al., 2019)

	VT symptom	Possible techniques
CBT Trauma focused	Irritability Hypervigilance Concentration issues Exaggerated startle response Sleep disturbance Distressing memories of client encounters Distressing dreams Physical or psychological distress of reminders Avoidance of reminders	Psychoeducation Mindfulness
CBT Trauma focused	Changes in client worldview Changes is cognitive schemas	Challenge thought distortion
EMDR	Changes in cognitive schema Intrusive images Anxiety Depression	8 stage EMDR approach for working with individuals
EMDR - GTEP (Group Traumatic Episode Protocol)	Thought distortion Hypervigilance Flooding Decreased functioning Decreased feeling of safety	EMDR approach applied in group setting.
Art Therapy	Depression Anxiety Hypervigilance Nightmares Decreased resilience Decreased functioning Changes in cognitive schema	Journaling Story writing Reflective processing Clay sculpture Collaging Horticulture In conjunction with supervision that focuses on helping professionals

		themselves, not the client trauma - Regenerative Model.
Somatic Therapy	Irritability Anxiety Depression Decreased feeling of safety Physical feelings of distress	Teaching unmirroring techniques. Grounding exercises Build body awareness Education on processing stored trauma Help develop rituals to let go of emotions connected to VT exposure.

Counsellor as a Consultant or Advocate When Working with VT

Given the support that organizational structure can reduce the effects, and amount of VT experienced by helping professionals (Bober & Regehr, 2006; Thiessen, 2024), a counsellor that is working within or in consultation with an organization that employs helping professionals can advocate for or facilitate a VT aware working environment. Each workplace or organization will require a unique approach to addressing VT within their helping professionals. The need for further research is indicated to provide information on what strategies organizations should employ, under what conditions to reduce the effects of VT on their staff and organization (Sutton et al., 2022).

Organizations may have health and wellness departments that are consulted to improve the health of employees through the work environment. Supporting the development of or facilitation of structures such as peer support groups and supervision for the helping professional can be done by a counsellor. Organizations that are seeking assistance with VT may ask for consultant services that a counsellor could provide. Practical approaches for the organization that could be recommended are balanced workloads regarding numbers and severity of cases, allowing for recovery time between periods when the helpers are exposed to trauma, and

ensuring support services through employee benefits such as Employee Assistance Programs are available to employees.

Counsellors can refer helping professionals to phone/text support lines when they are in crisis due to VT or just want to discuss issues affecting them including VT. For example, Care to Speak, https://careforcaregivers.ca/caretospeak/ (1-866-802-7377) is a peer based phone/text/chat service that provides support to healthcare and social services workers which is free. Connection to Care is another support line in British Columbia https://connectiontocare.ca/ (1-778-247-2273) that provides free mental health support by counsellors in training to local government workers. Professional organizations such as unions, such as the BC Nurses Union, or associations, such as the BC Association of Clinical Counsellors may have mental health supports available for their members. Knowing resources of this sort that are available to the employees of the organization a counsellor works with can broaden the support the employee can receive. If a counsellor is able to present to these organizations about VT, increasing their knowledge of the effects VT has on its members may promote further support provided by the organization/association.

Cultural awareness of the helping professionals within an organization is needed to ensure effective support can be provided. Understanding an individual's cultural beliefs around healing, such as if an individual approach or group (collectivist) approach is more appropriate for them. Recognizing there may be cultural differences in the appropriateness of sharing information and who the sharing may be done with could affect how VT can be processed. Being curious and therefore knowledgeable about a client, employee or group of employees will guide a counsellor developing and engaging in effective approaches for working with VT in an organization.

Counsellor Self and VT

Vicarious trauma is a known risk in a helping profession. Besides understanding how to work with VT and assist others experiencing it, understanding one's own vulnerability to VT and how to manage is important. Although it is common knowledge now that helping professionals need to keep themselves healthy, that sometimes does not come naturally or intuitively given their desire to help others and possibly put clients first. Understanding one's own relationship to trauma in general and the exposure that may be faced in the work a helping professional engages is helpful when it comes to VT (Harrison & Westwood, 2009). Knowing oneself and being able to recognize your own unique symptoms that may be related to VT will enable oneself to seek assistance as soon as possible. Obtaining help for VT sooner rather than later can help decrease duration and severity of symptoms.

There are practical steps a counsellor can take themselves to combat VT. One can engage in whatever self-care routines provide rest or an outlet for processing emotions arising from a workday. This could be activities such as exercise, meditation, socializing, reading, engaging in hobbies, completely resting, etc.

Seeking supervision for self when symptoms of VT arise or even prior to is suggested. Supervisors are responsible for educating and supporting their supervisees regarding VT (Harrison & Westwood, 2009; Trippany et al., 2004). Connecting with a trusted supervisor that understands yourself and VT in helping professionals can provide a sounding board and likely suggestions to manage VT.

Knowing when VT has impacted oneself to the point that one’s personal or work function has been affected is important. Obtaining counselling for one’s own direct trauma and VT is not only a professional obligation, but necessary to ensure one’s own best health.

Scheduling one's life to include a balance of non-work or recovery time with work time will assist a counsellor in coping with or building resilience to VT. This may require adjusting work schedules, which may not be possible, but if a helping professional is able to manage their work schedule, allowing for time between shifts or work encounters involving trauma for rest and recovery, this is a preventive and management strategy for VT. Modelling behaviours that acknowledge the risk of VT in a helping profession may be noticed by clients that are in the same field.

Future Research Recommendations

Although some researchers and practitioners are sharing their knowledge and experiences with VT interventions (Deblinger et al., 2020; Gibson, 2018; Graham, 2012; Keenan & Royle, 2007; Neswald-Potter & Simmons, 2016; Sprang et al., 2019; Tarquino et al., 2021, Torres et al., 2023, Thiessen, 2024; Tsouvelas, et al., 2019), further evidence-based research may provide counsellors with information on which approaches work best in which circumstances.

With respect to a counsellor assisting a helping professional in the counselling room, clearly defining symptoms and assessing the efficacy of an intervention with specific measures for VT related symptoms would be helpful (Kim et al., 2022). For examples, a specific CBT protocol for working with VT would be helpful for a counsellor. A breakdown of which symptoms of VT are effectively treated with which areas of CBT protocol backed by research, could lead to more effectiveness and efficiency for a counsellor working with VT. Or understanding when different applications of EMDR would be best suited for use, such as immediately post trauma or when a client has been developing VT over time would be useful for counsellors to be able to refer to. As for Art Therapy, given the potential outlined in case studies, further research in art therapy as an approach for both treatment and prevention of VT, would provide counsellors with additional options to assist helping professionals. Research on

the types of art therapy that may be most suited for their helping professional client, given the clients cultural, biopsychosocial, and historical makeup may help broaden the scope and efficiency in trialing the most likely to be effective therapy options for the client. The possible relationship between art therapy, or in fact any therapies and post traumatic growth may be a more recent area of interest when considering vicarious trauma. Working towards VPTG may be a powerful exercise for a counsellor to understand how to approach. Further research into how to determine if VPTG is something that can be cultivated with a client or is it a predetermined outcome given a client's predisposing factors, history, or environment would be valuable. If VPTG can be influenced in the counselling room, the most effective approaches to achieve this may be of interest to a counsellor. Outside of the counselling room, knowing what possibly foster VPTG within organizations, social structures, cultures or environments can is necessary to either advocate for the health of helping professionals or work within their systems to support them. Larger scope studies with longer term follow up on VT interventions are needed (Kim et al., 2022) as several studies reviewed were limited in that aspect.

A counsellor in the role of a consultant for systems or organizations dealing with VT would benefit from further research on when it is best to invest in preventative programs or services to manage VT with the population they are working with (Kim et al., 2022). Research that could support a counsellor in this role with data recognizing the impact (employee wellness and financial) VT has on individuals and organizations would assist the counsellor in advocating for funding programs to address VT. Data from outside sources such as Workers Compensation Boards or Disability Insurance carriers may be able to give information that could be translated to the data required by management and policy makers to implement changes that may increase the effects of VT. Further evidence-based studies on workloads, work schedules, and supportive

measures embedded into an organization and how they affect VT in helping professionals would be helpful to advocate for or employ changes in a system or organization,

Knowing if a client is connected to a professional organization, such as a union (nurses -BCCNM, healthcare workers, social workers) or governing body (counsellors - BCACC), and whether this professional body has support for VT could help a counsellor facilitate this connection for the client. A guide of sources available for VT for each professional organization and how to access them is a tool both a counsellor and client could refer to.

Counsellors may benefit from further understanding of the most effective forms of supervision for treatment or prevention of VT and how they may differ within organizations, different groups of helping professionals or work cultures. Guiding or influencing supervision practices within these groups may be a role a counsellor could take.

And finally, as a counsellor in training that is passionate about supporting humans that help other humans, further research to inform the most effective approaches to prevent and manage VT in oneself will always be of use. As counsellors experience levels increase, clientele changes, level of trauma they are exposed to changes, so may their experience of VT. Understanding the most effective interventions for differing circumstances would be helpful for the counsellor. Research to explore when self-care actions are most effective in minimizing VT symptoms could, for example, inform oneself if mindfulness or meditation practice is more helpful before a day of working with clients experiencing trauma, or after the day to process the trauma. How one can incorporate growth (VPTG) in oneself when dealing with one's own VT would be valuable. Further evidenced based research in the field of VT is recommended to further expand our knowledge and understanding of VT in the hopes of minimizing its effect on

the people in the world that spend most of their waking hours, and sometimes some of their resting hours, helping other humans.

Conclusion

Vicarious trauma can be experienced by helping professionals with a higher risk in those working with victims of trauma (Kim et al., 2022). Support for these individuals and organizations that include helping professionals is an area that a counsellor is able to provide assistance in. The need to address VT is apparent for individuals (Mittal et al., 2023; Torres et al., 2023) and organizations (Sutton et al., 2022). This literature review revealed several approaches a counsellor can take when working with VT. Which approach is most effective was a purpose of this capstone, however, results supporting the effectiveness of one treatment of another were not found. Approaches that have been reported to be effective were reviewed in order to provide an encompassing toolkit for counsellors working with VT. Which treatment or approach is more effective will depend on factors such as the helping professions job duties (ie. - nurse, firefight, social worker, therapist, etc.), their own background and cultural beliefs, and the organizational structures they are involved in (Kim et al., 2022). My hope for this literature review was to provide information a counsellor can use to inform their practice when encountering VT, perhaps promoting curiosity into treatments or approaches that can help the clients a counsellor is working with. Treatment approaches for VT in the counselling room that have been researched include CBT, EMDR, Art Therapy and Somatic Therapy. Exploring and integrating VPTG into whatever way a counsellor may be working with VT may provide positive outcomes from experiencing VT and promote a strength based integrative model of working with VT.

Should a counsellor be working within an organization attempting to reduce the incidence and severity of VT experienced in that organization, several effective strategies have been

reported. Providing support through peers or supervision, and education can be helpful (Sutton et al., 2022). Advocating for or facilitating balanced caseloads with respect to severity, work schedules that allow for appropriate time away from work and a workplace culture that recognizes the impact VT can have may also be valuable.

Possibly the most important approach for VT is related to helping professionals themselves. Strategies for recognizing, preventing and managing VT in oneself can include understanding signs and symptoms of VT, knowing one's own relationship with trauma, selfcare, seeking appropriate support through supervision, advocating for oneself and seeking help through counselling (Harrison & Westwood, 2009). A counsellor themselves as a helping professional can only assist others if they are feeling well and capable, highlighting the need for management of one's own connection with VT. At times counsellors may be the helping professional helping and at times counsellor will be doing the helping, therefore an understanding of VT from both the helper and self-perspective is imperative.

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