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Training the Resilient Psychotherapist: What Graduate Students Need to Know About Vicarious Traumatization

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There is a pressing need for more research, not only about the experience of vicarious traumatization (VT), but also how academic institutions can best prepare graduate students for this experience. This qualitative study provided insight into the shared, lived experience of VT, effective coping strategies, and the need for a graduate-level course in trauma therapy. A purposive sample of 11 master's-level trauma therapists, simultaneously enrolled in a doctoral program, responded to questions about their experiences with VT, their ways of coping, and ideas for a graduate-level course. Data were analyzed via a series of steps, as outlined by Moustakas (1994). That is, this researcher (1) read each interview transcript in its entirety to gain understanding about the meaning of the experience; (2) composed a list of statements in the text of the transcripts that relate to the phenomenon under study and are an essential component of the experience being studied; (3) labeled horizons that represent emotions, sensitivities, and/or actions involved in the experience of the phenomenon; and (4) developed individual, then group, depictions of the experience. Findings included 9 themes: adverse emotional and physical effects of VT, the need for a graduate-level course in trauma therapy, the double-edged sword of being a trauma therapist, coping on three levels (intellectual/professional, spiritual, and physical), how the experience of VT can facilitate a deeper sense of spirituality, self-doubt, decreased trust in other people, difficulty separating clients' experiences from one's own life, and fear of the unknown. Spirituality, an area thought to be damaged by VT, was found instead to be strengthened. This study serves to better inform graduate students, as well as those who educate them.

Keywords: *curriculum for therapist trainees, spirituality and trauma therapists, therapist self-care, vicarious traumatization, VT*

Introduction

Pearlman and Saakvitne (1995) define vicarious traumatization (VT) as "the transformation in the inner experience of the therapist that comes about as a result of empathic engagement with clients' trauma material" (p. 31). There is an abundance of literature on social workers, counselors, and psychologists who experience VT, as well as literature that defines VT as distinct from countertransference and burnout. With the prevalence of trauma survivors that seek mental health treatment, practitioners are certain to encounter these survivors in their work (Bride, 2007; Pearlman & Saakvitne, 1995). Mental health professionals have long acknowledged the negative effects of doing trauma therapy, which are similar to signs of posttraumatic stress disorder (Baird & Kracen, 2006; Courtois, 2009; Pearlman & Saakvitne, 1995). Researchers have concluded that VT is a normal reaction to doing trauma therapy (Neumann & Gamble, 1995; Pearlman & Saakvitne, 1995).

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Even so, practitioners may not be willing to disclose this experience to supervisors and/or colleagues, and may remain in denial that they have experienced VT (Barnett, 2007; Schoener, 2007). Some researchers have emphasized how the effect of VT negatively impacts not only the practitioner's quality of personal life, but also his or her ability to maintain best clinical practices (Barnett, 2007; Neumann & Gamble, 1995; Schoener, 2007) and spirituality (Pearlman & Saakvitne, 1995). Pearlman and Saakvitne surveyed the literature about this adverse impact of VT and state, "The pathognomonic sign of vicarious traumatization is the disruption to the therapist's spirituality" (p. 287). They also write, "The components of spirituality include beliefs about nonmaterial aspects of experience, about meaning and hope, about connection with something beyond oneself, and about awareness of all aspects of life" (p. 287). This researcher found one study that indicates some women psychotherapists are able to maintain a strong spiritual base, even though they work with a large number of trauma survivors (Brady, 1999).

Due to the various ways VT adversely affects a clinician, researchers have emphasized the central importance of therapist self-care to ethical client treatment (Barnett, 2007; Meyer & Ponton, 2006; Schoener, 2007; Trippany, White Kress, & Wilcoxon, 2004). Further, the American Psychological Association (2002) specifically noted the need for self-care in the context of helping others that have been traumatized. VT is a prevalent issue that will be encountered by most psychologists in the course of their clinical practice.

While there is an abundance of literature about VT in clinicians, most of the studies are quantitative, and very few focus on clinicians simultaneously enrolled in a graduate-level program. Harrison and Westwood (2009) emphasized the ethical requirement of not only professionals, but also those who educate and/or employ them, to address the problem of VT. In a similar vein, Courtois (2009) wrote about the urgent need to include psychological trauma in educational programs for mental health professionals. This researcher found only one study about graduate students and their experiences with VT (Adams & Riggs, 2008), and only one study that evaluated the efficacy of a mindfulness practice to ameliorate the effects of VT in graduate student practitioners (Newsome, Dahlen, & Christopher, 2006). In other words, there is a need for more research—not only about the experience of VT, but also how academic institutions can best prepare graduate students for this experience. Indeed, as Harrison and Westwood propose, through education, it could be possible to prevent VT.

Review of the Literature

Pearlman and Saakvitne's (1995) constructivist self-development theory (CSDT) provides a holistic conceptual framework that illustrates the interplay of complex factors that lead to disruptions in therapists' cognitive schemata. These cognitive disruptions occur in up to five basic psychological need areas: safety (feeling safe alone or with others), trust/dependency (ability to trust or depend on oneself and others), esteem (feeling important to, or valued by, others and oneself, as well as to value others), control (knowing how to manage one's feelings and behaviors and how to negotiate with others to influence their behavior toward oneself), and intimacy (a feeling of connection with others or to oneself). Also, the CSDT incorporates ego resources that can be affected by VT (one's resources that empower one to connect with others), self-capacities (ability to establish an identity or sense of oneself that is consistent over time), and frame of reference (the mental framework through which people interpret their experiences).

Various researchers (Harrison & Westwood, 2009; Meyer & Ponton, 2006; Neumann & Gamble, 1995; Pearlman & Saakvitne, 1995; Trippany et. al, 2004) have found coping strategies reported by therapists include but are not limited to peer support, clinical supervision/consultation, continuing

education, and some form of spiritual or religious practice. Rothschild (2006) provided an evidence-based approach to self-care strategies, emphasizing the psychophysiology of VT. In addition, researchers recommend that graduate training programs provide a course in trauma therapy and VT as a proactive approach to counteract and/or prevent significant VT. Indeed, several researchers conclude graduate training in terms of trauma therapy—as well as self-care—is central to the ethical treatment of clients (Courtois, 2009; Harrison & Westwood, 2009; Meyer & Ponton, 2006; Trippany et. al, 2004).

Harrison and Westwood (2009) conducted a qualitative study that explored self-care strategies among mental health therapists and found that empathic engagement with traumatized people actually provided a measure of protection against VT for participants. This finding is in contrast to earlier studies about how such engagement with trauma clients often results in VT (Pearlman & Saakvitne, 1995). Harrison and Westwood emphasized the ethical requirement of not only professionals, but also those who educate and/or employ them, to address the problem of VT. In a similar vein, Courtois (2009) wrote about the urgent need to include psychological trauma in educational programs for mental health professionals.

In summary, research demonstrates how VT negatively affects the self of the trauma therapist and what therapists can do to address VT., There is very little literature in two areas, however: the shared, lived experience of VT in master's-level clinicians who are enrolled in a doctoral-level training program and models of best practice for curricular requirements that would support their ability to maintain resilience in the context of VT. Through the selection of master's-level clinicians enrolled in a doctoral program and a qualitative approach, this study helps fill this gap in the literature. Indeed, this study facilitates social change on an individual and a community level, as well.

Method

This study utilized a qualitative design. The literature review revealed a lack of qualitative studies about VT, and only two studies about VT in therapist trainees (Adams & Riggs, 2008; Meyer & Ponton, 2006). Cunningham (2003) noted the need for a qualitative approach in future studies, to provide a deeper, richer understanding of the experience of VT. Because the chosen population (master's-level clinicians enrolled in a doctoral program) is quite underrepresented in the research literature, a qualitative approach provided the best way to describe the variables involved in one's experience of VT. Variables included but were not limited to a history of personal trauma, personal defense mechanism styles, length of time in practice, academic training, and number of trauma survivors on one's caseload. As Creswell (2007) points out that the qualitative approach to research is appropriate when the variables are difficult to identify. That is, because the participants were simultaneously enrolled in a doctoral program, there could be a number of variables that contributed to their experience of VT, such as financial stress, family obligations, and/or work obligations in conflict with academic pressure. Further, according to Rossman and Rallis (1998), "The ultimate goal of qualitative research is to transform data into information that can be used" (p. 11). As such, the qualitative approach was well suited for this study, as the findings could be used to inform graduate students, educators, clinical supervisors, and/or employers. The research questions, which guided the interview questions, were:

1. How do you experience VT?
2. What are some coping strategies that help counteract the effects of VT?
3. What have you learned about (or what do you need to learn about) trauma therapy and VT in your educational setting?

After approval was obtained from the university's Institutional Review Board, persons who met the inclusion criteria were asked to participate, and informed consent was obtained. Data were collected over a period of 15 months during two interviews. All interviews were by telephone, and were tape recorded and transcribed verbatim. The first interview focused on demographic information as well as the current experience of the participant, in terms of VT, and included the participant's description of the meaning of their experience. The first interviews lasted from 45 to 90 minutes, until no new themes were expressed, and second interviews lasted from 20 to 45 minutes in order to verify the accuracy of the transcripts.

Quality and Rigor

As someone that has experienced VT, this researcher remained keenly aware of, and guarded against, any preconceived notions about the meaning of the experience of VT, from the viewpoint of the participants. As Moustakas (1994) points out, the researcher's goal is to "suspend everything that interferes with fresh vision" (p. 86).

According to Creswell (2007), qualitative research findings can be verified by utilizing at least two of eight possible methods, including prolonged engagement and persistent observation, triangulation, peer review, negative case analysis, clarifying researcher bias, member checks, rich and thick description, or external audits. Of these, the researcher utilized clarifying researcher bias, member checks, and rich, thick description. This researcher completed a member check, in alignment with how Creswell (2007) defines this verification process. Of the emails sent to all 11 participants, 7 replies were received, and all of these confirmed that this researcher's depiction of their experience was accurate. Finally, rich and thick description was provided via excerpts from the interview transcripts, to highlight participant responses to the interview questions.

Participants

A purposive sample of 10 women and 1 man, all trauma therapists (defined as master's-level clinicians who work with trauma survivors), participated in this phenomenological study. There were five European Americans, three African Americans, and three Hispanics. All were working on a doctoral degree at a large Midwestern university in preparation to become psychologists. In this context, participants had the opportunity to communicate their training needs to faculty and/or administrators. The average length of time as a psychotherapist was 8.8 years, the average percentage of trauma clients on one's caseload was 28%, the average age was 42 years old, all but one were married, and all but two had children. Inclusion criteria were (a) currently enrolled in a Ph.D. program in psychology at the same Midwestern university as other participants, (b) minimum of one year experience as a therapist, (c) self-identified as having experienced VT, and (d) able to communicate in English. Potential participants were recruited through the university's participant pool, as well as during a poster presentation by this researcher.

Data Collection

The purpose of the study was to explore the shared, lived experiences of graduate students who are also practitioners, in terms of VT and how they maintain resilience in the context of VT. That is, interview questions were open-ended and were the same for all participants. The open-ended nature of the questions served to stimulate conversation with the participants. All participants were asked the following questions, which sometimes led to related questions, until all participants expressed their sense of completion in terms of their answers:

1.   When/how did you first know you were experiencing VT?

2. How would you describe the experience of VT?
3. What were the effects of VT on your professional life?
4. How did VT affect your physical health?
5. How did VT affect your spiritual or religious life/beliefs?
6. What do you find the most challenging in working with trauma survivors? The most rewarding?
7. What coping strategies do you find the most helpful?
8. What are your ideas about a course that graduate students might take as a way to understand VT?

Data Analysis

Data were analyzed via four steps, as outlined by Moustakas (1994). These steps included reading each interview transcript in its entirety to gain understanding about the meaning of the experience; composing a list of statements in the text of the transcripts that relate to the phenomenon under study and are an essential component of the experience being studied; labeling horizons that represent emotions, sensitivities, and/or actions involved in the experience of the phenomenon; and developing individual, then group, depictions of the experience. That is, the researcher composed an individual depiction of the experience of each participant, based on themes that recur in the interviews. Participant statements in response to interview questions were coded as themes if, in the opinion of the participant (during the second "member check" interview), these statements were essential for capturing the essence of the experience.

Results

For purposes of organization, themes expressed by the largest number of participants are listed first, followed by those expressed by fewer participants.

Theme 1: "Living Nightmare"—Adverse Emotional and Physical Effects

All participants reported adverse emotional effects as a part of the VT experience, and fear for one's (or someone else's) safety was prevalent. Some persons mentioned feeling sad, crying, and/or feeling much more fearful than in the past. One participant reported she started smoking more (even though since then she has quit smoking). She said, "I also felt very nervous, often, even when I wasn't at work. It was a little better when I wasn't at work, but I felt nervous a lot. I felt on edge, tearful." The clinicians' experiences of VT were permeated by a fear and sadness like no other feeling they had experienced before working with trauma survivors. For example, one participant said she noticed she would be "looking under the car in the parking lot" and others talked about how they "became hypervigilant." One clinician said she struggled with fear about what may happen when her child was at daycare, and another person talked about how she feared for the safety of her adult child. These were worries she had not experienced before working with trauma survivors. One clinician described fearful thoughts such as, "What if something that happened to a client happened to one of my family members?" The majority of participants described physical difficulties that had not been a problem prior to their work with clients who had a trauma history. For example, one person talked about how she had migraines and the doctor could find no physical reason for these. Others talked about feeling nauseated, sick to their stomachs—to the point they had to leave work and go home. Almost all participants talked about how they felt tired almost constantly due to not being able to sleep well. Most of these participants mentioned horrible nightmares based on their client(s) and waking up "in a sweat."

Theme 2: Working Toward Prevention—The Need for a Graduate-Level Course

All participants agreed on the need for a graduate-level course that would be required for students training to become mental health professionals. The course would build knowledge and skills as to the practice of effective trauma therapy, as well as the awareness of VT as a normal reaction to doing trauma therapy. As one participant said, "I think it's really unfortunate that institutions will send students out into a field without any skills around crisis intervention." Another person talked about the central importance of raising awareness about VT. As she said, "[…] making people aware of it. […] just making them aware […] and some coping skills for managing it." One participant said, "I don't think I've ever heard those terms [such as VT] in a class, ever." Others emphasized the need to educate students about how VT is a normal reaction to doing trauma therapy. As one therapist explained, "Not everybody takes it as what it is—a natural, normal process involved in counseling and psychotherapy." Another participant commented, "I think the most important thing to let students know is that it's all right to experience this; it's *normal*" (emphasis hers). Some participants mentioned how there could be case study review and/or a video that would help prepare students to do trauma therapy. As for the content of the course, one participant talked about spirituality as a coping skill. She said, "[…] maybe a course in finding one's own spirituality, whatever that means [to the student]." She also talked about how the course should include a component on self-care strategies and said, "If I'm going to help them, I better take care of myself, have my life fairly stable." Several therapists talked about how the course should be mandatory. As one person said, "I think it would be a great course to offer, and not really a choice, but as a requirement."

Theme 3: The Double-Edged Sword of Being a Trauma Therapist

Ten participants spoke of the experience of doing trauma therapy as if it were a double-edged sword. They expressed feelings of helplessness when they would see clients fail to make progress—along with the rewards of eventually seeing clients make progress. As one participant said when talking about the challenges and rewards of trauma therapy work, "In some ways, I think it's [rewards/challenges] the same thing. I think for me, one of the most challenging and yet the most rewarding things is to be able to witness this powerful increased self-awareness and knowledge that individuals get, in actual therapy, whether it is in group, individual, or family therapy." One therapist described this part of the experience by saying, "The most challenging part of working with trauma survivors is the feeling of helplessness, the times when you can't change what happened to them. You're sitting in that room, like, 'Help me feel better.' You know it's not going to happen right away. And, the most rewarding time is when you see somebody that has been through it, and it's something that is no longer happening to [him or her]. People with trauma, for a long time, they can feel like it's still happening to them. They're being traumatized over and over again […] the invasive thoughts, the flashbacks, and feelings, and court, and when you see somebody who's gone all the way through that, and they've got their life back, and it's not happening to them any more, something that happened to them. That's the most rewarding thing, to get to be able to see them move on." In a similar vein, another participant said, "The [biggest] challenge is with people that continue to place themselves, or find themselves, in situations where they get retraumatized." This participant went on to describe the rewards of doing trauma therapy by saying, "In terms of rewarding, it is being able to see people come through and move forward with their lives." Another participant described it by saying, "I think for me, the hardest thing is knowing that whatever trauma happened to them, they can't go back somehow and fix it […] it's a very helpless feeling." One participant described the challenges by saying, "I don't know, seeing them cry and experiencing some of what they go through or what they've been through, and then feeling like they're not moving forward." Another participant described the most rewarding part of being a trauma therapist was "seeing them get better—that is,

by far the most rewarding. Seeing them live a productive life." As another participant said, "Rewards are when they bounce back, make some progress, and move on with their life."

Theme 4: Coping on Three Levels—Intellectual/Professional, Spiritual, and Physical

Eight participants indicated the most effective means of coping with VT included talking with colleagues and/or supervisors. Seven of these also mentioned spiritual/religious practices (meditation, prayer, trust in God), and six participants also talked about exercise as a coping strategy. As one participant said, "Definitely speaking with colleagues […] about how you're affected, and not feeling like you're supposed to just 'take it all,' […] and, knowing that, even though painful things have happened to other people, I still deserve to be happy and have a life. That doesn't take that away from me. And, I got that through prayer, and meditation and quiet time, and introspective work." Another one said, "Exercise is really important. I live in a warm climate, so we can be out at the beach all year long. So, I walk on the beach a lot, and I do some swimming, and my husband and I take walks. Also, I've just taken up yoga, so I'm hoping it will help because it's the mind-body connection." One person said, "I do meditation, I practice yoga and tai chi."

Theme 5: A Deeper Sense of Spirituality

While Theme 4 involves the application of strong spiritual beliefs as a coping mechanism, Theme 5 speaks to how VT can serve to strengthen a therapist's sense of spirituality. Seven participants described their experience of VT as including a deepening and/or clarification of their religious and/or spiritual beliefs. One clinician said, "At first, VT challenged my faith in God, and then I became interested in studying different religions and spiritual practices. This clarified my spiritual beliefs." Others talked about how they had not been particularly religious in the past; however, as a result of VT, they turned to God and/or a spiritual practice such as prayer or meditation on a regular basis. Another participant said, "I blend the spiritual element into my therapy work. When I first started out, [I] was so depressed […] this has challenged my spiritual beliefs, because when you see so much bad happen to innocent people, innocent beings, you start to think, 'Is there a meaning to all of this?' Overall, it has strengthened my spiritual beliefs." Similarly, one therapist talked about her use of prayer. She would "say a short prayer that God would use me as a tool, as a vessel, because there was nothing that I could do to help these people, so it would have to come from Him […]" Another participant described the way her work with trauma survivors served to facilitate her spiritual growth. As she said, this work "developed a greater spirituality base—I think much more so as a way of coping."

Theme 6: Self-Doubt—"What Is Wrong With Me?"

Six participants talked about self-doubt. This took various forms, including not being sure one wanted to stay in the field, not feeling competent, feeling as if there was "something wrong" with them, or not feeling successful. For example, one clinician said, "I started to question, actually, whether I wanted to say in the field." Another said, "I thought maybe I was just not very good at being a therapist, or I was wondering what was wrong with me." Yet another clinician remarked, "I do feel incompetent." A fourth clinician expressed a "feeling of being overwhelmed, or tired, or not able to handle it all […] feeling like I didn't know what I was doing." A fifth clinician spoke about the heavy responsibility that goes with doing trauma therapy. She said, "I always felt a lot of responsibility […] like I wasn't successful unless, by the time the session ended or I went home, everybody felt good."

Theme 7: Decreased Trust in Other People, Pulling Away From Gentle, Previously Trusted Others

Six participants experienced a decrease in their ability to trust other people and/or began to pull away from other people they had trusted in the past. Participants emphasized how this represented a change in their usual nature, which was to be outgoing, friendly, and trusting. One clinician said, "It caused me to feel less trusting of the world and people." A second participant reflected on this dimension of VT and described herself as "just basically […] not as trusting as I used to be. I mean, I've had really very strong doubts about whether I really am prepared to do this work." A third clinician added, "From my experiences in working with children who have been abused, you learn not to trust anyone." A fourth clinician talked about how this became an issue more after becoming a parent. She said, "It really didn't affect me that much until I had my son […] vicarious trauma affected how I trust people. I used to take them at face value […]" Yet another clinician gave an example of how VT sometimes means pulling away from others in one's life. She said, "So, you know, you come home, and you see your husband, and he's excited to see you, wants to spend time with you […] I have had to learn to say, 'Look […] I've spent half my day doing EMDR [i.e., eye movement desensitization reprocessing] with clients around their sexual abuse. I'm in no position to be intimate with anyone.' I need to sit on the couch and watch some sitcom or something." Another person said, "I had a lot of self doubts, kept to myself more than I used to do."

Theme 8: Difficulty Separating Clients' Experiences From One's Own Life

Six participants talked about how they felt a need to set more clear boundaries between themselves and their clients with a history of trauma. For example, participants had dreams that contained images of their client(s) and/or thought about certain sessions that were especially difficult. One person talked about how she found herself "thinking a lot about clients." Another said, "I replay everything in my head as if it's happening […] it was those visuals that I had, not being able to get those out of my head. And then seeping into my outside life." Other participants spoke about the need to maintain clear boundaries between themselves and their clients. As one participant said while talking about her experience of VT, "I kind of chalked it up to the fact maybe I was over-empathizing with them. I told myself, 'I need to have better mental boundaries here.'" Another person talked about the difficulty involved in maintaining boundaries when she said, "I've had to work really hard to realize that my existence is separate from their existence. I'm really lucky that I am able to do something where I feel like I've made a difference, but it's not my job to fix things for them, to predict their journey." One participant talked about how she works with boundaries, and explained, "I want to hear what they're saying, but I don't want to absorb it." As one therapist said, "I believe the way [VT] has affected me the most is that it is really pushing me to clarify those therapeutic boundaries […]" One person added, "[…] leaving it at the office, sometimes, is very difficult, because your heart is so heavy when you leave."

Theme 9: Fear of the Unknown—"What Is Going on With Me?"

This theme speaks to the need for education about VT. Five participants described a general lack of awareness about VT—especially when they first began doing trauma therapy. They found it difficult to maintain resilience and balance in their lives, as a result of experiencing fear and/or sadness—yet not knowing why. As one clinician expressed it, "I really didn't know what was going on." In a similar way, another clinician said, "I replay everything in my head as if it's happening. And, for me, it was those visuals that I had, not being able to get those out of my head […] at first, I didn't even know what was happening." A third clinician talked about how a seminar on VT clarified her experience

and said, "I wasn't aware that I was experiencing VT at the time, until probably several months later when I was at a seminar […]"

Discussion

As clinicians, participants experienced fears and self-doubt, in addition to decreased trust in other people. Many of these individuals reported experiencing difficulties with separating clients' stories from their own, in addition to adverse emotional and physical effects. This study yielded the unique finding that VT serves to deepen one's spirituality, which is not consistent with previous findings about how VT damages one's spirituality. This deeper sense of spirituality augmented other coping strategies such as exercise; connection with supportive supervisors, colleagues, family, and friends; and professional growth activities. There was a consensus among all participants about the need for a course in graduate school regarding trauma therapy, VT, and self-care strategies. Worthy of note is the fact the sample was almost all female.

Theoretical Elements

Theme 1 (adverse emotional and physical effects of VT) is consistent with research mentioned earlier (Baird & Kracen, 2006; Courtois, 2009; Pearlman & Saakvitne, 1995). This theme is also consistent with the CSDT, especially in terms of safety needs (Pearlman & Saakvitne, 1995). That is, human beings need to feel safe and need to know others in their circle of family and friends are safe, as well. Adverse emotional and physical effects of VT are similar to signs of posttraumatic stress disorder and showed up in participants via general nervousness, hypervigilance, nightmares, unexplained migraine headaches, and stomach problems—none of which were experienced prior to working with trauma clients.

Theme 2 (the need for a graduate-level course) is consistent with research mentioned earlier (Barnet, 2007; Courtois, 2009; Harrison & Westwood, 2009; Meyer & Ponton, 2006; Schoener, 2007). Indeed, Harrison and Westwood posit VT could be prevented via education. All participants expressed their opinion that based on their experience of VT, there is a pressing need for a graduate-level course about trauma therapy, VT, and self-care strategies. Several students expressed the opinion that this should be a required course that would include a discussion forum, facilitated by an appropriately licensed faculty member.

Theme 3 (the double-edged sword of being a trauma therapist) spoke to the challenges and rewards of being a trauma therapist. This theme was not a prevalent one in the literature; however, some researchers have eloquently stated their experience of this "double-edged sword." Pearlman and Saakvitne (1995) describe the work of a trauma therapist as follows: "While it is a dark path, it is a spiritual journey, into the darkest recesses of people's private experiences, and one which deepens our humanity in increasing our awareness of all aspects of life. In this way, it is indeed a gift, a reward of doing this work" (p. 406).

Theme 4 (physical, intellectual/professional, and spiritual means of coping with VT) is confirmed by various researchers mentioned above (Harrison & Westwood, 2009; Meyer & Ponton, 2006; Neumann & Gamble, 1995; Pearlman & Saakvitne, 1995; Rothschild, 2006; Trippany et. al, 2004). Many participants described a range of coping strategies, including exercise, continuing education, consultation with supportive supervisors and/or colleagues, martial arts, yoga, and/or meditation.

Theme 5 (a deepened sense of spirituality) is not consistent with previous research findings about how VT typically damages the trauma therapist's sense of spirituality (Pearlman & Saakvitne, 1995). These researchers state, "The pathognomonic sign of vicarious traumatization is the

disruption to the therapist's spirituality" (p. 287). This researcher agrees with Pearlman and Saakvitne in terms of how to define of spirituality. That is, "The components of spirituality include beliefs about nonmaterial aspects of experience, about meaning and hope, about connection with something beyond oneself, and about awareness of all aspects of life" (p. 287).

Themes 1, 6, 7, 8, and 9 are consistent with Pearlman and Saakvitne's (1995) CSDT. That is, participants experienced fear, self-doubt, decreased trust in others, and difficulty separating clients' experiences from their own lives. Participants described feelings of incompetence and hypervigilance in the context of VT. Many of them described a shift in their worldview, in alignment with the CSDT. Although they used to experience themselves as generally trusting of others, they no longer felt anyone could be trusted and no longer held to their previous beliefs the world was basically a safe place.

Implications for Graduate Education

All study participants emphasized the need for a course that would include a definition of VT, suggestions for how to recognize it as a normal reaction to doing trauma therapy, and information about various self-care strategies. This course would also prepare students to conduct evidence-based psychotherapy with trauma survivors. Not only would the course be helpful, it would also provide a forum for graduate students to share their experience with their peers as a way to integrate theory and practice. As Harrison and Westwood (2009) posit, education about VT could prevent VT.

Future Research

Based on the responses of participants and the literature (Barnet, 2007; Courtois, 2009; Harrison & Westwood, 2009; Meyer & Ponton, 2006; Schoener, 2007; Trippany et. al, 2004), there is a need for more research into best practices in graduate education to prepare students for the experience of VT. According to Harrison and Westwood (2009), if a student were prepared effectively, it would be possible to prevent VT. Future research could explore the apparent connection between the experience of VT and a deeper spirituality. Also, a more diverse sample (in terms of gender) needs to be conducted. From this study, it could be posited that one's spirituality is affected by VT and has a direct effect on how well a therapist maintains resilience. It could also be suggested that spirituality is an important element of a psychotherapist's professional development. Indeed, further research into the connection between spirituality and the transformation of VT could facilitate important social change in a number of ways on individual, community, and global levels.

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