

**Dublin Business School**

**Donna Smith**

**The Resilient Therapist: Preventing Vicarious Traumatization.**

**Thesis submitted in partial fulfilment of the requirements of the Higher Diploma in  
Counselling and Psychotherapy**

**Siobain O'Donnell**

**6<sup>th</sup> May 2016**

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## **1. Introduction:**

The term “resilience” comes from the Latin “resilire,” which means “to recoil.” It means to rebound, spring back, and have elasticity or flexibility. For humans resilience refers specifically to our ability to endure and subsequently recover from difficult situations. Personal resilience is a characteristic that exists within a person. Taormina (2015) defines personal resilience as “a multifaceted construct that includes a person’s determination and ability to endure, adapt, and recover from adversity”. The four components are determination, endurance, adaptability, and the ability to recuperate.

The American Psychological Association defines trauma as “an emotional response to a terrible event like an accident, rape or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea.” (APA, 2016).

The concept of vicarious traumatization (VT) has received much attention over the years (Anderson, 2004; Jordan, 2010). It has also been referred to as compassion fatigue (Figley, 2002). Whichever term is used to describe this negative consequence of working with traumatised clients the result is the same. It is believed that counsellors working with trauma survivors experience vicarious trauma because of the specific work they engage in. The American Counselling Association describe VT as “the emotional residue of exposure that counsellors have from working with people as they are hearing their trauma stories and become witnesses to the pain, fear, and terror that trauma survivors have endured”. Signs and symptoms that counsellors and therapists need to be aware of include behavioural changes, interpersonal changes, changes to their personal values and beliefs, and changes to their job performance.

VT is distinct from burnout, as it only occurs for therapists who work with traumatised clients; however burnout can occur for any therapist (McCann & Pearlman, 1990). The prevention of burnout has been addressed in *Crisis Intervention Strategies* (2001) by James and Gilliland, however the differences between VT and burnout are distinct and make it clear that VT is worthy of its own individual attention.

The importance of self-care strategies, and the most effective strategies, have been widely studied and regular supervision or personal therapy appears to be of the utmost importance, not only for trauma therapists, but all mental health professionals (Cerney, 1995; Harrison and Westwood, 2009).

This paper will examine the importance of resilience, risk factors for vicarious traumatisation, the distinction between VT and burnout, and outline a number of strategies for the prevention of VT.

## **2. Resilience:**

What are the traits of an emotionally resilient person? Do they go beyond the four components of personal resilience; determination, endurance, adaptability, and the ability to recuperate? Hara Estroff Marano (2003) wrote that at the heart of resilience is a belief in oneself, yet also a belief in something greater than oneself. Resilient people are not defined by the situations they endure. They transcend any pain they encounter and move beyond it to something greater for themselves, knowing that tough times are temporary. The most resilient people tend to be more prepared for emotional emergencies and approach difficult times with flexibility rather than rigidity. Marano outlines a number of traits common to emotionally resilient people that are applicable to all, including, and perhaps especially, therapists and counsellors.

Faisal Hoque (2014), having grown up in Bangladesh and being witness to war, famine, and inhumane poverty, writes of what he sees as the traits of a resilient person. They control their own destiny and have an internal locus of control which allows them to create alternative plans in anticipation of, or in the midst of, adversity based on instinct. The most resilient people will find a way to embrace adversity, rather than fight it. Adversity does not always have to have a negative outcome. The resilient person will find a way to use it to their advantage and allow it to guide them forward. Perhaps one of the most difficult traits to grasp is that of patience. Patience in the face of adversity, in the face of difficult people or situations. It is during these difficult times that the most resilient people will utilise compassion, gratitude, and therefore patience. Emotional fear, fear of failure, fear of success, fear of the unknown, can hold a person back from realising their true destiny. Letting go of this fear can allow the person to see clearly, perhaps for the first time. It is this ability to let go, to become flexible and adaptable, which will strengthen resilience. Living in the moment allows a person to focus on the here and now, and not to look back to the past or far into the

future. It is this ability to be present in the moment that allows a person conserve the inner energy required to deal with adversity.

Resilient people know their boundaries. They understand that the cause of their suffering is temporary and not a part of who they are at their core, their permanent identity. They will surround themselves with supportive people, who will know how to give space, listen, and not try to solve the problem. The most resilient know when to seek help from those supportive people. Self-awareness is important in that it allows the person to get in touch with their needs, whether psychological or physiological. Cultivating self-awareness is more important than remaining blissfully unaware as a long term strategy. Accepting that pain or stress is a part of life is helpful in coming to terms with difficult situations. The most resilient are not caught up in distracting behaviours, they are willing and able to sit in silence and be in the moment without judgment or avoidance of the situation. However, one seemingly distracting behaviour that is useful is writing, for example keeping a journal. The simple act of getting thoughts out of your head and onto paper is useful to help stop overthinking and bring us back to the present moment.

Resilience is especially important for the novice counsellor or therapist. Skovholt and Rønnestad (2003) found that the main catalyst for stress to the novice practitioner is the ambiguity of professional work. Other elements include acute performance anxiety, the scrutiny of other professionals, rigid emotional boundaries, the fragile and incomplete self, inadequate conceptual maps, glamourised expectations, and a need for positive mentors. An important aspect of resilience, especially for the novice therapist, is whether or not it is a fixed personality trait or can be influenced by environment (Lee et al., 2013). The more positive view, one of vicarious resilience, would appear to show that resilience is not fixed and can in fact be influenced by outside factors. Hernandez, Engstrom & Gangsei, (2010) suggest that therapists are not only affected negatively by their work with clients, but may

also be affected in positive ways by witnessing the show of strength by certain clients, a concept known as vicarious resilience.

### **3. Vicarious Traumatization:**

Vicarious traumatization has been defined as “the transformation in the inner experience of the therapist that comes about as a result of empathic engagement with client’s trauma material” (Pearlman & Saakvitne, 1995, p 31). It has been shown to not only negatively impact the therapists own personal life but also their ability to maintain the most helpful, ethical, and therapeutic relationship with their client (Barnett, 2007).

Research to date has shown a number of factors impact on the susceptibility of the therapist to VT and that it is a normal reaction of the therapist to conducting trauma therapy (Pearlman & Saakvitne, 1995). One possible risk factor is a personal trauma history of the therapist (Pearlman & Mac Ian, 1995). Results of this study showed that therapists with a personal trauma history showed higher levels of distress than therapists with no trauma history. Those with a history of trauma were shown to have less experience working with trauma survivors, were not receiving supervision, were working in a hospital setting, and had not addressed their own personal trauma history in therapy. However this finding was not supported by Schauben and Frazier’s 1995 study to assess the effects on counsellors of working with survivors of sexual violence. It was found that counsellors with a history of trauma were not more distressed, by seeing clients with a history of trauma, than counsellors without a personal history of trauma.

Ekundayo’s study in the UK (2013) produced surprising results surrounding the engagement of therapists in individual supervision and self-care activities as being predictors for VT, as well as the previously supported risk factor of a prior trauma history. The majority of therapists were found to be within the average range for compassion satisfaction and burnout. The high risk for secondary traumatic stress was found in 70% of participants, 177 therapists.



Newell and Mac Neil, (2010) identified a pre-existing anxiety disorder, a mood disorder, a personal history of trauma, and maladaptive coping skills, such as suppressed emotions, as potential risk factors for VT in therapists. Mc Cann and Pearlman (1990) describe Post Traumatic Stress Disorder (PTSD) as a normal reaction to an abnormal event and conclude that VT is therefore a normal reaction to the stressful nature of working with traumatised clients. In contrast, a 2009 study by Harrison and Westwood found that empathic engagement with traumatised individuals provided a measure of protection against VT. Empathy is the experience of understanding another person's condition from their perspective. The findings of this study included nine significant themes across clinicians' narratives of protective practices in response to the question "How do you manage to sustain your personal and professional well-being, given the challenges of your work with seriously traumatized clients?": countering isolation (in professional, personal and spiritual realms); developing mindful self-awareness; consciously expanding perspective to embrace complexity; active optimism; holistic self-care; maintaining clear boundaries; exquisite empathy; professional satisfaction; and creating meaning. The unusual finding that empathic engagement with traumatised clients appeared to be protective challenges previous conceptualisations of VT. The clinicians in this study maintained "clear boundaries with regard to the distinction between empathy and sympathy". These clear boundaries are helpful to the client and also act as a protective measure for the therapist. One respondent explained that having these boundaries allows him to feel connected and touched by the clients' story, but to understand it is still their story, not his. The Harrison and Westwood study suggests the unusual finding that empathic engagement can actually be a protective measure for those clinicians working with traumatised clients. This result challenges previous assumptions as to the cause and inevitability of VT. The clinicians who engaged in what was referred to as "exquisite empathy" (a discerning, highly present, sensitively attuned, well-boundaried, heartfelt form

of empathic engagement) maintained that they were strengthened rather than worn out by their work with traumatised clients. Prior to this study, therapist empathy for traumatised clients had constantly been shown to be a serious risk factor for VT. A number of theorists have written that the emotional impact of working with this type of traumatic material can be contagious and transmitted through the process of empathy (Figley, 1995; Pearlman & Saakvitne, 1995; Stamm, 1995).

Vicarious traumatisation can therefore be predictable, and some would say inevitable, for the therapist working with a traumatised client. The therapist with their own history of trauma can offer something unique to their clients as the “wounded healer”, but if they fail to address possible vicarious traumatisation they and their relationship with their client can suffer hugely (Sexton, 1999). It is imperative that therapists, whether newly qualified or experienced, are mindful of the signs and symptoms of VT. Unchecked VT can result in poor professional performance by the therapist and may lead to errors in judgment. Behavioural changes include, but are not limited to, irritability, irresponsible behaviour, exhaustion, rejection of physical and emotional closeness, and critically talking to oneself. Interpersonal relationships may suffer due to impatience, poor communication with colleagues and others, withdrawal and isolation from others, and avoidance of working with clients with a history of trauma. Personal values and beliefs being affected by VT may result in apathy, detachment, questioning their frame of reference, worry that they are not doing enough for their client, and low self-image. Job performance may be affected by low motivation, increased errors, avoidance of job responsibilities, or becoming over involved in details and perfectionism.

#### **4. Self-care strategies:**

Cerney (1995) found that much secondary trauma can be avoided if the therapist engages in regular supervision. The purpose of this is to process the client material and any overwhelming emotions the therapist may be feeling. Effective supervision creates a relationship in which the therapist, under supervision, feels safe in expressing any fears, concerns, or inadequacies, without feeling ashamed or that they are not good enough (Welfel, 1998). It acts as an important protective factor and ensures early recognition and response to the possibility of succumbing to the effects of VT. Follette, Polusny, and Milbeck (1994) compared two groups of mental health professionals and law enforcement personnel, both with a history of childhood physical or sexual abuse. They found that the mental health professionals with a significant history of abuse did not experience significantly more negative responses to traumatised clients than mental health professionals without a history of abuse. They were also found to utilise more positive coping strategies. In comparison, the law enforcement group, working with sexual abuse survivors, showed significantly more distress than the mental health professionals. It was hypothesised that this difference could be put down to the use of personal therapy/supervision by 59.1% of the mental health professionals, compared to only 15.6% of the law enforcement personnel. Harrison and Westwood (2009) found that all clinicians they questioned maintained that supervision was a mitigating factor in the prevention of VT, whether it took place in an organisational setting, as part of a peer group, or as an individual consultation. It was said to alleviate feelings of shame and isolation on the part of the clinician.

Social support is very important for the therapist (Harris, 1995); however it must be noted that VT can affect not only the therapist but their family and friends (Cerney, 1995). A therapist that neglects to make the most use of their social support network, or isolates themselves from their peers, is at greater risk of VT. It is advisable to be proactive in

engagement with others, as this social support can act as a stress buffer (Hesse, 2002). The literature on traumatic stress emphasises the role of social support, in addition to variables in temperament, in affecting the impact of PTSD on therapists (Dirkzwager, Bramsen & van der Ploeg, 2003). Social support is also important in helping therapists gain an insight into their own abilities. This self-awareness can help change their assessment of traumatic stress and increase their own sense of resourcefulness (Cieslak et al., 2009). Despite these findings some studies on VT have shown contradictory results with regards to the role of social support (Adams, Boscarino, and Figley., 2006). The belief by a therapist, however subjective, that they have a strong social support network, could be a bigger factor in not suffering from VT than actual support (Robinaugh et al., 2011). Peer support has proven helpful when dealing with VT among therapists (Iliffe & Steed, 2000). The opportunity to process feelings of shame or fear in a supportive environment, with colleagues who have been through similar situations, can be especially helpful if the therapist is feeling isolated, and acts as an informal debriefing session.

Therapists can also gain important support from family and friends (Harrison & Westwood, 2009). Michalopoulos and Aparicio (2012) provided further support for the importance of social support and found that high levels of social support are a predictor for a decrease in VT symptoms. However, Hyman (2004), found no relationship between the intensity of VT symptoms and the perceived, rather than actual, social support among emergency workers. This can be explained by the mere presence of VT symptoms resulting in a reduction in levels of actual support.

The importance of self-care, and taking time out for leisure activities, has been shown to reduce stress and therefore the risk of vicarious traumatisation in the therapist. Self-care is a far reaching term referring to anything the counsellor does to enhance or maintain their well-being (Eckstein, 2001) and includes, but is not limited to, adequate sleep, eating a balanced

diet, physical exercise as well as physical rest, and participation in recreational activities (Killian, 2008). Various coping strategies reported by therapists working with trauma survivors include peer support, clinical supervision, and some type of spiritual or religious practice (Rothschild, 2006). Margarita Tartakovsky (n.d.) writes on the importance of self-care for clinicians and outlines nine important points; to identify what activities make you feel your best, to block out time in your calendar for self-care activities, to fit in moments of self-care and relaxation whenever you can, to take care of yourself physically, to know when to say no, to check in with yourself regularly, to surround yourself with upbeat and positive people whenever possible, to consider the quality rather than the quantity of self-care, and to make self-care non-negotiable in your daily life.

Not only can a therapist become victim to the negative impact of vicarious traumatization, but also, more positively, vicarious resilience. Resilience is said to be the capacity to overcome emotionally difficult situations. Being resilient does not mean that you will never experience stress though. The concept of vicarious resilience suggests that some therapists may actually benefit from dealing with a traumatized client, in so far as it can empower and sustain the therapist through difficult times, having witnessed the strength shown by individuals who have experienced trauma (Hernandez, Gangsei & Engstrom, 2007).

## **5. Conclusion**

Resilience is not fixed; it changes over time, and can be seen as a developmental process. One interesting development in the studies into resilience comes from Lee et al (2013) as to whether or not resilience is a fixed personality trait or can be influenced by environment. Their results showed that the largest effect on resilience came from protective factors, such as life satisfaction, optimism, positive affect, self-esteem, self-efficacy, and social support. The importance of social support falls under the general category of self-care strategies for therapists and counsellors (Hesse, 2002). Risk factors, such as depressive symptoms, severe anxiety levels, and a high level of stress, were found to have a smaller influence on resilience than protective factors. Finally demographic factors, such as age and gender, were found to have the least influence on resilience.

Mc Cann and Pearlman (1990) describe Post Traumatic Stress Disorder (PTSD) as a normal reaction to an abnormal event and conclude that VT is therefore a normal reaction to the stressful nature of working with traumatised clients. VT can therefore be predictable, and some would say inevitable, for the therapist working with traumatised clients. The distinction between VT and burnout is that VT will only occur in therapists working in the area of trauma, whereas burnout can occur for any therapist. It is of the utmost importance that therapists are aware of the signs and symptoms of VT, including behavioural, interpersonal, and personal changes, and act to resolve them before they result in poor performance or judgment on the part of the therapist.

Of all the different self-care strategies a therapist can employ, to help build their resilience and prevent VT or burnout, numerous studies have shown that engaging in personal therapy and regular supervision is extremely important and valuable (Cerney, 1995; Welfel, 1998; Follette, Polusny, and Milbeck, 1994). The purpose of this is to process the client material

and any overwhelming emotions the therapist may be feeling. Rothschild (2006) reported that various strategies used by therapists working with traumatised clients included peer support, regular clinical supervision and some kind of spiritual or religious practice. Other practices the therapist can engage in that are helpful include eating a balanced diet, getting adequate sleep, participating in physical exercise as well as getting physical rest, and participation in enjoyable activities.

The overall importance of self-care for therapists, especially those working with traumatised clients and therefore at risk of succumbing to VT, cannot be emphasised enough. Future research is possible into the efficacy of teaching self-care strategies at a trainee level. This could result in it becoming a requirement of any counselling or psychotherapy training programme.

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