2021

Vicarious Trauma as Experienced by Male Therapists

Michael Felt
Walden University

Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

Michael Felt

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Eric Hickey, Committee Chairperson, Psychology Faculty
Dr. Leanne Parker, Committee Member, Psychology Faculty
Dr. James Brown, University Reviewer, Psychology Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2021

Abstract

Vicarious Trauma as Experienced by Male Therapists

by

Michael Felt

MS, Walden University, 2017

BS, Rabbinical Seminary of America, 2014

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

Walden University

August 2021

Abstract

Vicarious trauma (VT) is a recently focused on phenomenon that describes the negative effects of treating trauma victims. VT causes pervasive and permanent changes to the self-image and worldview of the therapist. Research is sparse regarding the ways male therapists experience VT. The purpose of this study was to explore the male therapist's experience with VT and is crucial for developing a greater understanding of VT in order to enhance awareness, resilience, and prevention. The study was based on the constructivist self-development theory because VT was developed through the lens of this theory and is primarily defined as the intrapsychic changes that occur within the therapist. The research questions addressed the lived experience of vicarious trauma as experienced by male therapists and, the coping skills of male therapists who experience vicarious trauma. Giorgi's method of phenomenological inquiry provided the framework for the data collection and data analysis. Semi structured interviews allowed the 15 respondents to freely describe their lived experience. The results were then analyzed using Giorgi's 5 steps of phenomenological analysis in order to recognize the "meaning units" inherent in the data and synthesize the results with the research. The meaning units were determined by the phrases and themes that were most common and descriptive. The findings indicated that male therapists experienced VT in both interpersonal and intrapersonal expressions through avoidance and intrusion. The study also found that the most common themes among the male therapists' coping skills were comradery, enhanced sense of self efficacy, and seeking sanctuary in self. Results contribute to positive social change with an enhanced understanding of VT management.

Vicarious Trauma as Experienced by Male Therapists

by

Michael Felt

MS, Walden University, 2017

BA, Rabbinical Seminary of America, 2014

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

Walden University

August 2021

Dedication

This dissertation is dedicated to my best friend, my closest confidante and my toughest coach, my wife Necham. The great talmudic sage Rabbi Akiva was surrounded by thousands of students when he finally returned home after 24 years of study. His wife Rachel tried pushing her way through the crowd to see her holy husband. Rabbi Akiva told his students to let her through as quickly and respectfully as possible because, “What is mine is hers and what is yours is hers, all of ours is hers.” I say the same to my wife Necham, all of my productivity, accomplishments, and the success of myself, future students, and patients are hers, “Sheli vShelachem Shela Hu” [Ketubot 63a].

Necham has been a source of devotion, support and encouragement for me to get this PhD, which was a monumental effort, considering that I was concurrently obtaining 2 unique rabbinical ordinations, teaching 3 classes, managing properties in NYC, and providing hours and hours of therapy for clients. Necham was always making sure to take care of our children, our home and my needs. She dedicated her entire being to my success and productivity. This doctorate, as well as my Rabbinical ordinations, and more importantly, what I have invested in developing myself as a better human being, a better husband and a better father, could not have happened without her. Thank you my love.

This PhD process was started by my dear Rebbi, my mentor and friend, Rabbi Dr. Chiam Feuerman ob”m, and is also dedicated to his memory. Rebbi, you would have been so happy to see where and what I am today, I know you are so proud of Necham and I. We can hear you cheering us on from above as we “go far” together.

Acknowledgments

I thank the faculty members involved in this project. First and foremost to my chairman, mentor, and dear friend, Dr. Eric Hickey. You have gone beyond the pale as my committee chair and I cherish the mentorship and lifelong friendship we have developed. May our families be blessed to only share in joy and happiness.

My committee member and first graduate school instructor, Dr. Leanne Parker, you took that diamond in the rough, and scraped, cut, and polished it until it gleams so brightly today. I was in terrible need of academic guidance and you held nothing back and really pushed and encouraged me forward. I deeply appreciate your care, concern, and conviction that helped mold my academic abilities.

Thank you URR Dr. Jimmy Brown, thank you for giving such detailed feedback and insisting on your standard of success, I know you only have the best interests of this paper in mind.

I also thank the Dean of my Rabbinical Seminary, my Rebbi, HaRav Dovid Harris shlita, for courageously allowing me to pursue my intellectual passion while in yeshiva. I appreciate that you respond to my questions with a sincere focus on what is best for me and you push away the interest of the institution to ensure that I can pursue my own personal success and succeed at what is uniquely best for me.

This dissertation would not be complete without thanking those who have come before me and those who come after me. A deep thank you is appropriate to my grandmother, “Ma” for always believing in my unique talents and gifts. You always encouraged me to speak publicly, to write, to share my personality with the world. Thank

you for being my biggest fan. Thank you Grandma and Zaidy Richter for being there for us, and being so helpful with the kids and our lives during these tough and challenging years of Kollel and graduate school. I know you get so much nachas and pride from seeing our success and you certainly earned it!

Thank you Mommy and Daddy for setting high standards in your home and not giving up on me and the challenges I engendered you throughout my childhood and multiple schools. Thank you for investing in me and for never giving up. I hope that you get a lot of yiddishe nachas from me and my contributions to the world.

Every marriage is a partnership and this partnership benefited deeply from the overwhelming love and support of my wife's parents, Savti and Abba, thank you for being such shining sources of joy, love and support for Necham and I, as well as for our delicious girlies, Tehilla and Haddar.

Which brings me to those two bundles of joy and love, positivity and kindness, Tehilla and Haddar. Girls, I hope you read this and when you do I want you to remember these three things:

1. I love you more than anything in the entire world.
2. I was young and under a lot of pressure when I wrote this paper and I know that you were disappointed time and again that I couldn't play with you as much as you wanted, or go on "dates" with you whenever you asked, and I am so sorry that I had to constantly shut my office door to you girls in order to finish this. This was not just a personal project for me, this is something that I hope will enhance my capacity as a researcher, as a clinician, as a human

being, and as a father. This PhD has made me a deeper and more thought out person and I want the primary beneficiary of that, and everything else this will afford us iy"H, to be you girlies. Always.

3. Daddy is a doctor now, I heal people who are in emotional and psychological pain, and the source of my giving, the source of my healing ability, will always be your precious faces, who look at me with such love and admiration, for you have taught me how to love and how to truly give.

You both fill me with so much joy and happiness when ever I see you precious human beings who are so kind to each other, so supportive and sweet, you are both so emotionally attuned to others and love to help. I am often the recipient of this, as you girls frequently remind me, "don't get upset Daddy, just focus on your girlies!"

I love you girls forever, you are my light, my joy, and my love, and I hope to never ever stop "focusing on my girlies!"

My final appreciation goes to those therapists who gave up their precious time for me during this crazy pandemic. All of you lead very busy and successful lives and I deeply appreciated that you were so kind and helpful to me and my study. Thank you for your time, and thank you for having the strength to open up about those vulnerable parts of yourselves. I hope to take your contributions and to invest them into real world practical solutions, so that your gifts to me can keep giving to the world that you all work so hard to help.

Table of Contents

List of Tables

Chapter 1: Introduction to the Study

Introduction

Western society has developed a great psychological awareness which has become a common part of their lexicon and culture. This is due in no small part to the popularity that psychology has attracted from the famous personalities of psychology, ranging from seminal scholars of the past such as Freud to the more contemporary, like author Brene Brown (Benjamin, 2007). This increase in psychological awareness is beneficial for society as a whole because with greater awareness often comes greater action (Handel, 2009). The amplified focus on psychology and in particular, therapy, has increased the amount of people seeking therapy and mental health services (National Institute for Mental Health, n.d.). Psychologists and mental health clinicians are frequently tasked with attending to the ever-growing mental health needs of the population. However, with great power comes great responsibility and attending to the population's mental health needs, specifically their trauma, can take a toll on the mental health providers.

Trauma contagion, refers to the spread of trauma to those who interact with the original trauma patient, including the clinician who attempts to treat it (Motta, 2020). The spread of trauma to the treating therapist can lead to negative emotional and psychological symptoms for the therapist (Figley & Ludick, 2017; Motta, 2020). This has been linked to decreased levels of clinical efficacy and diminished positive outcomes for the clients of affected therapists (Branson, 2019; Molnar et al., 2017). Research from as early as the 1970s has discovered that people who are exposed to the individuals who

experienced the trauma firsthand, can experience secondhand trauma, much like secondhand smoke or a virus (Figley & Ludick, 2017). This concept has been called by many names, including, but not limited to, vicarious trauma (VT), secondary traumatic stress (STS), compassion fatigue (CF), burnout (BO), and post traumatic stress disorder (PTSD) (Branson, 2019). These concurrent themes in mental health describe how indirect exposure to trauma can negatively affect the clinician and by extension hurt the client as well. While there is a lot of developing research about these concepts and even preventative measures, there remains a paucity of research about the experience of male therapists in relation to these various kinds of secondhand trauma and specifically VT (Baum & Moyal, 2020).

Background

Vicarious trauma (VT) is a recently researched phenomenon over the past decade and refers to the long-term negative effects of treating trauma victims and the permanent changes it can make within the therapists' self-perception and worldview (Branson, 2019; Figley & Ludick, 2017; Pirelli et al., 2020). The existence of VT has been noted in members of the military, their families, disaster response teams, and even children and adolescents exposed to media violence (Barcons et al., 2019; Ezell, 2019; Figley, 2002; Kanno & Giddings, 2017; Khalil et al., 2017; Rosen et al., 2020). However, the prevalence and occurrence of VT in mental health clinicians is especially troubling, as they are often tasked with attending to the needs of those with direct and indirect trauma, which has been recorded to increase the likelihood of VT (Branson, 2019; Canfield, 2015; Cosden et al., 2016; Pirelli et al., 2020). Mental health clinicians are the most

vulnerable population for VT because many are consistently exposed to severe trauma and overly exercised empathy (Branson, 2019; Ezell, 2019; Pearlman & Saakvitne, 1995). Many mental health clinicians have reported experiencing symptoms of PTSD even though they have not been personal victims of trauma (Figley & Ludick, 2017). These clinicians can find themselves experiencing secondary traumatic stress (STS) or VT and that they may have a decreased ability to be empathetic, increased anxiety, stress, loss of appetite, and disrupted sleep patterns (Ezell, 2019; Figley & Ludick, 2017; Lee et al., 2018; Masson, 2019). These negative symptoms have been reported to inhibit the clinician's ability to think properly, to effectively process emotionally and to objectively provide therapeutic interventions (Cosden et al., 2016; Dominey-Howes, 2015; Lewis & King, 2019; Masson, 2019). Most if not all, peer reviewed studies have been conducted on this topic that focus on the experience of female therapists and VT (Babei & Haratian, 2020; Boulanger, 2019; Ezell, 2019; Fansher et al., 2020; Lee et al., 2018; Lewis & King, 2019; Long, 2020; Masson, 2019; Owens-King, 2019). This study is needed to enhance the professional understanding of how male therapists experience and cope with VT.

Problem Statement

Many studies have been conducted to explore VT, yet these studies all have an overwhelming majority of female participants (Babei & Haratian, 2020; Boulanger, 2019; Ezell, 2019; Fansher et al., 2020; Lee et al., 2018; Lewis & King, 2019; Long, 2020; Masson, 2019; Owens-King, 2019). Even studies that purported to study gender differences in the way that VT affected clinicians had participant populations that were primarily female (Harker et al., 2016; Hensel, et al., 2015; McTiernan, & McDonald,

2015; Strolin-Goltzman et al., 2020). Males and females have unique ways of processing, responding to, and adapting to stress and trauma (Baum & Moyal, 2020; Carragher et al., 2016). Researchers have indicated that these differences are not only societal, but are also rooted in biological differences between the sexes (Bale & Epperson, 2015; Baum & Moyal, 2020; Carragher et al., 2016; Geary & Flinn, 2002).

The lack of focus on the male population of therapists has contributed to a gap in our ability to attend to the needs of the male therapists (Baum & Moyal, 2020; Branson, 2019; Hensel et al., 2015; Hernandez-Wolfe et al., 2015). Therefore, the current research on therapist resilience and mitigating factors for VT are underexplored for male therapists (Baum & Moyal, 2020; Carragher et al, 2016). This has resulted in a lack of available research regarding resilience for male therapists. The presented gap in the literature regarding experienced VT in male therapists leaves a lot that is not clear about how males process those changes in self-identity (Baum & Moyal, 2020; Branson, 2019; McTiernan, & McDonald, 2015). These omissions make it difficult to apply the findings of the collected studies in conclusive or scientifically sound ways to the greater community of male mental health clinicians.

The mental health profession has a stated obligation to ensure their ability to effectively attend to the needs of their clients, and ironically this responsibility is heightened when they are attending to those who have experienced extreme trauma, despite resultant or unanticipated VT (American Psychiatric Association, 2010). This ethical imperative underscores the critical need for the scientific community to

investigate the experience of VT, potential resilience factors, and all of those implications for each population of mental health clinicians, both male and female.

Purpose of the Study

The purpose of this qualitative study is to explore how male therapists experience VT. This includes how VT affects them in therapy and in their personal life. In order to most accurately address this gap, this investigation will utilize a phenomenological approach. The benefit of this phenomenological approach is that it can uniquely address and explore the human experience and underlying cognitive and emotional processes of this under-researched population of male therapists (Baum, 2016; Baum & Moyal, 2020; Cresswell, 2003; Cosden et al., 2016; Pirelli et al., 2020). The research aim is to better understand how male therapists cope with VT in their professional and personal life.

Research Questions

Research yields a large amount of investigations of VT and coping methods for therapists, yet most of these studies have been performed on predominately female populations. This study aimed to address the underserved male population.

RQ1: What is the lived experience of vicarious trauma as experienced by male therapists?

RQ2: What are the coping skills of male therapists who experience vicarious trauma?

Conceptual Framework

The conceptual framework that most aligns with this study is constructivist self development theory (CSDT) (Halevi & Idisis, 2018; Pearlman, 2013; Pearlman &

Saakvitne, 1995). This concept has been embryonic in the formulation of VT and was curated by the originators of the term VT, to not only explain the phenomenon of VT, but as its antidote as well. CSDT is based on the constructivist theory, which places supreme focus on the individual's unique interpretation of the events and experiences of a person and considers those labels and interpretations to be exclusively in the domain of the subject (Mahoney, 1997). This is very relevant for the exploration of VT as Pearlman and Saakvitne (1995) understood VT to emerge from the perspective of the therapist as a rescuer. In a sense, the therapist creates their own unique experience of VT (Halevi & Idisis, 2018; Pearlman, 2013). The therapist who is exposed to trauma is the one who allows the experience of the client's trauma to enter their life experience. This trauma becomes a part of the self of the therapist, and changes every aspect of the therapist's life, including professional, social, and therapeutic (Halevi & Idisis, 2018; Pearlman, 2013; Pearlman, & Saakvitne, 1995). Because constructivism is based on the integral idea that human beings actively create their own reality, this can help empower the clinician to act as their own gatekeeper (Mahoney & Marquis, 2002).

Theoretical Framework

Salutogenesis and the salutogenic model provide a particularly fitting theoretical framework for this study. Salutogenesis is described as a theory that links the individual's mental perspective to the physical responses and interactions effecting medical and cognitive health (Lindström, & Eriksson, 2005). Salutogenesis posits that people have unique way of assessing and consequently responding to life stressors, such as stress, disease, and adversity. Aronovsky labeled the unique perspective that a human being

encounters the world with, as a sense of coherence (SOC) (Lindström, & Eriksson, 2005). SOC as defined in salutogenic terms, is the outlook that people create which informs their perception of experienced levels of challenge and capacity to overcome. SOC is a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that (a) comprehensibility; the stimuli deriving from one's internal and external environments in the course of living are structured, predictable and explicable; (b) meaningfulness; the resources are available to meet the demands posed by these stimuli; and (c) manageability; these demands are challenges, worthy of investment and engagement (Antonovsky, 1987, p. 19). An individual's SOC may be developed from early childhood experiences and continues developing throughout life (Antonovsky, & Sagy, 1986; Nilsson et al., 2009). A stronger SOC is related to a higher sense of consistency, order, and weighted input/output in life, which in turn informs the SOC of the relevance and value of investing in challenges (Flannery & Flannery, 1990). Antonovsky felt that when people grew up with a high participation in shaping outcomes, it would influence their perceived stressors in life as manageable (1987). Similar to Frankl's theory forwarded in Man's Search for Meaning (1985), when an individual sees purpose and meaning in his/her struggle, and expects a reasonable amount of success, it can imbue the individual with enhanced strength and capability to succeed and be happy. This can be of exceptional utility to therapists and mental health professionals who engage in highly emotion-traumatic work.

Nature of Study

The nature of this study is phenomenological. Phenomenological inquiry is best suited for the exploration of the human experience, especially where presence and absence are under investigation (Broome, 2011). Giorgi (2009) argued that the data collected with phenomenological inquiry can reveal important properties and meaning that is only discernable beyond the concrete information. Body language, tone of voice, inflections, and pauses, will be recorded and analyzed as part of the data collection process. Giorgi's point is particularly important for a topic as sensitive and subtle as this (2009). Husserl stressed the importance of recognizing that the perceived human experience is self-correcting (Broome, 2011). This is very relevant for this study where each participant's story is to be taken into context and only then is it be understood, form a greater grasp of the bigger picture which includes that which was said and conversely, that which was left unsaid (Broome, 2011).

There are many tools available for qualitative research and one of the most appropriate tools for this study is interviewing (Giorgi, 2009). Semistructured interviews with the participants can help deepen our understanding about the experience of male therapists with VT (Creswell, 2014). The research questions were the primary inspiration for developing the semi-structured interviews in order to increase alignment between the instrument and the research goals of this study. The interview questions were designed to help prompt the participant to reflect on their experience treating trauma victims and how it affected them (Giorgi, 2009).

Because this is a phenomenological study, the research of the human experience requires the firsthand investigation of their lived experience (Creswell, 2014; Golafshani, 2003; Grant, & Osanloo, 2014). Therefore the researcher was a part of the research, interacting with and engaging the participants to reflect upon and articulate their lived experience treating trauma and how it affected their life.

Definitions

Burn out: Pirelli et al. (2020) defined BO as the "gradual decrease in work engagement because of chronic exposure to stressful situations" (p. 2).

Compassion fatigue: Figley defined Joinson's use of compassion fatigue (CF) as the "state of tension and preoccupation with the traumatized patients by reexperiencing the traumatic events, avoidance, persistent arousal associated with the patient" (2002, p. 1435).

Secondary traumatic stress: Figley defined STS as "the stress resulting from helping or wanting to help a traumatized or suffering person…with symptoms nearly identical to PTSD" (Figley, 2002, p. 1435).

Trauma contagion: This refers to the spread of trauma to those who interact with the original trauma patient, including the clinician who attempts to treat it (Motta, 2020). The spread of trauma to the treating therapist can lead to negative emotional and psychological symptoms for the therapist (Figley & Ludick, 2017; Motta, 2020).

Vicarious trauma: (VT) is the phenomenon which describes the cumulative negative effects of trauma and providing trauma therapy, upon the worldview, schema, and efficacy of the empathetically engaged therapist (Pearlman & McCann, 1990). The

descriptive element of the "empathetically engaged therapist" is critical to the definition and etiology of VT (Figley & Figley, 2017; Pearlman & Saakvitne, 1995).

Assumptions

Reliable qualitative research requires the disclosure of assumptions that precede the study (Golafshani, 2003). There are five assumptions for this study. This topic is very sensitive for male therapists to discuss. Therefore, the first assumption is that there may be more negative and pervasive symptoms that participants are not readily willing to initially share in the interview. A second assumption is that the respondents have experienced symptoms of VT inherently because of the fact that they work with trauma victims, which has been strongly asserted by Figley (2002). The third assumption is that whatever the respondents will share is truthful and accurate. This is critical for the validity of the data. The fourth assumption was that this topic aligned most closely with a qualitative method of inquiry. The study seeks to explore the lived experience of people participating in a phenomenon and the best fit for this kind of study is qualitative (Golafshani, 2003; Giorgi, 2009). The final assumption is that the CSDT was a fitting theory for this study. CSDT was developed by the original researchers who introduced VT to the psychological community and was chosen because it has a unique alignment with this study and the goals of this study which is how male therapists experience VT.

Scope and Delimitations

The scope of this study includes licensed and unlicensed male therapists who work with trauma victims. I explored the unique perspective of each therapist's subjective experience with VT and their coping mechanisms. The study pursued patterns

in the shared experience of VT of male therapists as well potential for improvement in the professional attitude and procedures for attending to the mental health needs of male therapists. This study did not use any scales or empirical measurement instruments so as not to lose the richness of the human experience to predetermined questions and descriptions of symptoms.

Limitations

There are a few limitations of this study, all of which are beyond the control of the researcher. Plans to adapt to these limitations are presented as well. The first limitations is the assumptions of potential male hesitation to share vulnerable feelings and experiences. Therefore, I relied on the shared gender and a tacit fraternal bond to encourage further disclosure. I also made sure to let the interviews follow the pace and comfort of the respondent, allowing them to take time to answer the more sensitive questions. Another method that put nervous participants at ease was to remind them that I will follow up with the interviewee to review what they shared in their interview and obtain their permission to use it for the study. This allowed the participants to retain an increased sense of control of the interview and the information they choose to share. The use of virtual communication also made it easier to open up as there was an increased feeling of anonymity with virtual communication as opposed to the intimacy latent in traditional face to face interviews.

There is another limitation, which is inherent in the recruitment method. If the people are recruited strictly by word of mouth, then the participant population may be limited to a specific geographic location, which limits transferability. Therefore, the

recruitment was distributed through social media platforms and spread throughout the continental United States. The snowball style of recruitment proved successful and helped reach enough participants for saturation.

A major limitation in this study was the lack of ability to collect and accurately interpret the unique life experience of each participant and the ways that the circumstances of their life affected their lived experience of VT. Collecting and attempting to record participant life experiences is too cumbersome for this study and was omitted. This limitation can potentially inhibit validity.

Significance

A comprehensive review of the current literature found that there are limited studies that specifically track the emerging prevalence of VT as a unique entity (Baum & Moyal, 2020; Branson, 2019; Kanno & Giddings, 2017; Knight, 2019; Powell, 2020). There are even less studies that explore this topic in depth, such as those conducted by experts in the field of VT like Pearlman and Saakvitne. Worse yet is when studies do mention VT, they often use it interchangeably with compassion fatigue (CF), secondary traumatic stress (STS), and burnout (BO) (Lewis & King, 2019; Molnar et al., 2017; Sorenson et al., 2017). This makes it harder to accurately understand how each phenomenon is accurately experienced and measured (Baum & Moyal, 2020; Branson, 2019; Pirelli et al., 2020).

For instance, Hensel et al. (2015) conducted a meta-analysis of studies related to secondary trauma and the effects of treating trauma victims. The study found that the majority of the 38 most relevant and reliable studies were comprised of female

participants, with an average of 75% female representation. However, the study used the terms VT and STS interchangeably, a problem that Branson deemed "vocabulary mismanagement" and leads to more confusion of the true elements of VT as a distinct phenomenon from STS (2019). Another limitation was the nature of the studies themselves, an inherent problem with empirical studies is the lack of full human expression of the social phenomenon under investigation (Giorgi & Giorgi, 2003).

Baum and Moyal (2020) just recently published a meta-review of peer reviewed articles on the negative effects of treating trauma survivors with a particular focus on gender findings. Their study indicated that the higher demographic representation of females in the relevant studies inaccurately indicate greater female susceptibility to secondary traumatic stress, as was previously assumed by the rest of the field (Baum & Moyal, 2020). They pointed out that further research is needed to prevent potential discrepancies caused by over representation of females in secondary trauma studies (2020). Yet this study as well, uses Figley's general definition of STS as the cost of caring, and include the symptoms of VT as part of STS, which makes it difficult to accurately utilize these results for a study of distinct experience of VT (Figley, 1995).

The widespread vocabulary mismanagement in the extant literature on secondary trauma requires clarification of VT and its distinction from the other terms. Therefore Chapter 2 will comprehensively explore each term and the unique elements that distinguish it from VT. This will enhance the appreciation of the gap in the literature regarding VT as an operational term and the experience of VT by male therapists (Branson, 2019; Pirelli et al., 2020). This study is therefore focused on the exclusively

term of VT as experienced by male therapists (Kanno & Giddings, 2017; Masson, 2019; McTiernan & McDonald, 2015). This study attends to that gap by addressing the unique aspects and characteristics of the male experience of VT and resilience through a qualitative framework. Giorgi and Giorgi (2003) posited that the phenomenological method of inquiry is the sincerest form of scientifically understanding a primarily constructivist phenomenon, such as VT (Pearlman & Saakvitne, 1995).

The results of this study facilitate greater positive social change by enhancing the therapeutic efficacy of the male therapist, as well as informing educational and professional understanding of the ways that VT is understood and experienced by male therapists. This can inform relevant stakeholders in resilience and protective factors for the mental health of male therapists. Psychology, as a professional community of scholar practitioners, has a moral obligation to attend to the needs of their own, but also a mandated ethical imperative, when failure to do so can result in potential harm to the client (APA, 2010).

Summary

Many studies have been conducted to explore VT and STS, yet all of these studies fail to adequately include or explore the lived experience of male therapists with VT (Babei & Haratian, 2020; Baker, 2012; Boulanger, 2019; Ezell, 2019; Fansher et al., 2020; Lee et al., 2018; Lewis & King, 2019; Long, 2020; Masson, 2019; Owens-King, 2019; McTiernan & McDonald, 2015; Tosone et al., 2012). Even researchers who purported to study gender differences in the way that VT affected clinicians had participant populations that were primarily female (Harker et al., 2016; McTiernan, &

McDonald, 2015; Strolin-Goltzman et al., 2020). The lack of research on the male population of therapists has contributed to a gap in our ability to attend to the needs of the male therapists (Hernandez-Wolfe et al., 2015).

The presented gap in the literature regarding experienced VT and STS in male therapists leaves a lot that is not clear about how males process those feelings of psychological and emotional distress, and other symptoms of VT (Baum & Moyal, 2020; McTiernan, & McDonald, 2015). These omissions make it difficult to apply the findings of the collected studies in conclusive ways to the community of male therapists.

The mental health profession has a stated obligation to ensure their ability to effectively attend to the needs of their clients, and ironically this responsibility is heightened when they are attending to those who have experienced extreme trauma, despite resultant or unanticipated VT (APA, 2010). This ethical imperative underscores the critical need for the scientific community of psychology to investigate the varied forms of VT, STS, CF, and all of the implications for each population of therapists, both male and female.

Therefore, the next chapter will explore the various forms of trauma contagion that can affect the male therapist. Chapter 2 will start with an explanation of the literature search and review process. The literature search discovered many terms used to describe the different ways that therapists are affected by treating trauma. These terms are VT, STS, CF, and BO, and they are exhaustively investigated and explained in Chapter 2. The gap in the literature regarding the lived experience of male therapists who live with VT will be explored in deeper detail throughout the next chapter.

Chapter 2: Literature Review

Introduction

Trauma has become a major focus of academic and government interests, especially as our world has become more exposed to and aware of trauma and its ill effect on people and communities. Tremendous amounts of energy, money, and research are invested in exploring trauma and its related fields (Branson, 2019). However, trauma is not in the exclusive domain of those who experience it (Figley, 2002; Pirelli et al., 2020). Trauma can spread to the clinician who attempts to treat it, leading to negative emotional and psychological symptoms for the therapist (Figley & Ludick, 2017; Motta, 2020). This has been linked to decreased levels of clinical efficacy and diminished positive outcomes for the clients of affected therapists (Branson, 2019; Molnar et al., 2017).

Research from as early as the 1970s has discovered that people who are exposed to the individuals who experienced the trauma firsthand, can experience secondhand trauma, much like secondhand smoke (Figley & Ludick, 2017). This concept has been called by many names, including, but not limited to, vicarious trauma (VT), secondary traumatic stress (STS), compassion fatigue (CF), burnout (BO), and post traumatic stress disorder (PTSD) (Branson, 2019). These concurrent themes in mental health describe how indirect exposure to trauma can negatively affect the clinician and by extension hurt the client as well. While there is a lot of developing research about these concepts and even preventative measures, there remains a paucity of research about the experience of male therapists in relation to these various kinds of secondhand trauma and specifically VT (Baum & Moyal, 2020).

The purpose of this literature review is to present five themes that comprise the critical aspects of secondary trauma and the degree to which the extant literature has overlooked male clinicians. The flow of these themes provides a comprehensive understanding of trauma and the effects of exposure to trauma on the people who help trauma victims. The review begins with a description of trauma, its effect and prevalence, and follows with an exploration of secondhand trauma and the related yet distinct terms used to describe the effects of exposure to trauma in the scholarly literature (PTSD, VT, STS, CF, & BO). The review will continue with an exploration of the development of each term, with attention given to the unique elements and aspects of each version. The prevalence and recorded consequences of PTSD, VT, STS, CF, and BO upon the community of help providers, practitioners, and clients alike are recorded to create a sense of the importance of the current study. The literature review will consistently guide the reader towards the gap in the literature, which is the deficit in understanding the western male mental health clinician's experience with VT.

Literature Search Strategy

This study began with the terms most central to this topic, vicarious trauma, gender, male, and therapist, and these terms were the start of the database search. The publication date was limited to studies published from 2015. The initial Walden University Library search for this combination of terms failed to produce any peer reviewed articles. The search was repeated in 2020 and it came up with a single study where the author lamented the lack of studies on gender and VT (Baum & Moyal, 2020). More keywords were added as the iterative process of research illuminated the many

different terms for this concept. The study used keywords that included but were not limited to *trauma, vicarious trauma, secondary traumatic stress, compassion fatigue, burnout, post-traumatic stress disorder, PTSD, males, gender specific, vicarious post traumatic growth, compassion satisfaction, shared trauma, male clinicians, male mental health practitioner,* and *male therapist*. These keywords were entered into Google Scholar and the Walden University Library. Google Scholar alerts were also utilized to keep up to date on emerging studies that matched the key words, which contributed to the abundance of extremely contemporary studies. Databases used were ProQuest Central, PsycInfo, and Sage Premier. All of the articles that were used in the study are peer reviewed and every attempt was made to keep them current and contemporary; however, some older articles and works may be included if they were deemed critical to the understanding of the relevant literature. This was decided by noting which authors and articles were being consistently and constantly cited by other relevant studies on the topic. The seminal works on the foundations of vicarious trauma, compassion fatigue, and secondary traumatic stress were included and used as the basis for both the operating terms and theoretical foundation of this study. These include, but are not limited to, the foundational works of Pearlman, Saakvitne, McCann, Figley, Maslach, and Joinson.

Theoretical Foundation

One of the primary theoretical frameworks and orientation in this field is the constructivist self-development theory (CSDT), an empirically tested theory which has been used when studying this theme and touches on many of the affected areas of VT and STS (Halevi & Idisis, 2018; Pearlman, 2013). Pearlman and Saakvitne (1995) have used

this theory to understand and treat individuals affected by VT, CF, and STS. The constructivist lens is very appropriate for the exploration of unique human experiences. Constructivist theory places primacy on the subjects' personal interpretation of the events and experiences of a person and considers those labels and interpretations to be exclusively in the domain of the subject. Golafshani, (2003) defined constructivism from the social perspective as "the view that all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context" (p. 42).

Constructivism is based on the integral idea that human beings actively create their own reality (Mahoney & Marquis, 2002). Clients and therapists consistently create their own reality, as they perceive and curate coherence of their life experiences (Mahoney, 1997). Qualitative research is the preferred method to understand social phenomena and the "real world" experience of humanity (Creswell, 2014). Therefore, a sound epistemology for this study would include the use of qualitative research that is dependable and credible (Grant, & Osanloo, 2014; Roberts, 2010). Qualitative research is a very personal experience and dependability and credibility are critical tools for the researcher to determine the accuracy of the data (Creswell, 2014; Golafshani, 2003). These criteria must be a part of the researchers' ontological perspective as they compose the research design (Grant & Osanloo, 2014). This is especially important in qualitative research where the investigator is sometimes the actual instrument of the research itself (Creswell, 2014; Grant & Osanloo, 2014). This makes it more important for the

investigator to include tools to determine both dependability and credibility within the ontological framework of the research.

Salutogenesis and the salutogenic model also provide a particularly fitting theoretical framework for this study. Salutogenesis is described as a theory that links the individual's mental perspective to the physical responses and interactions affecting medical and cognitive health (Lindström, & Eriksson, 2005). Salutogenesis posits that people have unique ways of assessing and consequently responding to life stressors, such as emotional strain, disease, and adversity. Antonovsky labeled the unique perspective that a human being encounters the world with, as a sense of coherence (SOC) (Lindström, & Eriksson, 2005). SOC, as defined in salutogenic terms, is the outlook that people create which informs their perception of experienced levels of challenge and capacity to overcome. SOC is a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that (a) comprehensibility; the stimuli deriving from one's internal and external environments in the course of living are structured, predictable and explicable; (b) meaningfulness; the resources are available to meet the demands posed by these stimuli and (c) manageability; these demands are challenges, worthy of investment and engagement (Antonovsky, 1987, p. 19). An individual's SOC may be developed from early childhood experiences and continues developing throughout life (Antonovsky, & Sagy, 1986; Nilsson et al., 2009). A stronger SOC is related to a higher sense of consistency, order, and weighted input/output in life, which in turn informs the SOC of the relevance and value of investing in challenges (Flannery & Flannery, 1990). Antonovsky felt that when people grew up with a high

participation in shaping outcomes, it would influence their stressors in life to be perceived as manageable (1987). Similar to Frankl's theory forwarded in *Man's Search for Meaning* (1985), when an individual sees purpose and meaning in their struggle, and expects a reasonable amount of success, it can imbue the individual with enhanced strength and capability to succeed and be happy. This can be of exceptional utility to therapists and mental health professionals who engage in highly emotional-traumatic work. This has similar correlations to the proposed study, as VT is primarily induced by difficult uniquely human experiences, that influences the weltanschauung of the affected individual, and directly impacts the intrapsychic processes of the therapist (Pearlman & Saakvitne, 1995).

Conceptual Framework

The conceptual framework that most aligns with this study is constructivist self-development theory (CSDT) (Halevi & Idisis, 2018; Pearlman, 2013). This concept has been embryonic in the formulation of VT and was curated by the originators of the term "VT", to not only explain the phenomenon of VT, but as its antidote as well. CSDT is based on the constructivist theory, which places supreme focus on the individual's unique interpretation of the events and experiences of a person and considers those labels and interpretations to be exclusively in the domain of the subject (Mahoney, 1997). This is very relevant for the exploration of VT as Pearlman and Saakvitne (1995) understood VT to emerge from the perspective of the therapist as a rescuer. In a sense, the therapist creates their own fate of VT. The therapist who is exposed to trauma is the one who allows the experience of the client's trauma to enter their life experience. This trauma

becomes a part of the self of the therapist, and changes every aspect of the therapist's life, including professional, social, and therapeutic (Halevi & Idisis, 2018; Pearlman, 2013; Pearlman & Saakvitne, 1995). Because constructivism is based on the integral idea that human beings actively create their own reality, this can help empower the clinician to act as their own gatekeeper (Mahoney & Marquis, 2002).

Literature Review

Much of the confusion regarding the interchangeability in the use of the many terms used to describe secondary trauma is due to the early writings of the originators of each term, such as Pearlman, McCann, Saakvitne, Figley, Maslach and Joinson (Figley, 2002). Figley (2002) defined Joinson's use of CF as the "state of tension and preoccupation with the traumatized patients by reexperiencing the traumatic events, avoidance, persistent arousal associated with the patient" (p. 1435). In other places, Figley has described compassion fatigue as the suffering that occurs from empathizing with the sufferer and leaves the provider feeling helpless and confused, with a sense of isolation from supporters, in a sense like a traumatization from the trauma (Figley, 2017). Therefore, according to many who quote Figley's definitions, these terms would reasonably include the experience of VT as just another negative effect of exposure to trauma victims.

STS, developed by Figley as well, was defined as a subset of PTSD and developed through extended exposure to trauma suffering (Figley & Ludick, 2017). STS has become the most popular term to describe the constellation of symptoms included in VT and CF (Branson, 2019). Figley (2002) himself made this area of study even more

confusing when he decided to annex the term STS into the category of CF, because he believed that CF is a less stigmatizing term for the same experience. Although Figley had a noble and potentially beneficial motive, Branson noted that this has led to greater difficulty when operationalizing terms and utilizing measurements and scales specific to each term (2019).

Even BO, which is a term that is so generic that it is used within commercial settings, exercise studies, and industrial research, has also become an interchangeable term for VT (Barcons et al., 2019; Brand et al., 2020; Rosen et al., 2020). This is no doubt traceable to Maslach's use of empathy as an operative vehicle of the stress that arises from helping others (Miller et al., 1988). In fact Maslach framed BO as unique to the helping profession and explained the three dimensions of BO to be (a) negative shift in response toward care recipient; (b) negative shifts in personal response to self; and (c) emotional exhaustion, characterized by an inability to continue to help or serve care recipients (Miller et al.,1988, p. 251). Therefore, the base definition and development of the term BO would seem to include the elements unique to VT, such as distorted schema, avoidance, intrusion and cynical perspective of clients.

Because each term addresses overlapping factors and symptoms and there is no salient distinction absent of comprehensive analysis of the terms, it makes sense why researchers of the secondary trauma would use the terms interchangeably. Researchers have recently decried the widespread vocabulary mismanagement and subsequent hindrance to research needed to develop preventive and resilience factors for VT (Baum & Moyal, 2020; Branson, 2019; Pirelli et al., 2020). They have pointed out that many

studies will therefore be hindered by this interchanging use of the terms and therefore many previous studies lose a lot of their operational efficacy for the understanding of the distinct elements and prevalence of each concept (Branson, 2019; Pirelli et al., 2020). Therefore, this review will begin at the beginning with an exploration of trauma and progress through the development of the unique terms used to describe the various effects and prevalence of secondary trauma.

Trauma and Its Discontents

A deeper understanding of trauma requires a review of the psychoanalytical foundations of trauma and trauma therapy (Pearlman & Saakvitne, 1995). According to Pearlman and Saakvitne (1995), there are four major themes which form the foundation for understanding trauma and trauma therapy. The first is the significance of childhood experiences and the symptomatic expression of pathology later in adulthood. The second foundational theme is the "integration of cognition, affect, memory and knowledge" (Pearlman & Saakvitne, 1995, p. 39) which describe the efforts of the mind to protect itself from the negative repercussions of the trauma and its effect on the individual's "self-protective beliefs about safety, control predictability, and attachment" (Pearlman & Saakvitne, 1995, p. 32). The third theme critical to understanding and implementing effective trauma work is transference, reenactments, and the repetition compulsion (Pearlman & Saakvitne, 1995). The final theme, which is most relevant to this study, is countertransference. This especially pertinent when considering the targeted demographic of this study, as male therapists are at a higher risk for countertransference when attending to female trauma survivors (Pearlman & Saakvitne, 1995). Pearlman and

Saakvitne also highlight the “Person of the Therapist”, which refers to the presence and impact of the therapist joining the client in a joint exploration of self and pursuit of personal meaning, or in salutogenic and constructivist terms, a sense of coherence (Keyes, 2014; Pearlman & Saakvitne, 1995). All of these themes are built on the basis of understanding and diagnosing trauma. Pearlman and McCann, the originators of CSDT, defined trauma as; “an experience is traumatic if it (1) is sudden, unexpected, or non-normative, (2) exceeds the individual’s perceived ability to meet its demands, and (3) disrupts the individual’s frame of reference and other central psychological needs and related schemas” (1990, p. 10).

Prevalence of Trauma

Trauma and stress are infamous psychology terms which have become a part of public nomenclature. Trauma has exploded into our modern world where unparalleled exposure to acts of terrorism, natural disasters, and violence have become almost normal (Benjet et al., 2016; Branson, 2019; National Center for PTSD, 2019). Trauma holds the dubious distinction of being one of the most common occurrences across the palette of mental health distress in the United States (National Center for PTSD, 2019). Trauma affected around 70% of adults in America, and 20% end up with post-traumatic stress disorder (PTSD) (Wu et al., 2019). As many as 13 million Americans have PTSD at any given time (National Center for PTSD, 2019). The DSM-5 stated that PTSD can develop from direct exposure or indirect exposure to extreme trauma (APA, 2013). Figley and Ludick (2017) pointed out that the DSM-5’s description of PTSD noted that secondary exposure can come from hearing about a close friend or relatives extreme trauma

experience, which expands the deleterious effects of trauma. This idea that trauma spreads like a disease, affecting all who come in contact with it, including the male mental health clinician, has been articulated by many early researchers of trauma (Miller et al., 1988) as well as current researchers of trauma as a "social pathogen" (Boulanger, 2018; Coddington, 2017; Motta, 2020; Regeh et al., 2019; Rizkalla et al., 2017; Sorenson et al., 2017; Wu et al., 2019). This viral view of trauma, proposes that trauma spreads to all those whom the subject is in close proximity to, requiring what Rosenheck and Thomson (1986) dubbed *detoxification* of all infected parties, most often the caregivers and those close with the patient. Therefore, trauma is not necessarily most effectively neutralized when dealing with just patient zero. Effective treatment of trauma must take into account the entire ecosystem of support that interacts with the infected individual (Motta, 2020). If proper treatment and containment measures are not taken, the trauma has the ability to continue to infect and damage not only the original patient, but also the nuclear network of caregivers, both male and female (Coddington, 2017; Motta, 2020; Sorenson et al., 2017; Rizkalla et al., 2017).

Interpersonal Effects of Trauma

Research has illuminated the multifaceted ways that trauma has ruined marriages, friendships, and even family bonds (Bundy, 2020; Figley & Ludick, 2017; Hoppwood, Schutte, & Loi, 2019; Klimley et al., 2018). The ill effects of trauma on the individual can scare away loved ones, if not seriously hurt them (Branson, 2019; Bundy, 2020; Sorenson et al., 2017). PTSD has the ironic side effect of straining and sometimes chasing away those critical social support systems which have the potential to mitigate

the negative effects of trauma (Carragher, et al., 2016; MacEachern et al., 2019; National Center for PTSD; 2019).

Social support systems are an integral part of resilience and can provide a needed social support for therapists, both male and female. In an anthropological study of stress, resilience, and gender, Geary and Flinn (2002) asserted that men share a similar "tend and befriend" coping mechanism as females. They posited that men who are struggling with stress would seek out other males to form a social support network. Geary and Flinn argued that "men's coalitions [could] provide a protective social ecology" (p. 748). This biological characteristic of male social behavior applies equally for patients and providers and would be equally damaging for each if trauma drove them into isolation.

Taylor et al. (2002) disagreed with Geary and Flinn and asserted that men and women have very different methods of seeking social support. Taylor et al. proved from a cross cultural study of 19 varied cultures, including Western culture, that women have a greater drive towards stress induced affiliation then men. Meaning that men are much less likely to seek social support when under stress. Therefore, trauma and secondary trauma can have potentially more damaging effects on males who are at a biological disposition to have lower levels of social support (Taylor et al., 2002).

When trauma patients are become increasingly isolated, they increase their risk factor for PTSD and suicidality. This is especially true for police officers who have legal and easy access to firearms (Klimley et al., 2018). Wozniak, et al., (2019) demonstrated a predictor effect of close proximity to trauma, and the prevalence of PTSD. This was in congruence with other research which also indicated that an increase in exposure to

trauma correlates with a higher risk for PTSD (Bundy, 2020; Dar, & Iqbal, 2020; Knight, 2019; Wu, et al., 2019).

Professional Effects of Trauma

Professionals, especially first responders, those that take care of others, are ironically at a greater risk for PTSD (Bundy, 2020; Figley, & Ludick, 2017; Klimley et al., 2018; Knight, 2019). In an emotionally compelling metareview of the extant literature of trauma and PTSD, Klimley et al. (2018) observed how the nation grieved over the Parkland shootings and offers for counselors came pouring in for the students and their families, yet no offers were extended for the firefighters and sheriff deputies who had to collect the remains of the murdered children from the hallways of the school. Klimley, et al. estimated that almost 400,00 first responders across America experience PTSD. They reported that PTSD can hinder the professional's efficacy at their job, and have been correlated with comorbid diagnoses, like GAD, MDD, insomnia, and maladaptive coping mechanisms, such as substance abuse (Klimley et al., 2018). Klimley et al., stated that there was no significant relationship between prevalence of PTSD in first responders and gender, however they admit that is unclear if that is because men are just less willing to speak about PTSD due to the stigma which is not as prevalent for females. Baum and Moyal (2020) reported that male therapists also share that stigma of being labeled with a traumatic disorder and are more hesitant to disclose their struggle with trauma related themes than women. Therefore it is difficult to accurately assess the prevalence of trauma and trauma related symptoms of males.

Prevalence of Trauma Across Professions

Researchers of trauma have attempted to track the damage that trauma leaves in its wake as it travels from person to person, paying no heed to race, gender, socio-economic class, or profession (Branson, 2019; Butler, Carello, & Maguin 2017; Sprang et al., 2019). Even the health care professions, considered the zenith of Western science and medicine, suffer from the insidious effects of trauma (Bundy, 2020; Figley, & Ludick, 2017; Sorenson et al., 2017). Health care providers (HCP's) who worked with prolonged exposure to traumatizing experiences, such as infant deaths, late stage cancer patients, and palliative care, experienced physiological symptoms of PTSD, such as avoidance, fatigue, lack of joy or satisfaction, headaches, and difficulty focusing (Sorenson, et al., 2017). Sorenson et al., (2017) cited the financial cost of replacing a registered nurse, which can cost between "$36,900 to $57,300, resulting in an estimated cost of $729 million per year in the United States" (p. 561). The studies on health care professionals also suffer from an overwhelmingly female participant population. This is often due to the fact that most studies of healthcare professionals use nurses for their sample pool, which as a profession is predominantly female. Trauma has even made an ironic impact upon the profession most aware, educated, and trained to beat it, mental health (Branson, 2019; Diem et al., 2019; Donohue, 2020; Motta, 2020; Pirelli et al., 2020).

Application to Mental Health Clinicians (MHC)

Many consider mental health clinicians at a greater risk of "contracting trauma" than the rest of the population (Branson, 2019; Boulanger, 2018; Coddington, 2017; Figley & Ludick, 2017; Motta, 2020; Rizkalla et al., 2017). This is because they are

already in a higher risk bracket, similar to first responders, due to their increased exposure to those infected with trauma (Branson, 2019; Figley & Ludick, 2017; Pirelli et al., 2020). Pirelli, et al., (2020) recently rang the warning bell about the increasing danger of trauma as it effects the mental health clinicians and elaborated on Figley's "cost of caring" (2013). Pirelli et al., (2020) stressed the critical importance and ethical imperative for MHCs to gain a deeper understanding of trauma as it effects the therapist and others, elaborated on the far-reaching negative impact that the trauma has on the caregivers themselves, limiting their clinical efficacy, and continuing the vicious cycle of damage (MacEachern et al., 2019; Motta, 2020; Regehr et al., 2019).

Pirelli, Formon, and Maloney asserted that there is no such thing as a mental health clinician who is not exposed to trauma and is not negatively affected by it (2020). This sentiment was also expressed by Figley (2002) regarding secondary traumatic stress and compassion fatigue, where he said that "the very act of being compassionate and empathic extracts a cost under most circumstances" (p. 1434) (cited in Lewis & King, 2019, p. 97). Branson (2019) made a similar point as Pirelli, Formon, and Maloney, but brought to light the confounding issues plaguing the MHC's retention of effective methods to mitigate the spread of trauma to the therapist. Branson started with what she termed "vocabulary mismanagement" of the way the literature describes the phenomenon of how trauma affects the therapist and caregiver. The virus-like spread of trauma is known by many names; vicarious traumatization, compassion fatigue, secondary traumatic stress, and burnout (Branson, 2019; Figley and Ludick, 2017; Sorenson et al., 2017). The conflagration of different terms to describe the same phenomena has

confounded researchers attempting to accurately gauge and understand each term and its unique elements (Branson, 2019; Figley, 2002; Molnar, et al., 2017). A sincere effort to fully understand these concepts requires clarification of each term and their intended meanings. Therefore, this study will define each term as intended by its originator.

Vicarious Trauma

Definition

Vicarious Trauma (VT) is the phenomenon which describes the cumulative negative effects of trauma and providing trauma therapy, upon the worldview, schema, and efficacy of the empathetically engaged therapist (Pearlman & McCann, 1990). The descriptive element of the "empathetically engaged therapist" is critical to the definition and etiology of VT (Figley & Figley, 2017; Pearlman & Saakvitne, 1995). Researchers who contributed to the foundational understanding of VT and related concepts, all noted the operative effect of empathetic engagement as the predictor for an adverse response in the provider (Figley & Figley, 2017; Pearlman & McCann, 1990; Pearlman & Saakvitne, 1995; Sorenson, Bolick, Wright, & Hamilton, 2017). Empathy is a double-edged sword for both the therapist and the client (Pearlman & Saakvitne, 1995). On the one hand, empathy is integral to, and most often the operative factor of, an effective therapeutic alliance and a confident predictor of successful patient outcome (Figley & Figley, 2017; Pearlman & Saakvitne, 1995). On the other hand, empathy acts as the highway for transference, and consequently countertransference, to occur, which is exacerbated by the perceived role and sometimes need for the therapist to be the "helper" (Pearlman & Saakvitne, 1995). Therefore, mental health clinicians, and other carers, are at greater risk

for VT, as empathetic overextension is more often than not performed by the providers when tending to survivors of trauma (Figley & Figley, 2017). Chronic expenditure of empathy can deplete the provider of critical emotional resources, permanently altering their outlook, intrapsychic processes, and perceptions of therapeutic efficacy, as put eloquently by Pearlman and Saakvitne; "we no longer interject optimism, joy, and love in our shared pursuits… [we] withdraw emotionally in a state of disillusionment and despair"(1995, p. 33).

Development of VT

The foundations requisite for understanding VT are rooted in psychoanalytical and constructivist theory (Pearlman & Saakvitne, 1995). The originators of VT developed a construct of how VT compounds and surreptitiously distorts the worldview of the care provider (Pearlman & McCann, 1990; Pearlman & Saakvitne, 1995). VT mimics the methodology of trauma damage in general (Branson, 2019; Figley, 1995). The third factor for defining a traumatic event is defined as an action or event which: "…(3) disrupts the individual's frame of reference and other central psychological needs and related schemas" (Pearlman & McCann, 1990, p. 10). Similarly, VT corrupts the perspective of the provider, often exhibited by intrusion, avoidance, arousal, and negative changes to cognitions (Branson, 2019; Lee, Gottfried, & Bride, 2018). These symptoms become exclusive to VT when they become permanent and incorporated parts of the provider's lived experience, many times leading to boundary violations, apathy to work, and cynicism towards clients (Branson, 2019; Pearlman & Saakvitne, 1995; Pirelli, Formon, & Maloney, 2020).

A common question regarding the irony of VT, where therapists get traumatized by trauma therapy, asks why therapists are not aware of the indirect trauma and its effect on them. Pearlman and Saakvitne attributed this ironic phenomenon to a part of the symptomology of VT, that the effects and changes on the therapist are slow and insipid, and often do not warrant enough urgency to be attended to until its too late (1995). A distinctive trademark of trauma is its engrained and silent, almost unconscious effect on people. This is especially true for VT, which is mostly an intrapsychic process, affecting the internal cognitions and *weltanschauung* of the therapist first, before it metastasizes into physical expression and external maladaptive behaviors (Figley, & Ludick, 2017; Long, 2020; McCann & Pearlman, 1990; Saakvitne, 2002).

Effects and Symptoms of VT

Vicarious Trauma can affect those exposed to indirect trauma in many different ways. Recent research has illuminated physical, neurological, emotional, cognitive and sexual changes in providers who treat, and maintain prolonged exposure to, trauma victims (Boulanger, 2018; Coddington, 2017; Molnar et al., 2017; Strollman-Goltzman, et al., 2020). All of these studies had a primarily female participant pool, and the first two were narrative studies conducted by a female author, presenting from a uniquely female perspective. There is yet to be a study that has noted any differences in the changes that come from VT while controlling for gender (Baum & Moyal, 2020).

It seems that there is almost no aspect of the providers self which is safe from the harmful effects of VT (Pirelli, Formon, & Maloney, 2020). Symptoms of VT can present as intrusive imagery, avoidance behaviors, hyper-arousal, and negative changes to

cognitions (Branson, 2019, p.3). Intrusion can be experienced by bothersome thoughts of clients and their stories, vivid imagery of graphic scenes disclosed during therapy, and disturbing dreams about clients (Lee, Gottfried, & Bride, 2018; Hunt, 2019). Avoidance behaviors are often described as: avoiding clients and other people; inability to recall client information; diminished activity level; detachment from other people; emotional numbing; and foreshortened future (Lee, Gottfried, & Bride, 2018, p. 231). Hyper-arousal has been documented as: difficulty sleeping, irritability, difficulty concentrating, hypervigilance, and easily startled (Branson, 2019; Lee, Gottfried, & Bride, 2018, p. 231). Branson details some of the negative changes to cognition which occur in clinicians affected by VT as: increasingly pessimistic view of the world; loss of clinical motivation and work ethic; distance from spiritual beliefs; and negative coping skills (2019, p.3). As most meta-reviews have greater numbers of female participants, research indicated that females are at a higher susceptibility for VT (Hensel et al., 2015; Sorenson, et al., 2017). Figley argued that females may be more predisposed to negative cognition changes because of a deeper need to heal and tend for victims (2017). However, in an older article, Way, VanDeusen, and Cottrell (2007), found that male therapists had higher levels of disruption in their sense of self, which indicate that they also see themselves primarily healers and VT can affect that element of their schema as well. Way et al., found that male therapists with VT actually have lower levels of self-esteem (2007). This is another indicator that Figley' premonition about self-image as a biological variable may not accurately reflect the reality. The study conducted by Way et al., still reported a predominantly female participant demographic that was double that of the male

participants, and that the male participants were significantly older then the female sample size which lowers the transferability of the results (2007).

Many of these VT symptoms present as very similar to the symptoms of trauma, which contributes to the confusion surrounding the accurate diagnosis and tracking of the prevalence of VT (Branson, 2019; Pirelli, Formon, & Maloney, 2020). This also accounts for research which purporting to study the effects of indirect trauma, inadvertently included observations of direct trauma, such as studies which investigated PTSD in mental health providers and failed to screen for the differences between direct and indirect trauma (Berger, et al., 2012, cited in Molnar, et al., 2017).

Prevalence of VT; My Trauma Will Go with You

Milton Erikson's famous *My Voice Will Go With You* has inspired some to refer to compassion fatigue, secondary traumatic stress, and vicarious trauma with the phrase, my trauma will go with you (Norcross, 2018). This is a very apt expression to describe how exposure to the trauma of others does indeed go on with the therapist. Research indicated that those who invest in and work closely with victims of trauma, carry some of their patients' trauma with them (Figley, 2017; Molnar, et al., 2017; Pirelli, Formon & Mahoney, 2020). Many professions are, by definition, more hazardous to the emotional health of the professional, especially those which work with people exposed to trauma such as mental health clinicians, firefighters, nurses, lawyers, advocates, police, researchers, and other first responders (Bundy, 2020; Coddington, 2017; Fenge, Oakley, Taylor & Beer, 2019; Klimley, Van Hesselt, & Stripling, 2018; Taylor, Gregory, Feder, & Williamson, 2019).

Studies which explored the effects of exposure to trauma on helpers, have identified concurrent themes of indirect trauma and negative reactions (Molnar et al., 2017). These themes have an epistemological limitation in that most studies did not differentiate between direct and indirect exposure to trauma (Molnar et al., 2017). As a result, most of the studies of non-mental health workers were built on PTSD instruments of measurement (Molnar et al., 2017). Lawrence, (2017) in a multidisciplinary review, explained that most first responders and medical health providers will be exposed to a traumatic event that they will not be able to process properly. Lawrence maintains that this can be considered normal, and many of these workers will carry that event with them in an unprocessed state. This is a form of subjective trauma, which occurs when one cannot process what one viewed or experienced (Silver, 2015). This can lead to adverse reactions, and maladaptive coping mechanisms, if not also damage to one's schema (Pearlman & Saakvitne, 1995). First responders, who are exposed to traumatic events both directly and indirectly, at a greater rate then the general population, report correspondingly higher rates of PTSD: a 10% prevalence rate, as opposed to 4% for the general population (Molnar et al., 2017). This high exposure frequently leads to indirect trauma and its ill effects upon the provider, to the degree that Figley and Ludick assert that indirect trauma and its associated negative effects are an occupational hazard of being a professional carer (2017). Interestingly, research has indicated that volunteers display higher rates of PTSD than their professional counterparts (Molnar et al., 2017). Thormar et al., (2010) upon review of 9 studies of volunteer rescuers, with over 3000 collective participants, found that they presented with symptoms of PTSD at a rate of 24-

46%, compared to the average of 10% for professional rescue workers (as cited in Molnar et al., 2017). Similar figures were found by Zhang et al., 2016, who conducted a cross cultural study comparing PTSD reporting from volunteer rescuers by the Oklahoma City bombing to Nairobi volunteer rescue workers (cited in Molnar et al., 2017). Another group that reported higher-than-average rates of VT due to exposure to indirect trauma are sexual assault nurse examiners (SANE)(Raunick et al., 2015). Higher rates of negative effects from indirect exposure has also been found in federal agents who work for Internet Crimes Against Children (ICAC) (Bourke & Craun, 2014). ICAC agents are tasked with identifying victims and perpetrators of child pornography, and their rates of STS have been recorded as being between 18-33% (Bourke & Craun, 2014). However, this study used scales that measure STS, and these aren't entirely accurately applicable to VT. Another limitation of this study was the participants exclusive exposure to child pornography, one of the most intense forms of trauma exposure, and limits applicability to therapists who work with milder trauma.

Exposure to direct trauma can yield indirect trauma which has pervasive and permanent effects across the spectrum of helpers, and can cause irreversible damage to the provider, sometimes even leading to their departure from their field, or worse, suicide (Branson, 2019; Figley & Figley, 2017; Pearlman & Saakvitne, 1995; Pirelli, Formon, & Maloney, 2020).

Unfortunately, VT is difficult to screen, diagnose, and treat promptly because the of the gradual onset of symptoms and the desensitization which occurs with many of the intrapsychic symptoms (Branson, 2019). Some clinicians may disregard even the somatic

symptoms, as many of those somatic symptoms, such as headaches, problems sleeping, and fatigue, are typical results of working long hours, a common ailment of the American worker (Ezell, 2019).

Confusion of Terms

There are many terms that are used to describe the experience and phenomenon of VT, or the negative effects of indirect trauma upon the therapist/care provider. Contemporary studies have raised the concern that this "vocabulary mismanagement" confounds research on VT and the effects of second hand trauma (Branson, 2019; Knight, 2019; Pirelli, Formon, & Maloney, 2020; Sprang, et al., 2019). This has been confusing for researchers who are stymied by the usage of different terms to explain the same topic, while others used those same terms to define distinct elements of this phenomenon, if not an entirely different phenomenon altogether (Branson, 2019; Sprang, et al., 2019). What makes this all the more difficult is that even according to the literalists who maintain operational distinction between the terms, some of these terms still have many overlapping aspects and characteristics (Branson, 2019; Sprang, et al., 2019). This study attempts to remain as accurate to the operational use of the terms as envisioned and delineated by their originators. Pearlman and Saakvitne define vicarious trauma as specific to the cumulative transformative and long-term effects of indirect trauma exposure upon the psychological schema and worldview of the care provider (1995). Extant literature reveals three other primary terms to describe similar but distinct phenomena: compassion fatigue (CF), secondary traumatic stress (STS), and burnout (BO) (Branson, 2019; Figley & Ludick, 2017; Molnar, et al., 2017; Sprang, et al., 2019)

Compassion Fatigue

The Cost of Caring

In 1995, Figley expanded the concept of compassion fatigue, coining the now famous phrase, “the cost of caring”. Compassion fatigue was first introduced by Joinson (1992, cited in Figley, 2002) to describe the emotional exhaustion of nurses and their response to constant emergencies for patients under their care. Figley defined compassion fatigue as the “state of tension and preoccupation with the traumatized patients by reexperiencing the traumatic events, avoidance, persistent arousal associated with the patient” (2002, p. 1435). In other places, Figley has described compassion fatigue as the suffering that occurs from empathizing with the sufferer and leaves the provider feeling helpless and confused, with a sense of isolation from supporters, in a sense like a traumatization from the trauma (Figley, 2017). When this term was first introduced, it was compared to and included as a subset of PTSD (Figley & Ludick, 2017). Similar to VT, CF is predicated upon empathetic engagement with the primary source of trauma and is spread through that empathetic engagement (Figley, 1995; Figley & Ludick, 2017). Another similarity between VT and CF is the predictor role of the provider’s personality and sense of self (Joinson, 1992; Pearlman & Saakvitne, 1995). Research has noted that people who view themselves as helpers are at greater risk for VT and CF (Joinson, 1992; Pearlman & Saakvitne, 1995). This kind of personality is generally internally drawn to the helping profession and is therefore more at risk for empathetic overextension (Figley, 2002; Joinson, 1992; Pearlman & Saakvitne, 1995). In an attempt to make CF detection more scientific, Figley developed eleven criteria that form a causal relationship for

compassion fatigue: empathetic ability, empathetic concern, exposure to the client, empathetic response, compassion stress, sense of achievement, disengagement, prolonged exposure, traumatic recollection, and life disruptions (Figley, 2002). When the majority or all of these criteria are present in the helping professional, who Figley asserted is not limited to those in the mental health field, they are almost certain to be diagnosed with CF (Figley, 2002).

Prevalence of CF

Joinson (1992) introduced compassion fatigue as an occupational hazard of nursing. She collected stories of nurses who were caring beyond their capacity. These nurses had all been exposed to trauma (the death of a long-term patient) and were deeply affected by it, each in their own way. Joinson discovered that the nurses had three basic coping mechanisms: bury the emotions; ignore the emotions; and address the emotions (1992). The nurses who buried their emotions were suffering the most, but what was unique was how the physiological effects were similar with the nurses who just ignored their emotions. Both kinds of coping mechanisms were expressed in angry, ineffective, apathetic, and depressed behavior (Joinson, 1992). This kind of response was called compassion fatigue by Doris Chase, cited by Joinson in her article, who asserted that the external stimuli which cause CF are unavoidable (1992). The external stimuli are the traumas experienced by the patients under these providers' care. The major limitation of this study was the almost exclusive use of female participants.

As is evident from the nurses who struggled when they could not *care enough* to save their patients, CF is very much the result of carers being limited by either internal or

external restrictions, and the resultant negative effects of taking that failure personally. In a mixed methods study of 250 forensic investigators (FI), Fansher, Zedaker, and Brady found that the majority displayed symptoms of CF and STS as measured by the STSS and the ProQOL-V (2020). The qualitative analysis explained this as coming from their constant exposure to client who experienced trauma at the hands of adult care givers, and the ensuing feelings of helplessness which initiated strong feelings of CF, and when internalized, VT, ultimately leading to BO (Fansher, Zedaker, & Brady, 2020). This study highlights the transferability of the phenomena of CF and STS to professions where people are expected and asked to care for those experiencing trauma, even in indirect ways, yet are constrained by either organizational or legal limitations (Fansher, Zedaker, & Brady, 2020).

While most studies on CF have been conducted upon medical professionals, more specifically nurses, and this trend has continued into contemporary research, lately there has been an added focus on compassion satisfaction. This term refers to "the positive feeling of being able to relieve the confusion of others and satisfaction with the ability to perform one's job correctly" (Babei & Haratian, 2020). This emerging area of research is being explored as one of the antidotes to CF, alongside resilience and self-care (Figley & Ludick, 2017). More research is needed to explore the male experience and prevalence of compassion satisfaction (Baum & Moyal, 2020; Branson, 2019; Pirelli, Formon, & Maloney, 2020).

Contrast to VT

Figley and Ludick clarified that the distinction between compassion fatigue and vicarious trauma is that VT was designed and operationalized within a psychodynamic framework (2017). This was critical for elucidating the unique characteristics of VT as opposed to CF, because VT was used primarily to describe the intrapsychic processes of the therapist who is negatively affected by exposure to the trauma of clients under their care (Pearlman & Saakvitne, 1995). Figley understood VT to be unique from CF and STS specifically because of the theoretical orientation of the development of VT (2002). Figley and Ludick explained that CF does not share the etiological role of counter transference that is often very active in the process of VT (2017). This is because CF doesn't require the therapist or care provider to see themselves in the patient, rather CF is the result of extended compassion beyond the resources of the provider and can be present in any profession that is exposed to trauma and not just mental health (2002). Figley therefore relegated VT to be used as a term which describes the process for *how* a mental health clinician can develop the various manifestations of CF and STS (2002).

Comparison to VT

CF and VT share a salient feature which is the critical role which empathetic engagement plays in the process and onset of symptoms of both phenomenon (Figley, 2002). Both terms result from situations which required the provider to be empathetically engaged with the client, and the disorder emerges specifically because of this empathetic engagement (Figley, 2002; Pearlman & Saakvitne, 1995). This is what Figley referred to as the "cost of caring", and the ironic double edged sword of empathy, where the need for empathetic engagement is critical for the process of helping and healing central to the

work of the care provider, yet at the same time it is the source of strain and mental and emotional distress for the care provider (2002). Lewis and King recorded that Figley (2002) stated that, “the very act of being compassionate and empathic extracts a cost under most circumstances” (p. 1434) (2019, p. 97). This is the most significant similarity between VT and CF, which often leads to the overlapping use of the two terms to describe this unique process of empathetic engagement gone bad regardless of the more specific aspects, demographics, and symptomologies of each term (Branson, 2019; Sprang, et al., 2019). Another difficulty in contrasting these two terms is the comorbidity with which they often occur, especially in mental health clinicians (Sprang, et al., 2019). When compounded with the observation of the core clinical operation of empathetic engagement of both terms, rationalization for interchanging these terms increases (Figley, 2002).

Comparison with STS

Figley maintained that compassion fatigue is a part of secondary traumatic stress, which is a subset of PTSD (2002). The only difference that Figley admitted was that STS and CF can come from association with patient zero; the original person affected by or who experienced the trauma, while PTSD is limited to the one who experienced the trauma (2002). Figley summarized it succinctly when he said that PTSD is experienced by the sufferer of trauma, while STS is experienced by the witness to the suffering (2002). Therefore, Figley had no qualms using both CF and STS interchangeably.

Yet this interchangeability of terms has been the subject of contemporary papers and professional gatherings (Branson, 2019; Molnar, et al., 2017; Sprang et al., 2019).

This was specifically addressed by a recent gathering of experts in the field of trauma, where the consensus was that some level of distinction between the terms is beneficial for the field of study (Sprang, et al., 2019). The presenting concern was that amorphous use of STS with CF watered down the true characteristics of both concepts and resulted in a general focus on interventions that pursue generic wellbeing and the common self-care methods, both of which fail to properly attend to the more specific underlying issues affecting those exposed to indirect trauma (Sprang, et al., 2019). The committee agreed that in order to further the development of preventative interventions, there needed to be a targeted focus on the "effects of indirect exposure to others' trauma" (Sprang, et al., 2019). This included, but was not limited to, unique methods of assessment and measurement tools, and a general call for further research (Sprang, et al., 2019). To enhance specificity, Sprang et al., (2017) spelled out distinct measurements for determining CF and STS as the Professional Quality of Life Scale (ProQOL-V), developed by Stamm in 2010, and the Secondary Traumatic Stress Scale (STSS) developed by Bride, et al, 2004.

Secondary Traumatic Stress

Figley was also one of the founders of STS and outlined the development of STS which he discovered when treating Vietnam veterans who had been tasked with caring for others, such as combat medics (2002). Figley noticed the similarity between the standard PTSD diagnosis that the other veterans had, compared to the slightly more unique elements of the carers' perspective (2002). Figley defined STS as "the stress resulting from helping or wanting to help a traumatized or suffering person…with

symptoms nearly identical to PTSD" (Figley, 2002, p. 1435). Figley and Ludick expanded on the conception of STS which was first noticed in the wives of soldiers returning from combat (2017). These studies both emphasized the proximity to trauma and its correlation to the contagion of PTSD, spreading the symptoms of trauma and PTSD from the sufferer to those who live with the sufferer (Figley & Ludick, 2017). The common theme remained the same when researchers turned to other caring professions or demographics where people were in close proximity to one who suffered trauma (Molnar, et al., 2017). This global view of STS was described by Figley as "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other-the stress resulting from helping or wanting to help a traumatized or suffering person" (2002, p.1436). STS can be experienced both psychologically and somatically with symptoms that mimic PTSD and include; intrusion, avoidance, arousal, and emotional numbing (Molnar, et al., 2017).

Distinction from VT

Many people and studies use the terms VT and STS interchangeably, and while they share many similar psychosomatic symptoms, there is a conceptual difference between the two. VT refers to the intrapsychic transformation of the providers worldview and sense of self, this most often occurs through the empathetic engagement with clients and patients who have experienced direct trauma (Pearlman & McCann, 1990). The theoretical foundation of VT is distinctly unique from STS, as VT is based on a psychodynamic model of understanding client-therapist interactions (Pearlman & Saakvitne, 1995). VT is therefore based on the mechanics of transference and

countertransference which occurs between the clinician and the client and develops gradually sometimes resulting in permanent distortions of the providers schema (Pearlman & Saakvitne, 1995). VT is therefore more accurately a description of the cumulative effects of exposure to direct and indirect trauma and is unique to those working with trauma survivors. However, STS refers to the more global experience of developing PTSD symptoms from exposure to indirect trauma as opposed to direct trauma (Figley, 1995). This can occur quite suddenly, and while most often contracted via empathetic engagement, like CF and VT, it is not limited to a permanent change of the providers self-image and worldview (Figley, 2002). Figley and Ludick maintained that the effects of STS, similar treatments to PTSD, is not limited to the psychodynamic or constructivist theory that define the etiology, experience, and understanding of VT (2017).

Prevalence of STS

Molnar et al, (2017) and Figley and Ludick (2017) collected studies that demonstrated how STS is present in every profession which provides care for people including but not limited to: qualitative transcriptionists (Kiyimba & O'Reilly, 2016); medical examiner office employees (Coleman et al., 2016); health sciences librarians (Becker & McCrillis, 2015); para-professionals working with refugees (Lusk & Terrazas, 2015); spoken-language interpreters (Mehus & Becher, 2016); alcohol and drug workers (Ewer, et al., 2015); certified child life specialists (Fisackerly et al, 2016); asylum evaluators (Mishori, Mujawar & Ravi, 2014); military psychologists (Johnson, et al., 2014); telephone and online counselors (Furlonger & Taylor, 2013); psychotherapists

(Želeskov-Đoric´, Hedrih, and Đoric´, 2012); attorneys and their administrative support staff (Levin et al., 2011); marriage and family therapists (Negash & Sahin, 2011); jurors (Robertson, Davies, & Nettleingham, 2009); animal caregivers (Figley & Roop, 2006) (cited in Molnar, et al., 2017, p. 134). Of course, some professions are more susceptible for STS than others, depending on the frequency and intensity of the exposure to trauma, as well as the level of empathetic engagement (Figley, 2002). Berger et al., (2009 cited in Molnar, et al., 2017) conducted a comprehensive meta-analysis of 28 studies that spanned almost half a century and included over 20,000 cumulative first responders from 14 countries. These studies included varied roles within first responders; from emergency medical technicians to professional rescuers who worked on disaster response teams. All of the participants shared the common theme of empathetic engagement and exposure to trauma victims, and Berger et al., found the worldwide rate of PTSD-like symptoms among these first responders to be at 10% (Molnar et al., 2017). Berger et al., estimated that this is an understated figure as many professional first responders may have been intimidated from revealing more symptoms of PTSD because of the stigma attached (2009, cited in Molnar, et al., 2017). According to Figley's conceptual framework of STS as a subset of PTSD, where caregivers exhibit the same symptoms as the trauma victims they care for, this statistic would be akin to an expression of the prevalence of STS among first responders (Figley, 2002). However none of these studies were applicable to the experience of male therapists and VT, not only because of the majority of female participants, but also because of the almost exclusive use of STS scales (Baum & Moyal, 2020).

Lee, Gottfried and Bride, stress the widespread prevalence of STS among social workers which they determine to be related to the fact that 89% of social workers occasionally provided trauma-related care and 53% did so on a much more frequent basis (2018). They collected data on STS prevalence among social workers by mailing the Secondary Traumatic Stress Scale (STSS) to 2500 social workers across the United States. 731 surveys were completed and sent back and indicated that "34% experienced intrusive thoughts about clients, 28% avoided clients, 23% had difficulty sleeping, 22% experienced irritability and 19% had difficulty concentrating" (Lee, Gottfried & Bride, 2018, p. 230). This study had an 81% female participant population.

Hensel et al., (2015) identified 17 risk factors for STS that were found in a meta-analysis of 38 studies of mental health professionals, ranging from psychologists, psychiatrists, child protective service workers (CPSW), and licensed social workers, again the majority of participants were female, which the authors made mention of. STS prevalence was noted at 34% for CPSW, 15% for social workers and an overall 55% scored high enough on the STSS to be diagnosed with PTSD (Hensel et al., 2015; Molnar et al., 2017). Some of the risk factors that were identified were caseload; volume, frequency, and ratio (Molnar et al., 2017). This has led some to wonder if the concurrence of overwhelming work conditions with STS diagnoses, is a comorbidity of STS and BO, or just a confusion within the current means of measuring STS and limited ways to differentiate between the two concepts (Molnar et al., 2017).

Burnout

Burnout is another term that is often used interchangeably with CF, STS and VT. Pirelli, Formon, and Maloney (2020) define BO as the "gradual decrease in work engagement because of chronic exposure to stressful situations" (p. 2). Some point out that BO, like CF, does not require exposure to trauma, rather the primary motor of the exhaustion can come from the work environment itself without any client contact at all (Branson, 2019; Pirelli, Formon & Maloney, 2020, p. 2). Maslach (1982) the originator of the term BO, contributed to the sense that "…it is more related to the cumulative effects of stressors of a job, particularly when one believes that there are not enough resources to meet the needs of the job"(cited in Sorenson et al., 2017, p. 560). Symptoms of BO are depersonalization, reduced sense of personal accomplishment, low job satisfaction, and feeling discouraged as an employee (Sorenson et al., 2017, p. 560). There is a lot of overlap with VT, CF, and STS, mostly because BO can be concurrent with the experiences of those suffering with VT, CF and STS.

The study conducted by Lewis and King (2019), is exemplar of the difficulty of accurately determining the unique aspects required for understanding how the research applies to each, if any, of these terms. The study aimed to explore the self-care practices of social work students in preventing compassion fatigue, burnout and vicarious trauma (Lewis & King, 2019). The study was working with social work interns, and measured STS and CF, without any exploration of the cumulative intrapsychic changes to the self-image and worldview of these therapist-in-training. This was despite the fact that the title contained the term Vicarious Trauma in its heading and purpose. This is a misuse of the

term VT, and especially when it was used interchangeably with BO, which is defined as the acute response to an employee feeling overwhelmed with the demands of the employer or organization (Branson, 2019; Owens-King, 2019; Pirelli, Formon, & Mahoney, 2020). VT is a uniquely subjective experience which is exclusively dependent upon treatment of trauma victims, and its constructivist framework is hard to apply to organizations. BO is a term that applies to any and all professions, and occurs on an individual and organizational level, regardless of exposure to trauma or client contact (Sorenson et al., 2017).

Distinction from VT, CF and STS

While BO can be comorbidly present in those suffering from VT, CF and STS, it is also the most distinct from those terms, primarily because the core mechanism of VT, CF, and STS is exposure to trauma and empathetic engagement, while BO can and does often develop without either of those features (Branson, 2019). BO is similar to VT in the cumulative build-up of stressors that result in symptomatic expression but is distinct from CF which is characterized by an acute development of symptoms (Sorenson et al., 2017). In general BO is primarily an industrial term and while a unique construct from VT, CF, and STS, it is frequently present among helping professions, as these professions have their fair share of overwhelming work conditions and stressors, indistinct of VT, CF, and STS (Branson, 2019). However, BO is its own distinct construct, irrespective of its comorbidity with or occurrence as a result of, VT, CF, and STS (Branson, 2019; Figley, 2002). Branson (2019) and Figley (2017) both agree that BO in a mental health setting, is more operationally accurate as a result of secondary trauma.

Pearlman and Saakvitne clarified that VT is a construct which is experienced uniquely by each person because of the constructivist nature of how VT is understood, and because of the subjective nature of VT's effects on each therapist (1995; Pearlman, 2013). Therefore, questions should be focused on the subjective experience of the male therapists. This can help provide the level of depth that is missing from the previously mentioned empirical studies.

Summary and Conclusions

There are a lot of studies on VT, CF, and STS, however they all suffer one of three major limitations. The first is that most of them focus primarily on women. This can be a result of simple demographics, as females make up the majority of those in many of the helping professions most hard hit by VT, CF, and STS (Baum & Moyal, 2020). The second limitation is the lack of clear operationalized terms to distinguish between PTSD, VT, CF, STS, and BO in the studies and their recorded effects on gender. While some argue that these terms are all referring to the same thing, most agree that VT is distinct from PTSD, STS, CF, and BO (Branson, 2019). Even those who maintain that VT is concurrent with the other phenomenon, they would agree to the purists that VT occurs comorbidly (Pirelli, Formon, & Maloney, 2020). The third and final limitation is that most of these studies, especially the more modern ones are exclusively quantitative and rely heavily on scales and measurements to determine the extent of the secondary trauma in therapists (Baum & Moyal, 2020). All authors agree that further research is needed in order to further the professional understanding of VT and how it impacts male therapists. The goal of this study was to determine how male therapists experience and cope with

VT. This study explored the gap in the extant literature by conducting a qualitative phenomenological study of exclusively male therapist and their experiences with VT and resilience. The method of inquiry will be explained in Chapter 3.

Chapter 3: Research Method

Research Design and Rationale

This qualitative study utilized a phenomenological approach with semistructured interviews. 15 male therapists were enough to gain a deeper insight into the lived experience of the male therapist and how VT affected them (Creswell, 2014; Mason, 2010). The small sample size was fitting for a study that explored the lived experience of the subject (Mason, 2010). This way each participant was able to share the particulars of his lived experience in a manner that allowed the interviewer to explore the feelings and experiences shared in the interview process (Creswell, 2014). This methodology was especially appropriate considering the sensitive nature of the topic under analysis. This chapter explains the rationale for this particular inquiry method. That is followed by an explanation of how my research was conducted, starting from sample selection all the way through to the coding and analysis of the data.

The purpose of this study was to explore how male therapists experience VT. This included but was not limited to how VT affects them both in therapy and their personal life. In order to most accurately address this gap, this investigation utilized a phenomenological approach. The benefit of this phenomenological approach is that it can uniquely address and explore the human experience and underlying cognitive and emotional processes of this under-researched population of male therapists (Baum & Moyal, 2020; Cosden et al., 2016). The research aimed to better understand how male therapists experience VT in work, therapy, and personal life.

Research yields a large amount of investigations of Vicarious Trauma and coping methods for therapists, yet most of these studies have been performed on predominately female populations. This study addressed the underserved male population.

RQ1: What is the lived experience of Vicarious Trauma as experienced by male therapists?

RQ2: What are the coping skills of male therapists who experience Vicarious Trauma?

The nature of this study is phenomenological. Semistructured interviews with the participants helped deepen our understanding about the experience of male therapists in the context of VT. Because this is a phenomenological study, the research of the human experience requires the firsthand investigation of their lived experience (Creswell, 2014; Golafshani, 2003; Grant, & Osanloo, 2014). Golafshani, (2003) defined constructivism from the social perspective as "the view that all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context" (p. 42). The constructivist approach to exploring people experiences is particularly fitting for this topic because of the theoretical framework of VT itself. Pearlman and Saakvitne (1995) have asserted that VT is an intrapsychic process that is uniquely subjective and distinct for each person. They consider the constructivist perspective a critical foundation for understanding VT and how it affects the clinician (1995). Therefore, the most appropriate method of inquiry for this particular

topic would be a phenomenological approach, building on the constructivist leanings of the Husserlian philosophy of scientific analysis (Giorgi & Giorgi, 2003).

Role of the Researcher

Qualitative research is a very personal experience and dependability and credibility are critical tools for the researcher to determine the accuracy of the data (Creswell, 2014; Golafshani, 2003). These criteria must be a part of the researcher's ontological perspective as they compose the research design (Grant & Osanloo, 2014). This is especially important in qualitative research where the investigator is sometimes the actual instrument of the research itself (Creswell, 2014; Grant & Osanloo, 2014). This makes it all the more important for the investigator to include tools to determine both dependability and credibility within the ontological framework of the research.

In the pursuit of validity and reliability, five practices were conducted throughout the data collection process. First, all of the data were triangulated and reviewed by the researcher with multiple methods of analysis (Stadtlander, 2018). Second, there was a research journal which included all reflections, perspectives, and considerations about potential associations between data and participants (Creswell, 2009). Third, there was a continuous review conducted that covered both the interview responses and the interviewer's conclusions (Groenewald, 2004). Fourth, bracketing was used to ensure ethical transparency (Giorgi, 2009). Bracketing was conducted during all three stages of the data collection: before the interview, during the interview, and after the interviews were collected and analyzed. Relevant or related prior experiences, biases, and prejudices were recorded before the interviews on a separate paper. These were kept in mind during

the interviewing process and reviewed again during data collection in order to keep them independent of the participants' perceptions and experiences (Giorgi, 2009). This helped keep the researcher's perception of the phenomenon in its original and raw form, which is critical to the phenomenological process (Giorgi, 2009).

Methodology

The participant selection of this study was focused on male therapists who treat trauma. Therefore, the study was confined only to male therapists who provide therapy to people who suffered trauma. Purposeful sampling was utilized to recruit male therapists who have experience with or are currently treating trauma victims. The recruitment flyers specified that each participant should be male, a licensed mental health professional, treats trauma survivors, and have experience with VT or CF. Consent to record was obtained before any call or video was recorded as per IRB ethical requirements and New York State law. Participants were allowed to talk about the process and experience of the interview itself in a post interview debriefing if necessary. If any topics became too sensitive for the participant, a licensed psychologist that offers telehealth services offered to provide services for the participants of the study. The contact information of the psychologist was provided on the consent form.

Recruitment

This study was conducted during the novel Covid-19 coronavirus pandemic, which has caused well over 200,000 deaths in the United States alone. Government officials have put certain quarantine measures in place and people are expected to stay home. Therefore, certain traditional elements of recruiting and interviewing participants

were tailored to reflect the recommendations of the World Health Organization (WHO), while maintaining strict fealty to Walden University's IRB. In lieu of face-to-face interviewing, social media, telecommunications, and virtual communication platforms were utilized to recruit and interview the participants of this study. This study utilized purposeful sampling and searched specifically for male therapists with experience treating trauma patients. The data collection went as follows:

1. Researcher posted Social Media flyer to reach potential participants.
2. Flyer invited participants to email a dedicated password protected email address for the study's consent form.
3. Respondents were emailed a consent form.
4. Consent: Participants reviewed the consent form. If they completed the consent form, they were invited to arrange a time for the virtual interview.
5. Data Collection Procedures: Participants completed the interview online or over the phone with the researcher. The interview is included in Appendix A.

Data Collection

Data were collected over telecommunication and virtual communication platforms. The timing and format for each interview was determined by the convenience and scheduling of the participants. Participants were offered to choose which format was most comfortable for them in order to insure the greatest potential for safe, honest, and open interviews. Both of these electronic methods of communication included an option for recording and transcribing the calls. Every interview was recorded and transcribed to whatever degree possible. The interview recordings and transcriptions were stored on a

designated computer specific for this research study and is password protected to protect the privacy of the participants.

Every effort was made to collect 15 participants in order to ensure transferability and saturation (Mason, 2010). The minimum participation requirement for this study was eight people, which is the average number of participants in qualitative dissertations and studies on the same and similar topics (Adams, 2020; Baker, 2012; Hunt, 2019; Mason, 2010).

Instrumentation

The purpose of this study was to explore how male therapists experience VT. This included but was not limited to how VT affects them both in therapy and their personal life. In order to most accurately address this gap, this investigation utilized a phenomenological approach. The benefit of this phenomenological approach is that it uniquely addressed and explored the human experience and underlying cognitive and emotional processes of this under-researched population of male therapists (Baum & Moyal, 2020; Cosden et al., 2016). Research will aim to better understand how male therapists experience Vicarious Trauma in work, therapy, and personal life.

I used an interview form as my instrument, included as Appendix A. The interview was built around my research questions.

RQ1: What is the lived experience of Vicarious Trauma as experienced by male therapists?

RQ2: What are the coping skills of male therapists who experience Vicarious Trauma?

During the interviews, each participant was asked about how many years of experience he has as well as what training he has received. Then the interviewing examined the lived experience of the male therapists. Phenomenological study is focused on the lived experience of the subject. The goal of interviewing was to allow the subject to express and describe their lived experience of the phenomenon under study (Giorgi, 2009). The subject of this study is the male therapist and their lived experience with VT. Therefore, the questions of the interview were designed to allow the subject to explain and describe his unique lived experience with VT. The follow-up questions built upon the description provided by the subject and followed the theme of the second research question. The goal of the second research question was to explore how the subject experienced VT in his personal life. Therefore, initial and follow-up questions expanded the description of the phenomenon to include these other areas of the lived experience of the male therapist, such as their professional and personal life.

VT is built upon Constructivist Self Development Theory (CSDT), which places supreme focus on the individual's unique interpretation of the events and experiences of a person and considers those labels and interpretations to be exclusively in the domain of the subject (Mahoney, 1997). This is very relevant for the exploration of VT as Pearlman and Saakvitne (1995) understood VT to emerge from the perspective of the therapist as a rescuer. In a sense, the therapist creates their own unique experience of VT (Halevi & Idisis, 2018; Pearlman, 2013). The therapist who is exposed to trauma is the one who allows the experience of the client's trauma to enter their life experience. This trauma becomes a part of the self of the therapist, and changes every aspect of the therapist's life,

including the professional, social, and therapeutic (Halevi & Idisis, 2018; Pearlman, 2013; Pearlman & Saakvitne, 1995). Consequently, the interview questions explore how trauma affected the therapist in all areas of their life. The interview questions maintained a delicate balance to ensure that they are not leading yet still allowed for a deep exploration of the ways that VT affected the intrapsychic processes of the therapist. The symptoms of negative impacts of VT on the therapist's personal life can often be noticed in either the work or personal life of the therapist (Pearlman & Saakvitne, 1995). Therefore, the interviewer asked the participant to describe what affects VT has had on those areas of their life. Pearlman and Saakvitne mentioned that sometimes these effects of VT are not as noticeable to the therapist themselves, therefore the interview questions asked what other people have said about the therapists' lived experience after exposure to trauma. The interview was as gentle and non-intrusive as possible while balancing the deepest exploration of this phenomenon in pursuit of science.

Data Analysis Plan

The data were collected by recording the interviews and having them transcribed. Then the data were subject to the steps of phenomenological analysis outlined by Giorgi, Giorgi, and Morley (2017) and used in practice by Whiting (2001) and Broome (2011). Giorgi et al., spelled out the 5 steps critical to phenomenological analysis of data (2017). The steps all focused on achieving what Husserl said was the most important goal of phenomenology, "to come back to the things themselves" (Giorgi, 2003, p. 8). The focus is on the subject of the study, and in this study the subject was male therapists who provide therapy to trauma patients. After the interviews were recorded,

phenomenological analysis followed a strict regimen as outlined by Giorgi, Giorgi, and Morley (2017). These steps are: (a)"Get a general sense of the whole" (b) search for "meaning units" that relate to the phenomenon under study (c) analyze meaning units for meaning (d) synthesize meaning units into descriptions of subjects lived experience and finally to record the descriptions and meanings of the data (Giorgi 1985, p. 10). The last step is to write up the themes and patterns of the collected data and units of measure (Giorgi et al., 2017).

Data were entered either by a transcription service, or by hand on notepads on to a word processor that was specifically formatted for the interview results (Stadtlander, 2018). Then the data were organized by themes and patterns in accordance with Giorgi's steps of phenomenological analysis (Broome, 2011; Giorgi, 2003; Giorgi et al., 2017).

Summary

Phenomenological research is the preferred method to understand social phenomenon and the "real world" experience of humanity (Creswell, 2014). Therefore, a sound epistemology for this study included the use of phenomenological inquiry which is dependable and credible (Grant & Osanloo, 2014; Roberts, 2010). Giorgi wrote that the most important part of phenomenological research is to hear the voice of the subject, therefore, interviews were chosen as the instrument of this study. The interview questions were built around the research questions and reflected the focus of the study. The subject of the study was male therapists and their lived experience with VT. The interviews were recorded and transcribed, and the data were collected onto a secure computer that was password protected and accessible only by the researcher. The collected data were then

analyzed according to Giorgi's steps of phenomenological analysis. These steps are: (a)"Get a general sense of the whole" (b) search for meaning units that relate to the phenomenon under study (c) analyze meaning units for meaning (d) synthesize meaning units into descriptions of subjects lived experience and finally to write up the descriptions and meanings of the data (Giorgi, 1985, p. 10). The overarching theme throughout phenomenological research and this study was to unearth and display the *lebensweld* of the subject. In alignment with the constructivist conceptual framework of VT, the interviews were conducted with a focus on amplifying the subjects' voice of their lived experience with VT (Giorgi, 2003). This chapter spelled out the recruitment, collection, and analysis of the data. The next chapter will discuss the results.

Chapter 4: Results

Introduction

There is currently a gap in the literature about how male therapists experience and manage VT (Adams, 2020; Baum & Moyal, 2020; Taylor, 2018; Pirelli et al., 2020). The purpose of this qualitative study was to explore how male therapists experience VT. This includes how they manage and prevent VT in their professional and personal life. This investigation utilized a phenomenological approach in order to most accurately explore and record the lived experience of male therapists and VT. The phenomenological approach is uniquely suited to comprehensively explore the human experience and underlying cognitive and emotional processes of this under-researched population (Baum, 2016; Baum & Moyal, 2020; Cresswell, 2003; Cosden, Sanford et al., 2016; Pirelli et al., 2020). The research aimed to better understand how male therapists experience and cope with VT in work, therapy, and personal life.

RQ1: What is the lived experience of Vicarious Trauma as experienced by male therapists?

RQ2: What are the coping skills of male therapists who experience Vicarious Trauma?

This chapter presents the collected data and findings of this study. The chapter begins with a description of the setting and demographics of the study. This is followed by a description of the study, including but not limited to the data collection, data analysis, and the method of inquiry. The chapter ends with a description and elaboration of the results and a conclusion which summarizes the answers to the research questions.

Setting

The study began after Walden University's IRB provided approval (10-07-20-0661678) to start recruitment. A very important physical consideration that took place during the time of this study was the novel Covid-19 pandemic. The novel Covid-19 coronavirus pandemic has caused over 220,000 deaths in the United States alone. Government officials have put certain quarantine measures in place and people are expected to stay home. Because of the unique nature of the societal changes due to Covid-19, many people migrated to virtual platforms. Therefore, social media was chosen as the ideal place to recruit male therapists for this study. The interviews took place virtually, either by phone or video conferencing, where the participant and the researcher were in a private setting, in order to minimize distraction and maximize confidentiality.

Demographics

This study was conducted with exclusively male therapists. The first eight interview questions were used to gather descriptive demographic information from the participants. These questions ranged from "What is your age?" to "What is your highest education level?" This helped collect the background information that was critical for understanding the context of the final interview questions about VT. The next eight questions invited the participant to describe his experience with and methods of managing VT.

All of the therapists interviewed actively treat clients and provide direct intervention services. Fourteen out of 15 participants were Caucasian. Nine out of 15 treated mostly patients with CSA. Seven of the therapists had a doctorate in clinical

psychology or a related field. Every participant was provincially licensed to provide direct therapy services. There was a wide range of age and experience as indicated by Table 1.

Table 1

Study Demographics

Participant	Age	Years of Trauma Experience	Client SES	Degree
1	25	3	Low	MFT
2	29	3	Low	PhD
3	63	25	Mid	PhD
4	57	38	High	PsyD
5	32	8	Mid	MSW
6	40	13	Mid	MSW
7	54	8	Mid-High	MSW
8	41	7	Mid-High	MSW
9	46	20	Mid-High	PhD
10	43	10	Mid-High	MSW
11	54	10	Mid-High	EdD
12	42	20	Mid-High	MSW
13	32	5	Low-Mid	PhD
14	53	20	Mid-High	MSW
15	40	13	Low-Mid	PsyD

Data Collection

The data collection began after approval from the IRB at Walden University was obtained (10-07-20-0661678**)**. Recruitment flyers were posted and spread via social media. The first interviewee P1, expressed interest in the study and invited some of his mental health colleagues and snowball sampling ensued. There was a total of 15 participants, and they were all labeled with numeric codes. One or two interviews were completed every day for two weeks. Each interview ranged from 25-75 minutes

depending on the responses and time availabilities of the participant. The data were recorded on the device the interview took place on, for instance those who chose to interview on Zoom, had the interview saved on the computer that the virtual interview took place on. Those participants who chose to conduct a phone interview were recorded by the researcher's iPhone 5 SE. During the interviews the researcher transcribed the participant responses, and when it was not possible to transcribe during the interview, the researcher listened to the recordings and transcribed them. Each interview produced a minimum of two pages of single spaced transcribed notes. Some respondents, such as P1, P5, P6, P11, P12, and especially P15, were gracious enough and passionate about the topic to have provided an hour to an hour and a half long interviews as displayed on Table 2. Every effort was made to create a safe and comfortable environment for the participants therefore many of these interviews were very intimate, and a lot of disclosure took place.

Table 2

Interview Details

Participant	Length of Interview in Minutes	Number of Transcribed Pages
1	90	6
2	45	2.5
3	60	4
4	60	4
5	70	5
6	90	6
7	40	2
8	60	4
9	50	3
10	60	4
11	70	5
12	60	4
13	45	2.5

14	30	2
15	90	6

Data Analysis

After the interviews were recorded and transcribed, the phenomenological analysis followed the strict regimen outlined by Giorgi, Giorgi, and Morley (2017). These steps are: (a)"get a general sense of the whole" (b) search for "meaning units" that relate to the phenomenon under study (c) analyze meaning units for meaning (d) synthesize meaning units into descriptions of subjects lived experience and record the descriptions and meanings of the data (Giorgi, 1985, p. 10). The last step is to write up the themes and patterns of the collected data and units of measure (Giorgi et al., 2017).

In order to "get a greater sense of the whole," an Excel spreadsheet was created to contain all of the data. This was accomplished by putting the interview questions along the header of the spreadsheet, and the participant numbers along the first column, with the corresponding participant response copied and pasted into the appropriate place. This let me see all of the data at once in a clear and organized way. Then I looked for "meaning units" and changed their font if they stuck out as a potential unit of meaning. The way I looked for meaning units was to discern which words were most relevant to the study and had greater utility and relevance to the study's aims. Those words chosen by their relevance and frequency in the collected data from the literature review and included terms such as; intrusion, avoidance, detachment, hyper arousal, effective skills, coping, management, exercise, personal therapy, supervision, and training. These codes were supplemented by phrases that had the most utility in expressing the participants lived experience and response to the stressors of VT. These participant comments were

then highlighted, changed into unique fonts and colors. The varied fonts and colors helped distinguish common themes and patterns them easily.

Finally, I synthesized the data into descriptions of the subjects' lived experience which helped form the themes that were supported by the data. In order to analyze the meaning units for meaning, each of the meaning units were categorized under patterns that started to emerge from the data. I started a separate document labeled "Data Analysis 2" which was focused on just the numbers of both the demographic data and the amount of times each meaning unit occurred (Appendix B). This provided a clear sense of how many times each meaning unit came up, which meaning units formed patterns, and which ones were more prevalent with which demographic subtype. These numbers were contrasted with patterns that evolved from clusters of meaning units within the data. For instance, I noticed there were a lot of meaning units such as "detachment." I cross referenced the presence of that meaning unit of detachment with the type of clients that each of those participants treated, in order to see if there was a salient theme or pattern. I found that five out of the nine therapists who treated CSA had reported that same meaning unit of "detachment."

The third set of data analysis focused on two primary categories which aligned with the research questions. The first category was the participants' lived experience of VT, and the second category was the support systems available to and utilized by the participant to minimize the effects of VT, which was referred to as VT management.

The codes developed organically from the participant responses and were chosen by their frequency and strategic utility. Those codes were: intrusion, avoidance,

detachment, hyper arousal, effective skills, exercise, personal therapy, supervision, personal space, peer support, spousal support, and spirituality, and are illustrated in Appendix C. Appendix C builds on the raw numbers from Appendix B, which themselves provided insights and patterns that were instrumental in synthesizing the rest of the data to answer the research questions as will be explained below. Appendix C was helpful to develop the meaning units as each participant statement that was relevant to the meaning unit or theme was collected and analyzed for a common denominator. Those common denominators provided the meaning for the subsequent meaning unit which developed the themes.

The fourth round of data analysis used the more common and frequently cited codes to develop a shorter list of themes aligned with each research question. Some themes were developed about the way male therapists experienced VT in their personal and professional life. The majority of the insights and themes were mostly regarding the participants' methods and strategies for managing VT. The participants were more willing to share about how *well* they were managing, instead of focusing on their struggles with VT. It is almost as if they unconsciously knew more about the *good* they were doing than the *bad*.

Then I synthesized the meaning units into descriptions of the subjects lived experience and recorded the descriptions and meanings of the data. This was accomplished by creating yet another data analysis document, Synthesis of Meaning Units, that contained all of the themes with their relevant quotes (Appendix D). Appendix D collected all of the relevant quotes and organized them by theme and then had the code

words in varied fonts to help make patterns and related themes more salient and easily apparent to the researcher. This helped break down the meaning units and create a synthesis of the participants descriptions of their lived experience with the rest of the collected data to determine the most relevant and insightful patterns.

The first research question explored the lived experience of male therapists and VT. There was a major underlying theme throughout all of the participants' lived experience which was the inevitable presence of VT symptoms regardless of management techniques. The majority of the therapists expressed that symptoms of VT seeped into their lives despite their best efforts to keep them at bay. This was expressed by every participant, in both demographic categories: CSA therapist and general trauma therapists. There were two other salient themes which emerged from the exploration of the lived experience of the male therapist. The way that symptoms of VT were expressed in the life of the therapist was manifested in two distinct realms, a) when interacting with other people, and b) within the mind of the therapist. I coded the first theme as the interpersonal expressions of VT symptoms, and the second theme as the intrapersonal expressions of VT symptoms.

The second research question explored how male therapists managed their symptoms of VT. There were four outstanding themes: a) almost all of the participants (14/15) gave themselves an extremely high rating regarding their ability to manage VT despite their lack of VT specific training, b) almost all of therapists (14/15) engage in some sort of supervision either with a mentor or peers, c) a majority of therapists (9/15) said spirituality helped them manage VT and provided them with purpose, support and

meaning, and d) almost all of the therapists (14/15) reported that they found it helpful to create personal space, forget the world, or to take a break from treating trauma.

I labelled the first theme as male self-enhancements, after Taylor's seminal theory of positive illusions, which posits that humans who are facing adversity actively create a more optimistic perspective of themselves and their abilities than reality would suggest (Taylor, 1983). I labelled the second theme as supervision. The third theme was spirituality, which was broadly defined as any supernatural or higher belief system that provided inspiration, rituals or practices that male therapists used to cope with VT. Spirituality was divided into three subthemes to present the unique ways that participants utilized spirituality, which was purpose, support and meaning. The final salient theme was the description of the varied processes that therapists used to disconnect. This was broken down into three subthemes: creating personal space, forgetting the world, and separating from treating trauma.

Evidence of Trustworthiness

In the pursuit of credibility and transferability this study collected almost double the number of participants that were used in similar studies. Fifteen qualified participants responded to the recruitment methods, which was higher than required for this type of study. This area of research is incredibly limited and the opportunity to interview and collect data from so many qualified participants was a boon for science, the profession of psychology, and the community of male mental health practitioners.

In order to ensure dependability, validity, and confirmability, five practices were adhered to throughout the data collection process. First, the researcher triangulated and

all of the data and reviewed it with multiple methods (Stadtlander, 2018). Second, there was a research journal which included all reflections, perspectives, and considerations about potential associations between data and participants (Creswell, 2009). Third, there were continuous reviews conducted that covered both the interview responses and the interviewer's conclusions (Groenewald, 2004). Fourth, bracketing was used to ensure ethical transparency and dependability (Giorgi, 2009). Bracketing was conducted during all three stages of the data collection: before the interview, during the interview, and after the interviews were collected and analyzed. Relevant or related prior experiences, biases, and prejudices were recorded before the interviews on a separate paper. These were kept in mind during the interviewing process and reviewed again during data collection in order to keep them independent of the participants' perceptions and experiences (Giorgi, 2009). This helped keep the researcher's perception of the phenomenon in its original and raw form, which is critical to the phenomenological process (Giorgi, 2009).

Results

The study found that there were two distinct ways that male therapists experience VT and there are four primary themes within the way they coped with VT. Those two primary manifestations of VT symptoms that were most often experienced by the participants was avoidance and intrusion. The results also described how these symptoms were exhibited both interpersonally and intrapersonally. This answered the first research question, which aimed to understand male therapists' lived experience of VT.

The second research question explored the way that male therapists cope with or manage their VT symptoms. The four primary themes of coping techniques were a sense

of self-enhancement, supervision, utility of spirituality, and disconnecting from trauma. These developed from the synthesis of the meaning units with the rest of the data using the attached appendixes, which helped aid the synthesis and analysis of the data into salient themes and patterns that provided insight to answer the research questions.

This section is divided by the categories of the prominent themes and subthemes which answered the study's research questions. The first part is about the themes that were found in the description of the participants' lived experiences of VT. Within the exploration of the lived experience of VT symptoms, a distinction emerged between interpersonal expressions of VT and intrapersonal expressions of VT. The first type of admitted symptoms of VT were most expressed in interpersonal relationships or in the interactions between the therapist and others. The latter description refers to the symptoms of VT that existed mostly within the therapist himself and remained mostly as an intrapsychic experience. The description of themes related to the experience of VT symptoms is followed by an explanation of the themes and subthemes that were found in the participants' descriptions of their coping and management techniques. There are many times that the therapists who treated clients with CSA would have clusters of similar responses and patterns that emerged from their responses when compared to the responses of the therapists who treated general trauma. For the sake of brevity the first category of therapist who primarily treat clients with CSA will be referred to as CSA therapists and the others will be referred to as general trauma therapists.

Lived Experience of VT

The most salient symptoms that were articulated by the participants were avoidance and intrusion. These were expressed in both interpersonal and intrapersonal manifestations. The following contains excerpts from the participant's responses to question #10 on my semi-structured interview (Appendix B), which was: "Vicarious trauma could include symptoms of intrusion, avoidance, hyperarousal, and negative changes to cognitions. Can you describe your experiences with any of these types of symptoms?"

Interpersonal expressions of VT

Avoidance

This was the most prevalent and highest occurring symptom of VT among the research participants, as 10/15 of all participants and 8/9 of the CSA therapists reported symptoms of avoidance. Avoidance was most often expressed as a compulsion to avoid emotional and social engagement. This wasn't limited to client-focused interactions, but even in interactions with "civilians," like P6, a social worker admitted:

> The biggest one for me is avoidance. (Follow up) more from other people, the more intense my week is with trauma, the less inclined I am to hang out with friends, to feel the free-spiritedness of sending out funny texts.

The symptom of avoidance had both active and passive expressions. The active ways were reported by some participants as manifesting itself in increased impatience with perceived "insincere interactions" with other nontrauma focused people, like family members and lay people. Trauma therapists reported feeling that others are just not nearly

as in tune with real feelings and readily articulative of those feelings in conversations. They felt compelled towards more intense and real interactions that mimic the intercourse of feelings in therapy sessions. As P3 said, “I’ve become a junkie for honest communication, I get put off by insincere communication.”

A common theme and more passive manner of avoidance was an overall bored weariness when interacting with people, both civilians and clients. Some participants mentioned the effects of avoidance in normal social interactions, and others reported this expression of avoidance in therapy sessions as well. This was articulated by P15, a renowned doctoral level CSA therapist who said: “[I noticed I had a] greater difficulty empathizing, when you heard the story thousands of times...I sometimes get bored with things that are so grueling, and I would rather not be sitting through 45 sessions carrying people through.”

Intrusion

The majority of participants (8/15) reported feelings of intrusion, such as bothersome thoughts of clients and their stories, vivid imagery of graphic scenes disclosed during therapy, and disturbing dreams about clients, and these were not so present in interpersonal settings. Of those participants who expressed experience with intrusion, the majority of them were from the CSA therapists (5/9).

Each group had a different way of describing the intrusion, where the general trauma therapists had more broad descriptions of the intrusion than the CSA therapists. P5, a younger general trauma therapist found that he was always speaking about his cases with his wife and, “sometimes my wife will comment ‘enough of this, let’s talk about

something other than therapy.'" The experiences of intrusion were not only at home, but sometimes even occurred during the therapeutic session. P11, a general trauma therapist who is a veteran and specializes in treating other veterans, said that during one session, "I got sucked into the story, I got stuck in my feelings and wasn't present for my client, and I couldn't bring myself back, and I couldn't even bring myself back." Some therapists reported that there is intrusion that occurs in atypical ways which then generates more traditional forms of intrusion. For instance P10, a general trauma therapist, said:

> One client I have worked with for 3-4 years, and she had multiple traumas, she started to stalk me, going to where my wife was, she asked me if she could talk to my wife, and when I said I wasn't comfortable, she got triggered, and then it got weird and I had to terminate. I got trauma from her, I'm not sure if that's VT or a standard trauma. My wife figured out who the client was because she kept walking around my house, and my wife noticed that I became emotionally distressed and put two and two together. I dealt with intense traumas before, and this never happened, I started [finding myself] eating my wife's cookies at night, directly related to when the woman was stalking me.

However, those therapists who primarily treated CSA had much more intense experiences of intrusion in their interpersonal lives. P7, who specializes in treating sexual acting out, told me, "I do notice the effects of a heavy day on my interactions with my children, I need self-care, I need to chill, I can't just go from the frying pan to the fire."

Detachment

While not many of the participants reported experiences of detachment (5/15), the majority of those that did, were CSA therapists (4/5). Most of their descriptions of detachment took place in interpersonal settings and primarily within their therapeutic interactions with clients. Their expressions of detachment were described in either one of two ways: either as a reluctantly accepted deficit in their therapeutic engagement with clients or as a goal that they strive for in order to prevent VT. P2, a general trauma therapist described it as the latter, "…I find it easier to avoid the other symptoms by just detaching." A second respondent, P4, who is a CSA psychoanalyst said that he experiences, "Disassociation, which is the enemy of treatment, but you need it in order to disentangle what they are telling you." This psychoanalyst also explained his detachment as a requisite element of therapy and that he experiences, "Evacuation that occurs when working with people, you have to give in to it when working with people, I feel a sense of indifference."

Some of the participants say that they are learning to live with detachment in therapy, like P13, who said, "I became used to it, it was more shocking and hard to sit with in the beginning, but then I learnt my limits and that thinking about it doesn't help, you kinda desensitize, depersonalize." P15, a CSA therapist who described his experiences with detachment as part of his answer to interview question #10 said he feels:

> Dissociation, bored, less focused, less empathically entuned. More distracted, less fully entuned, maybe even a subtle resistance to affect, I notice these subtle shifts, I notice that I am getting more bored, wanting to distract myself, I thinks it's more

about the amount of hours I work, it doesn't help that all I hear is human tragedy and suffering all day, every day.

Intrapersonal expressions of VT

Avoidance

Although avoidance is most often expressed as an urge to avoid interpersonal interaction, there were a few expressions of avoidance in an intrapsychic sense, where the therapist himself felt this powerful need to avoid anything related to therapy and even silently yearning for a break from the onslaught of trauma cases. P5 responded to interview question #10 that he feels:

> Avoidance, sometimes I feel myself being a little burnt out, feeling relieved when the client cancels. I don't think that's related to trauma, as much as it is burnout from the work. I think I am affected by my clients, sometimes the work can burn me out. It's not from their stories or their trauma [per se], but if [when] we look at how their trauma affects them.

Another expression of avoidance was noted in passive ways, as an emotional fatigue, where sometimes the therapist just gets wiped out from emotionally engaging with trauma clients all day. P7, a CSA therapist explained that he experiences, "…fatigue, when people call me to discuss a case, I feel fatigue, I already dealt with that the whole day and I don't have the energy to deal with it."

A few others also described a physical tiredness, being worn out by a long day of emotionally extending oneself with clients. P4, a CSA psychoanalyst said, "like when I finish, I often have to lie down, I have a sense of exhaustion."

Intrusion

Many of the respondents said that they experience a lot of intrusion from treating trauma clients (8/15). Of the eight participants who reported experiences of intrusion, the majority of them were CSA therapists. Some participants spoke of intrusion in more general terms such as P14, "Sometimes I think about client stories especially when they were particularly horrible" and others said something similar to P8's answer to interview question #10:

> The second thing is that a lot of the descriptions of what the guys tell me are pretty horrific, I definitely had nights having a hard time falling asleep because of what I heard. Intrusion, really sad and uncomfortable thoughts about [what I hear].

Even one of the general trauma therapists, P11, provided a vivid description of intrusion such as,

> Like one time I had a 22-year-old mother whose 3-year-old drowned, and I thought of my own child, the details of the case, how the child changed from warm to cold and blue. That description bothered me for days, I had dreams. I imagined it as my own child and I could feel my child's skin becoming cold.

This ends the descriptions of the male therapist's lived experience with VT and how it affects them in interpersonal ways. It is important to note that these experiences are specific in the sense that they occurred in relation with other people. The next few paragraphs describe the male therapists' interpersonal ways of managing VT, again, particularly in relation to other people.

Coping Methods

There were four primary themes that emerged from their responses about coping with VT. The first theme was the incredibly high level of perceived self-competency that the participants expressed when they were asked interview question #11: "How would you describe your ability to minimize the risk of vicarious traumatization?" The overwhelming majority of participants (14/15) responded with "good" or "very good." This theme was coded as male self-enhancement and was the biggest and most penetrating insight of the study.

The second and third themes materialized from the responses to interview question #12: "What skills or techniques were effective to help you minimize your risk of vicarious traumatization? Why?" The majority of respondents said that they engage in some sort of supervision with either an individual or with a group (14/15). A smaller but still significant portion of respondents said that they managed VT using spirituality (9/15). This was divided into two subthemes as different respondents described different forms of utility from spirituality. The two subthemes are (a) meaning and purpose, as well as; (b) support, which corresponded with the emergent patterns within the participants' responses.

The last and most insightful theme came from the responses to those interview questions as well as the last three interview questions, #14, 15 and 16, which asked about support systems in personal and workplace settings. This final theme of male coping mechanisms was "disconnecting." as the majority of participants answered that they either create personal space, forget the world, or separate from treating trauma (14/15).

Male Self-enhancement

I coded the first theme as male self-enhancements, after Taylor's seminal theory of positive illusions, which posits that humans actively create a more optimistic perspective of themselves and their abilities than reality would suggest (Taylor, 1983). Taylor refers to this phenomenon as self-enhancement, where people utilize self-deceptions to help them cope with potentially overwhelming adversity (1983). I came to this conclusion because of the negative response that the majority of respondents (13/15) gave to interview question #9: "Have you received training on vicarious traumatization?" It seemed odd, because these professionals have only earned their degrees and licenses in order to treat others through research, education, and empirically-based skills and techniques. How could they consider themselves so efficient at something that they have never received formal or research-based training for? This could be a form of what Taylor describes as positive self-deception or self-enhancement.

There are a few alternative explanations for the atypically rosy picture of the participants' affirmation and confidence in their ability to manage VT. The first is the simplest, that maybe this self-selective sample represents the elite of trauma therapists who want to share their success at managing VT and they really in actuality are all good or very good at managing VT. A more culturally aware answer can be that many participants may have responded with a flippant or generic "good." Almost like the default response to the Western greeting, "How are you?", where the response of "good" isn't a definitive indication of the positive well-being of the respondent. However, this would imply that the responses and results of these therapists who were involved in a

deep and intimate exploration of VT were less than accurate or potentially dishonest when sharing about their experiences with VT and VT management.

Positive illusion or optimism in the face of adversity is built upon three pillars that Taylor (1983) identified; meaning, mastery, and self-enhancement. Meaning describes the causal attributions that people use to understand why they are experiencing their adverse experience and the implications that the threatening event has on their life now. Mastery refers to the efforts people make to try and gain control of the challenging experience. Self-enhancement is the effort to restore the sense of self and self-esteem through self-deceptive thoughts that people use to comparatively assess and describe their own positive ability to manage the adversity.

P15 is a renowned expert on trauma and not only attended but also provides, training on managing VT. He responded to interview question #11 with a sardonic laugh and explained:

> Ha ha, I don't want to be one of those therapists who says that he is amazing at self-care and VT management yet is totally naive, but really I think I am way above average, in terms of capacity, not necessarily always in the ideal form, I have very strong defenses to be able to turn inwards to handle stress, difficulty, but in a little of a, a very powerful ability to put up a wall. Much less likely than many of my colleagues to have nightmares, and burst into crying, feel overwhelmed, given that ability, there is a greater capacity for, a trend for "pulling away" from that fully empathically engaged connection, I feel less likely to be pulled into complete empathetic engagement.

> I believe that there are more protective factors, I am more intelligent and have deeper training and personal experience in the process of healing and working through issues, I can handle the challenges, vicissitudes, setbacks, relapses, better than most. I think that over time, moving dramatically away from my training of trying to be a blank screen to being very real raw open, both in therapy and with others about what is going on is a very protective factor.

It seems like this respondent may also strongly suspect his colleagues and/or other participants of being naïve or perhaps engaging in some sort of self-deception about their ability to manage VT. P9, another doctoral level therapist, responded to interview question #11, which asked the respondent to describe his ability to manage VT,

> Very good, because of my training, very scientific-based cognitive behavioral modality creates boundaries to prevent transference, very specific goals in treatment and constant focus on boundaries, the script of CBT is very specific and helps avoid these enmeshments. As opposed to more psychodynamic modalities have a hard time separating where the client ends, and they start.

This participant is creating causality between his treatment modality of choice and his higher than average ability to manage VT. Similarly, P11, who wrote his dissertation on VT and CF, explained that he is very good at managing VT because,

> I try to depersonalize, to work the problem, because it's really easy to get sucked into the story. I try to think of the structure of the problem, instead of the content. Through my training, which is to "work the problem, not the story."

P7, a masters level clinician, reflected a little more inwards and elaborated why he thinks he is very good at managing VT:

> I am very good at noticing and accepting my own feelings, but if and when I am empathetically engaged with a client, I do feel it, there is some activation, with/from the clients, and when I am aware of that I take some time to analyze and process some space for myself, at the end of the day before I go home (I wish I could do it between clients).

The meaning and mastery theme is repetitive, as many of the respondents found an attributable rationale for their perceived competency at managing VT. Out of the entire sample size, only two therapists said that they received VT specific training, and only one therapist said he does not experience any symptoms of VT. Yet almost 90% of the respondents said they are "good" or "very good" at managing VT.

Supervision

Supervision has always been a sacred cornerstone of successful self-care and it was reassuring to see that the results of this study replicated that time-tested wisdom. For the purposes of this study, supervision is defined as a process where cases are reviewed by an objective and knowledgeable person. This definition of supervision includes the traditional consultation with a more experienced supervisor in a mentoring role, but also reviewing cases with colleagues and peers.

P4, a psychoanalyst with over 30 years of experience, said supervision is absolutely critical for successful trauma work and that he uses, "supervision twice a week, makes me very happy, I can't do the work without it." P6 strongly emphasized the

benefit and utility of supervision, as did P12. They were referring to the traditional role of the individual mentor. Others also emphasized the benefit of the traditional model of supervision and elaborated on the additional benefits that supervision offers. Not everyone pursued supervision strictly to prevent and manage VT, rather some viewed supervision as a way to learn skills, specialize, and climb the career ladder, as P8 said, "The way you specialize is through supervision and training, my primary training was from my supervisor." Other participants echoed this idea that supervision was where one really learned the art of therapy as P15 said, "I learned nothing in school. [I] learned most of what I know in supervision."

Some participants, like P8, maintained both peer consultation and the traditional model of supervision; "my supervisor is invaluable, we have been meeting every week for 7 years. I kept it on despite it not being required to after the first 3 years." P8 also explained why he utilizes peer supervision as well,

> The fact that I am part of a practice where everyone deals with this, is super supportive. Peer supervision is super important, helps process things that are very heavy. I also supervise 2 other guys, talking it out with them is also healing, because it is validating that I hear others going through the same things. My colleagues are the biggest one [help], I talk to them a lot, especially the ones who are involved in trauma work, I feel they really get it. Guys I hadn't known before, that I met through the therapy world. Not just regular colleagues, specifically the ones I became friends with, close to.

Most participants described the utility of just speaking it over with another informed professional and stressed the benefits of peer supervision. P6 said that peer supervision is helpful even in informal ways, “having friends who are therapists and speak the language [helps].” This was mentioned by P2 as well who said, “Talking it over with colleagues in work, peer support which is more informal [was helpful].”

P5 said that informal consultation with peers beats the alternative, which is isolation, “just talking about a case with another therapist helps, being isolated with it makes it worse, I try not to be isolated, I don’t do that for preventing VT per se rather as a tool for clinical efficacy.”

Even though almost all of the participants mentioned the use of supervision, not everyone had such favorable impressions or utility with informal supervision, as P1 said, “my supervisor is very systematic and managerial, meets once a month, rather than [real] supervision [it was] superficial not very helpful, very collegial, not so professional, casual.”

Spirituality

A slight majority of the participants said spirituality helped them manage VT (8/15). I defined spirituality very broadly for the data analysis of this study. Spirituality can include anything from a belief in a supernatural power or a greater-than-self concept, to the more traditional sense, as religion and religion-based dogmas or practice. The participants said that spirituality and religion provided them with purpose, support, and meaning. I made each of those into a subtheme in order to give clarity to each element of this overarching theme of spirituality.

Purpose

The first subtheme referred to the experience that many therapists described in varying forms, as finding and creating purpose or personal growth from treating trauma clients. P11 said that,

> Spirituality is also important, knowing that there is a reason. Someone once told me "God gave you to me" and I thought about it and it makes sense to me, it's kinda helpful to use spirituality. I believe there is a higher reason for why this happens.

Many defined spirituality as a specific religious outlook, belief, and practice which gave them an overarching sense of purpose in life both in and out of therapy. P5 said that his religion's practice and beliefs are not just useful for himself, but even helped him curate therapeutic alliance:

> Religion is very important, religious servicers and activities give my life a lot of meaning and purpose. I identify as an orthodox Jew, learning Torah, I give a shiur which is very important and meaningful [to me], Orthodoxy is about growth mindset and it's hard but meaningful and gives me purpose. It's not all about work, there's other things that give my life purpose and meaning. A lot of my worldview as a therapist is influenced by my religious view and Torah learning, I know that I get tools for helping people based on my Judaic knowledge and people comment about me being an orthodox Jew, using that to connect with clients, even those who aren't religious, with universal themes of religion and how it helps people.

Support

Some participants explained that spirituality, in its various forms, provides them with support, sometimes just through ideology and other times through physical rituals and processes. P9 said, “I do find religious practice to be a support,” and P13 elaborated on his utility of religious practices as support, saying that he does a lot of,

> praying, meditating, I meditate while I pray. Sometimes I feel like God talks to me through the texts, there is a mystical connection I get with the text and with God that are very meaningful for me. [Follow up: How does this learning and praying/connection with God help you prevent or manage VT?] It helps me to trust myself, my intuition and my internal processes.

P1, the youngest participant said, “I do energy stuff, I do rituals to create a space between me and my clients” and “I am very into Kundalini yoga, [it’s a great support for me].”

Meaning

The last subtheme of spirituality was the inspiration and meaning that male therapists found in treating victims of trauma. Many said that finding meaning in their work is very important for them. Participants said this pursuit of meaning gave context for the therapy they provide, and shared two different kinds of frameworks; one was finding meaning in their client’s stories and pain, such as P15, who said that, “I try to use a religious spiritual frame to ease perspective, give meaning, and purpose to what clients are going through and my role.” The other context was to use the experiences from

therapy sessions to provide the therapist with meaning outside of the office. As P6 explained,

> I also give shiurim (sermons), which helps mitigate my VT because I get to talk about my clients and turn what they are going through into s/t meaningful. It's helping me to take everything I experienced and take from my clients and do something with that. It's been very very helpful for me.

The majority of participants described pursuing meaning in terms of professional fulfillment, such as finding meaning in or from providing therapy. However, P13 said that it was helpful for him to find meaning in his life independent of therapy; "It's not all about work, there's other things that give my life purpose and meaning" and P15 said that, "I personally turned towards certain mindfulness and meditation." This theme aligns with the theory of self-enhancement, where people pursue and create meaning within and from their adverse or threatening life experience (Taylor, 1983).

Self-care Practices

Self-care is considered a universally accepted, almost gold standard of requisite behavior to prevent and manage VT. Almost all of the respondents shared descriptions of self-care methods that they utilized to prevent and manage VT.

A few participants even expressed this deeper understanding of self-care as a concept, rather than just behaviors or rituals. P13 spelled out an aspect of this distinction when he critiqued what he considered the colloquial and common conception of self-care, "I never found the self-care thing to be a lot of help, just read a book or go to the beach,

take a day off wasn't so helpful." P15 spelled out a similar critique of the more skill-based self-care techniques, what these therapists refer to as a kind of superficial self-care,

> I think general "skills" are sorely lacking, most skill-based self-care is extremely limited, if it works, I think the placebo effect is what is doing it. The most important things are the empathy, targeting the shame components that come along with this, dealing with the underlying issue is what is best, interpersonal healing is what is most potent. The bedrock is that stories are shared in loved and caring spaces. I think outside factors are also relevant.

Overall, the participants expressed many different versions and variations of self-care, ranging from skill-based techniques to more conceptual models of self-care. Originally, I had coded each specific form of self-care activity as independent themes, like physical exercise, or mindfulness. The distinctions melted away as I realized the common core that threaded through all of these activities. These therapists weren't just performing the rituals of self-care, rather, they were engaging in a cycle of emotional and psychological rejuvenation by disconnecting.

Disconnecting

Sometimes the very act of disconnecting allows the therapist to reconnect, whether it is with family, friends, and especially, with himself. Disconnecting allows for reflection, depth and reconsolidation of the self. This was the second greatest finding of this study, which was the utility that many male therapists found from disconnecting, and deeper benefit that came from disconnecting from trauma to reconnect with the self. This theme inspired a theory that male therapists utilize self-care techniques to seek sanctuary

in themselves. This means that each of them used different techniques to disconnect from trauma therapy and find unique paths towards meaning and personal purpose.

This theme of disconnecting was divided into the various ways that the therapist created that disconnection, and the subthemes are: creating some sort of personal space, taking breaks, and forgetting the world. Each subtheme is elaborated upon below.

Creating personal space

The overwhelming majority of therapists reported that they found it helpful to create personal space (14/15). Some therapists said that they even create some sort of personal space within themselves during therapy. P7 said,

> I am very good at noticing and accepting my own feelings, but if and when I am empathetically engaged with a client, I do feel it, there is some activation, with/from the clients, and when I am aware of that I take some time to analyze and process some space for myself, at the end of the day before I go home (I wish I could do it between clients).

P1 said he utilizes rituals and even physical objects to create some sort of space before and during therapy,

> I do rituals to create a space between me and my clients, during therapy I carry an item or rock, ornament to hold their feelings, where the energy goes there instead of towards me and I also visualize myself being shielded with a white light before I meet them.

Another therapist creates that space in his mind by depersonalizing and keeping himself removed from the trauma story, as P11 said,

> I try to depersonalize, to work the problem, because it's really easy to get sucked into the story. I try to think of the structure of the problem, instead of the content. Through my training, which is to "work the problem, not the story."

P1 echoed that concept and similarly said, "For me it's a story, it may be true or not, but it's a reality I could live with when I'm with you." This concept of removing oneself during therapy was also expressed by P15 when describing his ability to handle VT,

> I think I am way above average, in terms of capacity, not necessarily always in the ideal form, I have very strong defenses to be able to turn inwards to handle stress, difficulty, but in a little of a, a very powerful ability to put up a wall. Much less likely than many of my colleagues to have nightmares, and burst into crying, feel overwhelmed, given that ability, there is a greater capacity for, a trend for "pulling away" from that fully empathically engaged connection, I feel less likely to be pulled into complete empathetic engagement.

Taking breaks

Another element of disconnecting was taking breaks, where the real utility came from the psychological and sometimes physical separation from treating trauma. Creating a separation between work and personal life has been extremely helpful as P15 explained, "There are certain things, such as shutting off at times, and consciously distracting, and setting very strong boundaries in terms of when I work, how many clients I see, have all been very important." Another respondent, P4 stressed the importance of creating boundaries to build a break in the day, "I have never maintained evening hours, this way,

my day ends. And I can start again tomorrow" as did P11. P10 said that, "I take very good care of myself," and upon follow up shared that he utilizes many various physical forms of creating separation, "I go skiing, I do a lot of outdoor sports, a lot of mindfulness, especially in the outdoors." P12, who also takes a weekly day off to hike said that, "It takes you out of your own mind and see it objectively for what's going on. I take a day off every week to hike…." P1 said that he uses Kundalini Yoga, and mindfulness to take a break from treating trauma. Two doctoral level therapists, P9 and P15 said that they also use mindfulness and meditation.

P13 critiqued the common usage of skill-based self-care, and asserted that effective self-care is more about creating a mindset where the therapist can effectively disconnect,

> …if it's about leaving it at the door, that helps. When I walk out of the door, I leave it there, my work is my work, and my life is my life. To me self-care means emphasizing the work life balance, not so helpful to just say take a break. It's more like having a mindset of "that's not me."

P8 said that he needed to take a real break by teaching university courses in order to lighten the pressures of treating trauma,

> I think that at one point when I was seeing a lot of trauma cases, it became too much, more like compassion fatigue, instead of VT, and my self-care behaviors weren't sufficient enough. I started teaching a clinical class, to give me a change of pace, a different part of routine, I shifted from being a purely trauma therapist

> so that it isn't so intense. I give my-self breaks. Days or parts of days, that I can do non trauma or not therapy related..."

Forgetting the world

The final subtheme of disconnecting was when participants said that they purposely sought to forget the world. There were a few different ways that this was accomplished, some by more mental activities like meditation and mindfulness, but also specific hobbies that were particularly good for zoning out, letting go, or forgetting the world. Zoning out was described by P11 who explained,

> At the end of the day, my wife gives me half an hour of not talking to me, to give me space where I watch an old TV show, just decompression with a mindless activity. I think it helps me compartmentalize and process.

P11 elaborated how this process helps him manage VT because,

> As people tell a story, we apply our own meaning, like we imagine our own dog, so when things come cup I talk it over with my wife or friends, so for me letting my mind rest helps me process the events of the day. The processing happens mostly on the unconscious level.

This idea of letting oneself go, engaging in a total mindless activity where one can just let loose, was also expressed by P15 who said, "I take long baths" and P2 who said that he became a, "big foodie, because it's just me and the food, and food doesn't talk back to you, and also no one's life is in the balance." P10 said that going for hikes was helpful for him and P12 said, I take a day of every week to hike or chill." Other therapists said that they find normal social experiences are also helpful, like P1, aged 25,

who mentioned partying with friends and alcohol, and P9, aged 49, who said, “jogging, reading, religious practices, and a good beer every once in while.”

Running or using physical activity to disconnect and let go was expressed by P11 who said, “I exercise every day, I run 5 miles, I put my headphones on and just go, I forget everything I just heard.” P1 said that he gets a similar rush of mindless release when going for a spin on his motorcycle. P12 said that, “I bought a convertible, driving around, top down, my kids love it, my wife loves, everyone loves it.”

But not everyone was trying to space out or shut their brain off, as P5, P6, P8, P13, P14, and P15 all said that they found in-depth Talmud study or scientific research to be helpful, which indicated that some of these therapists utilized self-care practices to not just run away, rather to focus on their personal pursuits. Some said that the utility came from regaining their sense of self, and others said that engrossing themselves in the literature was fun, exciting, and part of their identity as a therapist and a healer.

The personal pursuits that were effective to help stave off VT were not limited to purely intellectual exercises, but could even come from other mindfulness-like activities, as P1 described how gardening was helpful to disconnect from trauma treatment and ground himself,

> I find that planting helps ground me, the feeling of the dirt, it makes me realize that trees are savage mofos, waiting for you to die and feed them, [it’s the] circle of life, it’s very grounding and cathartic.

Discrepant cases

All of the therapists included in the study were licensed which was critical to determine adequate experience. There was nothing abnormal or any outliers within the data.

Summary

Regarding the first research question, the results indicated that male therapists primarily struggle with two specific symptoms of VT, avoidance and intrusion, more than the other commonly recorded symptoms such as hyperarousal and negative changes to cognitions. These symptoms were found in both categories of human interactions, interpersonal and intrapersonal.

The second research question explored the way that male therapists cope with or manage their VT symptoms, which according to the results of the study are primarily avoidance and intrusion. There were four salient themes that emerged; a sense of self-enhancement, supervision, utility of spirituality, and disconnecting from trauma. These were categorized into two distinct conceptual strata. The first strata is male self enhancement, which contained the first salient theme, which was that 95% of the participants said that they were “Good” or “Very Good” at managing VT despite acquiescence of experiencing unwanted symptoms of VT. The second strata is disconnecting in order to reconnect, labelled as seeking sanctuary in self. This contained four of the most frequent themes; supervision, utility of spirituality, and disconnecting from trauma. Supervision and spirituality provided both the colloquial and literal meanings of the word’s guidance and direction, as well as a sense of personal validation.

This helped the mental health provider recalibrate and reenergize. The last theme was further broken down into more basic units of meaning, which were the unique ways that the participants sought and maintained that disconnection from trauma. These were to create some sort of personal space, forget the world, and seek some separation from treating trauma.

Research Q1: What is the lived experience of VT for male therapists?

The most salient symptoms that were articulated by the participants were avoidance and intrusion, which were expressed in both interpersonal and intrapersonal manifestations. The majority of participants who primarily treated CSA reported the highest levels of avoidance, but only around half of them reported symptoms of intrusion, detachment and hyperarousal.

Research Q2: What are the coping skills of male therapists who experience VT?

Overall, the participants expressed many different versions and variations of self-care, ranging from skill-based techniques to more conceptual models of self-care. Upon closer examination, patterns emerged that indicated that there was a deeper meaning to the varied self-care techniques that the male therapist used, which was to disconnect. The disconnecting was done in pursuit of reconnection, a reconnection with others and self. The way that male therapists engaged in these practices lent itself to two major insights from the results of this study: the theory of male self-enhancement and the theory of sanctuary of self.

Male Self Enhancements

One of the ways that people respond to extreme adversity and trauma is to find meaning and purpose in the pain, using it as a cloak to gird themselves in greater strength and live with a renewed sense of satisfaction and happiness (Taylor, 1983). This study builds upon these foundations and combines with Taylor's theory of cognitive adaptation to provide a more profound way of understanding how male trauma therapists utilize a self-enhancing perception of their abilities to manage VT.

Taylor found that people utilize these self-deceptions in order to provide themselves with hope and purpose in the face of potentially overwhelming adversity. These practices provide an adequate form of coping during the trying times that contributed to the development of this illusory and wishful thinking. People use social comparison when they are challenged in order to maximize information and positive self-perceptions (Taylor & Lobel, 1989). What has happened is that more often than not, these self-deceptive thoughts and beliefs generate fruitful and healthier physiological outcomes as indicated by studies of this phenomenon in medical models (Taylor, Lerner, Sherman, Sage, & McDowell, 2003). The underlying mechanics of this process are self-preservation in times of threat and the illusion of control and potential mastery to enhance the individual's capacity to resolve and thrive despite potentially overwhelming adversity.

Sanctuary of Self

The male therapists who use mindfulness and exercise as their coping mechanisms are all striving for the same holistic and eternal goal of sustaining their sense

of self. Almost all of the therapists said they share the horrors of therapy with others, such as supervisors, colleagues and spouses. What is unique in the descriptions of their lived experience of VT and management techniques, is that they are not unloading out of weakness, as many clarified that they practice restraint when they vent to others who aren't mental health professionals. Something much deeper is taking place.

The male therapist isn't just pouring his pain onto his colleagues and spouse, he is creating meaning from the mayhem of human misery; he is finding his truths within the terrors of treating trauma.

The male therapist is a warrior, he is fighting not just for the health and wellbeing of his clients, but also for his own sense of self. This combat takes place beyond the frontlines of human interactions but also within the mind of the male therapist himself, as he battles for the high ground of meaning and personal purpose.

All of these self-care techniques are not just means in and of themselves, they are part of a concerted effort to create and build a sanctuary within the self. This is happening in almost every act of self-care, the mindfulness, the supervision, the physical exercise, these are all elements of the battleplan to build and fortify the male therapist's sense of self. The jogging male therapist isn't merely running away from the trauma he treats, he is also running towards the sanctuary of himself.

This concludes the results of this study and the next chapter will explore how these data fit into the world of extant literature on VT and VT management. Chapter 5 will continue with a discussion of the interpretation of the findings, limitations of the study and recommendations, as well as the implications for positive social change.

Chapter 5: Conclusion

Introduction

The study was conducted to explore how male therapists experience VT and how they manage or prevent VT. This included how VT affects them both in therapy and their personal life. The investigation utilized a phenomenological approach in order to comprehensively explore the lived human experience and the underlying cognitive and emotional processes of this under-researched population. The goal of this research was to gain a deeper understanding of how male therapists experience and manage VT in therapy and their personal life.

This study found that the overwhelming majority of participants experienced inescapable situations of avoidance, and a slight majority also experienced intrusion. VT symptoms were much more present within the subgroup of therapists who treated CSA. The vast majority of CSA therapists experienced avoidance, a little over half also reported symptoms of intrusion and detachment, and less than half reported hyperarousal. Both groups of therapists expressed high levels of self-competence at managing VT despite not receiving VT specific training. Both groups utilized an extensive array of self-care methods, perceptions, and behaviors to manage VT. Despite all of their efforts for and perceived self-efficacy of self-care, the majority of therapists still reported experiencing symptoms of VT.

How could all of these therapists say that they are so good at managing VT when they are clearly experiencing avoidance and intrusion both in and out of therapy sessions? The resulting discrepancy indicates that male therapists are utilizing self-enhancement to

cope with the strain of VT. This doesn't mean that their self-care regimens are ineffective, au contraire, the vast majority of respondents seemed happy and seem to be doing well. The self enhancement could be an operative and helpful part of the equation and contribute to their ability to manage VT. Armor and Taylor (1998) explained that unrealistic optimism is associated with positive outcomes and could be because people facing adversity use self-deception to retain the requisite psychological resources for effective goal-setting and coping methods. Creswell et al. (2005) showed that social cognitions of self-enhancement, feelings of mastery, and/or unrealistic optimism can precipitate psychological effects on well-being. This was very apparent in the results of this study, as the participants expressed their descriptions of mastery, meaning, and self-enhancement.

This occurred when the overwhelming majority stated their self-enhancement regarding their ability to manage VT. Each respondent attributed their mastery of VT management because of their specific self-care procedures, preferred therapy style, or personal attributes. Next, the respondents reported finding meaning and purpose in their VT experience and the way they attempted to manage VT. Finally, the majority of respondents expressed an unrealistic optimism about their abilities to manage and prevent VT despite the universal occupational hazard of treating trauma and their own admissions of unavoidable VT symptoms in their life. I labelled this new form of cognitive adaptation and this contextual optimistic illusion, as male self-enhancement, and it provides a comprehensive explanation to the discrepancy in the participants' reported results.

Interpretation of the Findings

The participants descriptions of their lived experience helped provide insight and understanding that addressed both research questions.

Regarding the first research question, the results indicated that male therapists primarily struggle with two specific symptoms of VT, avoidance and intrusion, more than the other commonly recorded symptoms such as hyperarousal and negative changes to cognitions. These symptoms were found in both categories of human interactions, interpersonal and intrapersonal.

The second research question explored the way that male therapists cope with or manage their VT symptoms, which according to the results of the study are primarily avoidance and intrusion. There were five salient themes that emerged; male self-enhancement, to create some sort of personal space, personal validation, forget the world, and seek some separation from treating trauma. These were categorized into two distinct conceptual strata. The first strata is male self enhancement, which contained the first salient theme, which was that 95% of the participants said that they were “Good” or “Very Good” at managing VT despite acquiescence of experiencing unwanted symptoms of VT. The second strata is disconnecting in order to reconnect, labelled as seeking sanctuary in self. This contained four of the most frequent themes, which were to create some sort of personal space, personal validation, forget the world, and seek some separation from treating trauma.

This study disconfirmed three previously reported aspects of male responses to VT and confirmed three concepts already in the extant literature. The most important

upset was the disconfirmation of the widely held stigma about males and their hesitation to seek help out of fear of seeming weak, or vulnerable. Baum and Moyal (2020) had stated that men have a stigma against talking about stress from trauma work, yet the overwhelming majority of the study respondents reported seeking help and/or venting to multiple sources, such as spouses, colleagues, supervisors and even the other staff members who rent office space with them. None of them expressed any current feelings of shame or stigma regarding sharing or reaching out to others for emotional help. If anything, many participants were proud of the support systems they developed and rely upon for emotional support.

This study also disconfirmed what Van Deusen and Way (2006) said about male therapists reporting more cognitive disruption and limitations in their ability to trust others and engage in intimacy. This study found negligible reports of limitations to trust and intimacy. Only a few respondents described disrupted cognitions about self-esteem and self-intimacy as reported by Way et al. (2007).

The findings of this study confirm what previous studies have reported about the inevitable negative side effects that treating trauma can have on the therapist (Figley & Ludick, 2017; Pirelli et al., 2020). Pirelli et al., asserted that there is no such thing as a mental health clinician who is not exposed to trauma and is not negatively affected by it. This sentiment was also expressed by Figley (2002) regarding secondary traumatic stress and compassion fatigue, where he said that “the very act of being compassionate and empathic extracts a cost under most circumstances” (p. 1434). This idea was confirmed

by the findings of this study, as Figley and Ludick aptly noted, VT is an occupational hazard of professionally caring (2017).

This study confirmed what Baum and Moyal (2020) found, which indicated that male therapists experience a high amount of avoidance and intrusion symptoms. The results of this study were filled with expressions and experiences of avoidance and intrusion. Another important VT concept that this study confirmed was the critical importance of setting boundaries; this was emphatically stressed by Pirelli, Formon and Maloney's recent review of the extant literature on VT (2020).

The results of the study supported the theoretical bases of this study and of VT, which was CSDT, and how people form their own perceptions of the world based on their subjective experiences. Saakvitne (2002) elaborated that it is very helpful for therapists to prevent VT by transforming their VT into meaning, similar to what Frankl proposes in logotherapy (1959). The participants were actively creating a perception of VT that was congruent with their unique experience and ontological outlook. The male therapists utilized positive self-perceptions, perceptions of control, and unrealistic optimism to create their own reality. As research indicates, the results of this cocktail of self-deceptions are generally positive for mental and physical health (Taylor, Lerner, Sherman, Sage, & McDowell, 2003). They ascribed their own reasons and rationales for why they were so much better at managing VT then "everyone else", in effect creating a subjective reality where they really were effective at managing VT. This can also explain why the majority of participants did not describe so many expressions of negative changes to cognitions and hyperarousal. This is because they did not really see any

changes in their reality, as they could easily explain their experience with a personal logical narrative. Some of the participants in the study also shared similar experiences to what Frankl and Saakvitne stated, such as finding meaning both in and out of therapy and harnessed their VT to create meaning and personal productivity.

Limitations of the Study

There were three limitations of this study, one was within the participants, as three of the participants had under five years of experience. This was insufficient to create an independent subgroup within the study to discern subsequent effects on the results, which limits the transferability of the study from those with less than five years of experience. Another limitation in the transferability was that the population sample was self-selective. It could be that therapists who are not as confident about or as capable of managing VT did not reach out or feel comfortable to share an area of weakness. A final limitation of this study was the lack of other researchers in the study to provide a richer and more diverse array of perspectives and insight into the data and findings. Having more researchers could have added a greater level of diversity and depth in analyzing and understanding the collected data.

Recommendations

This study was not able to collect data on the complete personal history of the respondents. Pearlman and Saakvitne (1995) warn therapists who treat trauma that they must be very cognizant of their personal history and the ways that treating trauma can affect them. The literature is rife with the idea that therapists are statistically more likely to be the walking wounded, or as Taylor et al. call it, wounded healers (2019). CSDT

delineates the causative effects of trauma on the schema of the trauma therapists which is what generates the negative development of VT (Pearlman & Saakvitne, 1995). Accordingly, it would be very important to be able to determine any connections between specific events and occurrences in the personal history of the therapist who experiences VT. Further research can take a more holistic and long-term view of the trauma therapist, including but not limited to understanding what drew this person to the field of mental health and specifically, treating trauma.

Implications

This study offers a few powerful insights and additions to the extant literature on VT and VT management. There are three critical take-aways that emerge from the findings. The first implication for positive social change is on the organizational level, that the male therapist doesn't experience the exact same cluster of symptoms as female therapists. This is important for the relevant stakeholders who develop assessments and prevention protocols, as this study can inspire more accurate, targeted, and gender specific VT assessments.

The second implication for effecting positive social change is the realization that it is not impossible to overcome VT and even when it seems potentially overwhelming, there is another tool available: male self enhancement, which is to utilize unrealistic optimism, enhanced ability, meaning, and mastery in the battle against VT.

The third and final opportunity for positive social change is on a personal level, which is a new way of looking at disconnecting from trauma treatment. The findings of this study indicate a deeper insight into the mechanics of, and the potential purpose that

can be achieved through, disconnecting. One can engage in all of the popular skill-based self-care practices and harness all of those behaviors to contribute towards a more profound sense of purpose and self-actualization which can develop resilience and vicarious post traumatic growth (VPTG). This can be more easily accomplished if male therapists keep in mind that they are disconnecting in order to reconnect and recharge by seeking sanctuary in themselves.

Conclusion

This study provides effective insight and techniques for trauma therapists who are struggling with or afraid of developing VT. The results indicated that male therapists are more susceptible to avoidance and intrusion than the other major symptoms of VT. This study also provided practical applications for effective management of VT, to utilize the self-care theories and practices shared by these respondents. The theory of self-care that the majority found to be most helpful was to cultivate an identity that is independent of trauma work. The most effective self-care practices that the participants shared focused on developing and maintaining; peer support, personal therapy, and disconnecting to reconnect, which was accomplished by either taking time off, constructing boundaries, and creating personal space. Supervision was confirmed to be a critical factor in maintain clinical efficacy despite the threat of VT and provided a supportive factor for the majority of the therapists. A final theme that emerged from this study is the utility of cognitive adaptation which helped the therapists by providing meaning, mastery, and self-enhancement to seek sanctuary in themselves.

References

Adams, J. R. (2020). *A qualitative descriptive study on compassion fatigue with male mental health professionals who treat trauma survivors*. (Publication No. 27830553) [Doctoral Dissertation, Grand Canyon University]. ProQuest Dissertations and Theses Global

Almén, N., Lisspers, J., & Öst, L. G. (2020). Stress-recovery management: A pilot study using a single-subject experimental design. *Behavior Modification, 44*(3), 449-466. DOI:10.1177/0145445518825363

American Psychiatric Association, (2010). *Ethical principles of psychologists and code of conduct*. American Psychiatric Association. Retrieved January 14, 2014, from http://www.apa.org/ethics/code/index.aspx

Andren, S., & Elmståhl, S. (2008). The relationship between caregiver burden, caregivers' perceived health and their sense of coherence in caring for elders with dementia. *Journal of Clinical Nursing, 17*(6), 790-799.

Antonovsky, A. (1987). *Unravelling the Mystery of Health*. Jossey- Boss, San Francisco.

Antonovsky, H., & Sagy, S. (1986). The development of a sense of coherence and its impact on responses to stress situations. *Journal of Social Psychology, 126*(2), 213-226.

Aparicio, E., Michalopoulos, L. M., & Unick, G. J. (2013). An examination of the psychometric properties of the vicarious trauma scale in a sample of licensed social workers. *Health & Social Work, 38*(4), 199-206.

Babaei, S., & Haratian, M. (2020). Compassion satisfaction and fatigue in cardiovascular

nurses: A cross-sectional descriptive study. *Iranian Journal of Nursing and Midwifery Research, 25*(3), 212.

Baird, K., & Kracen, A. C. (2006). Vicarious traumatization and secondary traumatic stress: A research synthesis. *Counselling Psychology Quarterly, 19*(2), 181-188.

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

Bale, T. L., & Epperson, C. N. (2015). Sex differences and stress across the lifespan. *Nature Neuroscience, 18*(10), 1413.

Barcons, C., García, B., Sarri, C., Rodríguez, E., Cunillera, O., Parellada, N., ... & Ruiz, D. (2019). Effectiveness of a multimodal training programme to improve general practitioners' burnout, job satisfaction and psychological well-being. *BMC Family Practice, 20*(1), 155.

Barnett, J. E., & Cooper, N. (2009). Creating a culture of self-care. *Clinical Psychology: Science and Practice, 16*(1), 16-20.

Baum, N., & Moyal, S. (2020). Impact on therapists working with sex offenders: A systematic review of gender findings. *Trauma, Violence, & Abuse, 21*(1), 193-205. http://dx.doi.org. 10.1037/0033-295X.109.4.751

Benjamin, L. T. (2007). *A brief history of modern psychology*. Blackwell Publishing.

Benjet, C., Bromet, E., Karam, E. G., Kessler, R. C., McLaughlin, K. A., Ruscio, A. M., & Alonso, J. (2016). The epidemiology of traumatic event exposure worldwide: results from the World Mental Health Survey Consortium. *Psychological*

Medicine, 46(2), 327-343.

Bercier, M. L., & Maynard, B. R. (2015). Interventions for secondary traumatic stress with mental health workers: A systematic review. *Research on Social Work Practice, 25*(1), 81-89.

Blome, W. W., & Safadi, N. S. (2016). Shared vicarious trauma and the effects on Palestinian social workers. *Illness, Crisis & Loss, 24*(4), 236-260.

Bluth, K., Campo, R. A., Futch, W. S., & Gaylord, S. A. (2017). Age and gender differences in the associations of self-compassion and emotional well-being in a large adolescent sample. *Journal of Youth and Adolescence, 46*(4), 840-853.

Boulanger, G. (2013). Fearful symmetry: Shared trauma in New Orleans after hurricane Katrina. *Psychoanalytic Dialogues, 23*(1), 31-44.

Boulanger, G. (2018). When is vicarious trauma a necessary therapeutic tool?. *Psychoanalytic Psychology, 35*(1), 60.

Bourke, M. L., & Craun, S. W. (2014). Secondary Traumatic Stress Among Internet Crimes Against Children Task Force Personnel: Impact, Risk Factors, and Coping Strategies. *Sexual Abuse*, *26*(6), 586–609. https://doi.org/10.1177/1079063213509411

Brady, P. Q. (2017). Crimes against caring: Exploring the risk of secondary traumatic stress, burnout, and compassion satisfaction among child exploitation investigators. *Journal of Police and Criminal Psychology, 32*(4), 305-318.

Brand, S., Ebner, K., Mikoteit, T., Lejri, I., Gerber, M., Beck, J., ... & Eckert, A. (2020). Influence of regular physical activity on mitochondrial activity and symptoms of

burnout—An interventional pilot study. *Journal of Clinical Medicine, 9*(3), 667. doi: 10.3390/jcm9030667

Branson, D. C. (2019). Vicarious trauma, themes in research, and terminology: A review of literature. *Traumatology, 25*(1), 2.C140:C171

Branson, D. C., Radu, M. B., & Loving, J. D. (2019). Adverse childhood experiences scores: When social work students and trauma mix. *Journal of Baccalaureate Social Work, 24*(1), 339-360.

Bride, B. E., & Kintzle, S. (2011). Secondary traumatic stress, job satisfaction, and occupational commitment in substance abuse counselors. *Traumatology, 17*(1), 22-28.

Broomé, R. (2011). Descriptive phenomenological psychological method: An example of a methodology section from doctoral dissertation (pp. 1-23). Selected Works.

Bundy, W. L. (2020). Emergency medical dispatchers: PTSD and preventing it. *Crisis, Stress, and Human Resilience: An International Journal. 1*(4)192-213. https://www.crisisjournal.org/article/12208.pdf.

Butler, L. D., Carello, J., & Maguin, E. (2017). Trauma, stress, and self-care in clinical training: Predictors of burnout, decline in health status, secondary traumatic stress symptoms, and compassion satisfaction. *Psychological Trauma: Theory, Research, Practice, and Policy, 9*(4), 416.

Canfield, J. (2005). Secondary traumatization, burnout, and vicarious traumatization: A review of the literature as it relates to therapists who treat trauma. Smith College Studies in Social Work, 75(2), 81-101.

Carragher, N., Sunderland, M., Batterham, P. J., Calear, A. L., Elhai, J. D., Chapman, C., & Mills, K. (2016). Discriminant validity and gender differences in DSM-5 posttraumatic stress disorder symptoms. *Journal of Affective Disorders*, 190, 56-67

Coddington, K. (2017). Contagious trauma: Reframing the spatial mobility of trauma within advocacy work. *Emotion, space and society, 24*, 66-73.

Cosden, M., Sanford, A., Koch, L. M., & Lepore, C. E. (2016). Vicarious trauma and vicarious posttraumatic growth among substance abuse treatment providers. *Substance abuse, 37*(4), 619-624.

Creswell, J. (2014). Research design: Qualitative, quantitative, and mixed methods approaches (4th ed.). Thousand Oaks, CA: Sage.

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. Thousand Oaks, CA: Sage.

Dar, I. A., & Iqbal, N. (2020). Beyond linear evidence: The curvilinear relationship between secondary traumatic stress and vicarious posttraumatic growth among healthcare professionals. *Stress and Health, 36*(2), 203-212.

Diehm, R. M., Mankowitz, N. N., & King, R. M. (2019). Secondary traumatic stress in Australian psychologists: Individual risk and protective factors. *Traumatology, 25*(3), 196.

Dominey-Howes, D. (2015). Seeing 'the dark passenger'–Reflections on the emotional trauma of conducting post-disaster research. *Emotion, Space and Society, 17*, 55-62.

Donohue, M. (2020). Case Managers' Lived Experiences Working with Trauma Victims.

Eriksson, M. (2017). The sense of coherence in the salutogenic model of health. In The handbook of salutogenesis (pp. 91-96). Springer, Cham.

Eriksson, M., & Lindström, B. (2005). Validity of Antonovsky's sense of coherence scale: a systematic review. *Journal of Epidemiology & Community Health, 59*(6), 460-466.

Ezell, J. M. (2019). First, do no harm to self: Perspectives around trauma-informed practice and secondary traumatic stress among rural child protective services workers. *Journal of Child Custody, 1*-21. DOI: 10.1080/15379418.2019.1687061

Fansher, A. K., Zedaker, S. B., & Brady, P. Q. (2020). Burnout among forensic interviewers, how they cope, and what agencies can do to help. Child maltreatment, 25(1), 117-128.

Fenge, L. A., Oakley, L., Taylor, B., & Beer, S. (2019). The Impact of Sensitive Research on the Researcher: Preparedness and Positionality. *International Journal of Qualitative Methods*. https://doi.org/10.1177/1609406919893161

Feringa, A., & Wentzel, N. (2020). Smashing the stigma in mental health–a strategic blueprint for change. *The APPEA Journal, 60*(1), 10-18.

Figley, C. R. (1995). Compassion fatigue: Toward a new understanding of the costs of caring. In B. H. Stamm (Ed.), Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators (p. 3–28). The Sidran Press.

Figley, C. R. (2013). Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized. Routledge.

Figley, C. R., & Figley, K. R. (2017). Compassion fatigue resilience. The Oxford handbook of compassion science, 387-398.

Figley, C. R., & Ludick, M. (2017). Secondary traumatization and compassion fatigue.

Finklestein, M., Stein, E., Greene, T., Bronstein, I., & Solomon, Z. (2015). Posttraumatic stress disorder and vicarious trauma in mental health professionals.

Flannery Jr, R. B., & Flannery, G. J. (1990). Sense of coherence, life stress, and psychological distress: A prospective methodological inquiry. *Journal of clinical psychology, 46*(4), 415-420.

Foreman, T. (2018). Wellness, Exposure to Trauma, and Vicarious Traumatization: A Pilot Study. *Journal of Mental Health Counseling, 40*(2), 142-155.

Frankl, V. E. (1985). Man's search for meaning. Simon and Schuster.

Freedman, S. A., & Mashiach, R. T. (2018). Shared trauma reality in war: Mental health therapists' experience. *PloSone, 13*(2), e0191949. https://doi.org/10.1371/journal.pone.0194359

Geary, D. C., & Flinn, M. V. (2002). Sex differences in behavioral and hormonal response to social threat: Commentary on Taylor et al. (2000). *Psychological Review, 109*, 745–750.

Geyer, S. (1997). Some conceptual considerations on the sense of coherence. *Social science & medicine, 44*(12), 1771-1779.

Giller, E., Vermilyea, E., & Steele, T. (2006). Risking connection: Helping agencies embrace relational work with trauma survivors. *Journal of Trauma Practice, 5*(1), 65-82.

Giorgi, A. (Ed.). (1985). *Phenomenology and psychological research*. Duquesne University Press.

Giorgi, A. P., & Giorgi, B. M. (2003). *The descriptive phenomenological psychological method.* In P. M. Camic, J. E. Rhodes, & L. Yardley (Eds.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (p. 243–273). American Psychological Association. https://doi.org/10.1037/10595-013

Giorgi, A., Giorgi, B., & Morley, J. (2017). The descriptive phenomenological psychological method. In C. Willig & W. Stainton Rogers (Eds.), *The SAGE handbook of qualitative research in psychology* (pp. 176–192). London: Sage Publications Ltd..

Golafshani, N. (2003). Understanding reliability and validity in qualitative research. *The qualitative report, 8*(4), 597-606.

Gottfried, R., & Bride, B. E. (2018). Trauma-secondary, vicarious, compassion fatigue. In Encyclopedia of Social Work.

Grant, C., & Osanloo, A. (2014). Understanding, selecting, and integrating a theoretical framework in dissertation research: Creating the blueprint for your "house". *Administrative Issues Journal, 4*(2), 4.

Halevi, E., & Idisis, Y. (2018). Who helps the helper? Differentiation of self as an indicator for resisting vicarious traumatization. *Psychological Trauma: Theory, Research, Practice, and Policy, 10*(6), 698. https://doi.org/10.1037/tra0000318

Halpern, J. (2016). Maintaining helper wellness and competence in a shared trauma reality. *Israel journal of health policy research,* 5(1), 38.

Handa, R. J., & Chung, W. C. (2019). Gender and stress. In Stress: Physiology, Biochemistry, and Pathology (pp. 165-176). Academic Press.

Handel, S. (2009, October 18). *Awareness and action*. https://www.theemotionmachine.com/awareness-and-action/

Hardy, A., van de Giessen, I., & van den Berg, D. (2020). Trauma, Posttraumatic Stress, and Psychosis. In A Clinical Introduction to Psychosis (pp. 223-243). Academic Press.

Harker, R., Pidgeon, A. M., Klaassen, F., & King, S. (2016). Exploring resilience and mindfulness as preventative factors for psychological distress burnout and secondary traumatic stress among human service professionals. Work, 54(3), 631-637.

Hendron, J. A., Irving, P., & Taylor, B. (2012). The unseen cost: A discussion of the secondary traumatization experience of the clergy. *Pastoral psychology, 61*(2), 221-231.

Hensel, J. M., Ruiz, C., Finney, C., & Dewa, C. S. (2015). Meta-analysis of risk factors for secondary traumatic stress in therapeutic work with trauma victims. *Journal of Traumatic Stress, 28*(2), 83-91.DOI:10.1002/jts.21998

Hernandez-Wolfe, P., Killian, K., Engstrom, D., & Gangsei, D. (2015). Vicarious resilience, vicarious trauma, and awareness of equity in trauma work. *Journal of Humanistic Psychology, 55*(2), 153-172.

Hopwood, T. L., Schutte, N. S., & Loi, N. M. (2019). Stress responses to secondary trauma: Compassion fatigue and anticipatory traumatic reaction among youth

workers. *The Social Science Journal, 56*(3), 337-348.

Hunt, T. (2018). *Professionals' perceptions of vicarious trauma from working with victims of sexual trauma*. [Doctoral Dissertation, Walden University]. Walden University Scholar Works

Hyatt-Burkhart, D. (2014). The experience of vicarious posttraumatic growth in mental health workers. *Journal of loss and trauma, 19*(5), 452-461.

Idan, O., Eriksson, M., & Al-Yagon, M. (2017). The salutogenic model: the role of generalized resistance resources. In The handbook of salutogenesis (pp. 57-69). Springer, Cham.

Jones, C. T., & Branco, S. F. (2020). Trauma-Informed Supervision: Clinical Supervision of Substance Use Disorder Counselors. *Journal of Addictions & Offender Counseling, 41*(1), 2-17.

Joseph S., Sagy S. (2017) Positive Psychology in the Context of Salutogenesis. In: Mittelmark M. et al. (eds) The Handbook of Salutogenesis. Springer, Cham

Kang, J. H., & Yang, S. (2019). A Therapist's Vicarious Posttraumatic Growth and Transformation of Self. *Journal of Humanistic Psychology, 0022*1678198894 90.

Kang, X., Fang, Y., Li, S., Liu, Y., Zhao, D., Feng, X., ... & Li, P. (2018). The benefits of indirect exposure to trauma: The relationships among vicarious posttraumatic growth, social support, and resilience in ambulance personnel in China. Psychiatry investigation, 15(5), 452.

Kanno, H., & Giddings, M. M. (2017). Hidden trauma victims: Understanding and preventing traumatic stress in mental health professionals. *Social Work in Mental*

Health, 15(3), 331-353.

Karen W. Saakvitne Ph.D. (2002) Shared Trauma: The Therapist's Increased Vulnerability, Psychoanalytic Dialogues, 12:3, 443-449, DOI: 10.1080/10481881209348678

Keyes, C. L. (2014). Mental health as a complete state: How the salutogenic perspective completes the picture. In Bridging occupational, organizational and public health (pp. 179-192). Springer, Dordrecht.

Khalily, N., Ashfaq, W., & Saleem, T. (2017). The Unrelenting Media Exposure in Pakistan and its Link with Vicarious Trauma. Bahria Journal of Professional Psychology, 16(1).

Killian, K., Hernandez-Wolfe, P., Engstrom, D., & Gangsei, D. (2017). Development of the vicarious resilience scale (VRS): A measure of positive effects of working with trauma survivors. Psychological Trauma: Theory, Research, Practice, and Policy 9 (10), 23-31.

Klimley, K. E., Van Hasselt, V. B., & Stripling, A. M. (2018). Posttraumatic stress disorder in police, firefighters, and emergency dispatchers. *Aggression and violent behavior, 43*, 33-44.

Knight, C. (2018). Trauma-informed supervision: Historical antecedents, current practice, and future directions. The Clinical Supervisor, 37(1), 7-37.

Knight, C. (2019). Trauma informed practice and care: implications for field instruction. *Clinical Social Work Journal, 47*(1), 79-89.

Lawrence, M. (2017). Near-death and other transpersonal experiences occurring during

catastrophic events. *American Journal of Hospice & Palliative Medicine, 34*, 486–492. http://dx.doi.org/10.1177/ 1049909116631298

Lee, J. J., Gottfried, R., & Bride, B. E. (2018). Exposure to client trauma, secondary traumatic stress, and the health of clinical social workers: A mediation analysis. *Clinical Social Work Journal, 46*(3), 228-235.

Levin, J. S. (1996). How religion influences morbidity and health: Reflections on natural history, salutogenesis and host resistance. *Social Science & Medicine, 43*(5), 849-864.

Lewis, M. L., & King, D. M. (2019). Teaching self-care: The utilization of self-care in social work practicum to prevent compassion fatigue, burnout, and vicarious trauma. *Journal of Human Behavior in the Social Environment, 29*(1), 96-106.

Li, W., Leonhart, R., Schaefert, R., Zhao, X., Zhang, L., Wei, J., ... & Fritzsche, K. (2015). Sense of coherence contributes to physical and mental health in general hospital patients in China. Psychology, health & medicine, 20(5), 614-622.

Lindström, B., & Eriksson, M. (2005). Professor Aaron Antonovsky (1923–1994): the father of the salutogenesis. *Journal of Epidemiology & Community Health, 59*(6), 511-511.

Lindström, B., & Eriksson, M. (2005). Salutogenesis. *Journal of Epidemiology & Community Health, 59*(6), 440-442.

Long, S. (2020). Supervisors' perception of vicarious trauma and growth in Australian refugee trauma counsellors. *Australian Social Work, 73*(1), 105-117. DOI: 10.1080/0312407X.2018.1501587"

Lundman, B., Aléx, L., Jonsén, E., Norberg, A., Nygren, B., Fischer, R. S., & Strandberg, G. (2010). Inner strength—A theoretical analysis of salutogenic concepts. *International journal of nursing studies, 47*(2), 251-260.

MacEachern, A. D., Dennis, A. A., Jackson, S., & Jindal-Snape, D. (2019). Secondary traumatic stress: Prevalence and symptomology amongst detective officers investigating child protection cases. *Journal of police and criminal psychology, 34*(2), 165-174.

Mahoney, M. J. (1997). Viktor E. Frankl, 1905-1997. Constructivism in the Human Sciences, 2(1), 31.

Mahoney, M. J. (2002). Constructivism and positive psychology. Handbook of positive psychology, 745-750.

Mahoney, M. J., & Marquis, A. (2002). Integral constructivism and dynamic systems in psychotherapy processes. *Psychoanalytic Inquiry, 22*(5), 794-813.

Manning-Jones, S., de Terte, I., & Stephens, C. (2016). Secondary traumatic stress, vicarious posttraumatic growth, and coping among health professionals; A comparison study. *New Zealand Journal of Psychology (Online), 45*(1), 20.

Manning-Jones, S., de Terte, I., & Stephens, C. (2017). The relationship between vicarious posttraumatic growth and secondary traumatic stress among health professionals. *Journal of loss and trauma, 22*(3), 256-270.

Marquis, A., Warren, E. S., & Arnkoff, D. (2009). Michael J. Mahoney: A retrospective. *Journal of Psychotherapy Integration*, [s. l.], v. 19, n. 4, p. 402–418, 2009. DOI 10.1037/a0017971.

Mason, M. (2010). Sample size and saturation in PhD studies using qualitative interviews. *Forum: Qualitative Social Research, 11*(3)

Masson, F. (2019). Enhancing resilience as a self-care strategy in professionals who are vicariously exposed to trauma: a case study of social workers employed by the South African Police Service. *Journal of Human Behavior In the Social Environment, 29*(1), 57-75.

McCann, I. L., & Pearlman, L. A. (1990). Psychological trauma and the adult survivor: Theory, therapy, and transformation (No. 21). Psychology Press.

McTiernan, K., & McDonald, N. (2015). Occupational stressors, burnout and coping strategies between hospital and community psychiatric nurses in a Dublin region. *Journal of psychiatric and mental health nursing, 22*(3), 208-218.

Michalchuk, S., & Martin, S. L. (2019). Vicarious resilience and growth in psychologists who work with trauma survivors: An interpretive phenomenological analysis. *Professional Psychology: Research and Practice, 50*(3), 145.

Miller, K. I., Stiff, J. B., & Ellis, B. H. (1988). Communication and empathy as precursors to burnout among human service workers. *Communications Monographs, 55*(3), 250-265.DOI:10.1080/03637758809376171"

Mittelmark, M. B., & Bauer, G. F. (2017). The meanings of salutogenesis. In The handbook of salutogenesis (pp. 7-13). Springer, Cham.

Molnar, B. E., Sprang, G., Killian, K. D., Gottfried, R., Emery, V., & Bride, B. E. (2017). Advancing science and practice for vicarious traumatization/secondary traumatic stress: A research agenda. Traumatology, 23(2), 129.

Motta, R. (2020). Secondary trauma in children and school personnel. In Addressing Multicultural Needs in School Guidance and Counseling (pp. 65-81). IGI Global.

Nash, W. P., & Litz, B. T. (2013). Moral injury: A mechanism for war-related psychological trauma in military family members. *Clinical child and family psychology review, 16*(4), 365-375.

National Center for PTSD. (2019, October 17). *Veterans affairs. PTSD: National Center for PTS.* https://www.ptsd.va.gov/understand/common/common_adults.asp

National Institute for Mental Health, (n.d.). *Mental health information*. https://www.nimh.nih.gov/health/index.shtml

Nilsson, K. W., Leppert, J., Simonsson, B., & Starrin, B. (2009). Sense of coherence (SOC) and psychological well-being (GHQ): Improvement with age. *Journal of Epidemiology & Community Health*, jech-2008.

Norcross, J. C., & VandenBos, G. R. (2018). Leaving it at the office: A guide to psychotherapist self-care. Guilford Publications..

Owens-King, A. P. (2019). Secondary traumatic stress and self-care inextricably linked. *Journal of Human Behavior in the Social Environment, 29*(1), 37-47.

Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional psychology: Research and practice, 26*(6), 558.

Pearlman, A. L. (2013). Restoring self in community: Collective approaches to psychological trauma after genocide. *Journal of Social Issues, 69*(1), 111–124. doi:10.1111/josi.12006

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

Perez, L. M., Jones, J., Englert, D. R., & Sachau, D. (2010). Secondary traumatic stress and burnout among law enforcement investigators exposed to disturbing media images. *Journal of Police and Criminal Psychology, 25*(2), 113-124.

Pirelli, G., Formon, D. L., & Maloney, K. (2020). Preventing vicarious trauma (VT), compassion fatigue (CF), and burnout (BO) in forensic mental health: Forensic psychology as exemplar. *Professional Psychology: Research and Practice*.

Powell, S. K. (2020). Compassion Fatigue. Professional Case Management, 25(2), 53–55. doi: 10.1097/NCM.0000000000000418.

Regehr, K., Regehr, C., & Glancy, G. (2019). Murder at the dinner table: family narratives of forensic mental health professionals. *Journal of loss and trauma, 24*(1), 31-49.

Rizkalla, N., Zeevi-Barkay, M., & Segal, S. P. (2017). Rape crisis counseling: Trauma contagion and supervision. *Journal of interpersonal violence*, 0886260517736877.

Roberts, C. (2010). The dissertation journey: A practical and comprehensive guide to planning, writing, and defending your dissertation (2nd ed). Thousand Oaks, CA: Corwin.

Rosen, C. C., Dimotakis, N., Cole, M. S., Taylor, S. G., Simon, L. S., Smith, T. A., & Reina, C. S. (2020). When challenges hinder: An investigation of when and how

challenge stressors impact employee outcomes. *Journal of Applied Psychology*.

Rosenheck, R., & Thomson, J. (1986). “Detoxification” of Vietnam war trauma: A combined family-individual approach. *Family Process, 25*(4), 559-570.

Saakvitne, K. W. (2002). Shared trauma: The therapist's increased vulnerability. *Psychoanalytic dialogues, 12*(3), 443-449. DOI: 10.1080/10481881209348678

Sagy, S., & Mana, A. (2017). The relevance of salutogenesis to social issues besides health: The case of sense of coherence and intergroup relations. In The Handbook of Salutogenesis (pp. 77-81). Springer, Cham.

Sorenson, C., Bolick, B., Wright, K., & Hamilton, R. (2017). An evolutionary concept analysis of compassion fatigue. *Journal of Nursing Scholarship, 49*(5), 557-563.DOI:10.1111/jnu.12312

Sprang, G., Ford, J., Kerig, P., & Bride, B. (2019). Defining secondary traumatic stress and developing targeted assessments and interventions: Lessons learned from research and leading experts. *Traumatology, 25*(2), 72.

Stadtlander, L. (2018). *Finding Your Way to a Ph. D.: Advice from the Dissertation Mentor*. CreateSpace Independent Publishing Platform.

Strolin-Goltzman, J., Breslend, N., Hemenway Deaver, A., Wood, V., Woodside-Jiron, H., & Krompf, A. (2020). Moving beyond self-care: Exploring the protective influence of interprofessional collaboration, leadership, and competency on secondary traumatic stress. *Traumatology.*

Taylor, A. K., Gregory, A., Feder, G., & Williamson, E. (2019). ‘We’re all wounded

healers': A qualitative study to explore the wellbeing and needs of helpline workers supporting survivors of domestic violence and abuse. *Health and Social Care in the Community, 27*(4), 856-862. https://doi.org/10.1111/hsc.12699

Taylor, M. (2018). Invisible Wounds: Preventing Vicarious Trauma in Practicing Counselors.

Taylor, S. E., Lewis, B. P., Gruenewald, T. L., Gurung, R. A., Updegraff, J. A., & Klein, L. C. (2002). Sex differences in biobehavioral responses to threat: Reply to Geary and Flinn (2002).

Tosone, C., Lee, M., Bialkin, L., Martinez, A., Campbell, M., Martinez, M. M., ... & Gross, S. (2003). Shared trauma: Group reflections on the September 11th disaster. *Psychoanalytic Social Work, 10*(1), 57-77.

Tosone, C., Nuttman-shwartz, O., & Stephens, T. (2012). Shared trauma: When the professional is personal. *Clinical Social Work Journal, 40*(2), 231-239. doi:http://dx.doi.org.ezp.waldenulibrary.org/10.1007/s10615-012-0395-0

Walden University (Producer). (2013). Overview of quantitative methods. [Online tutorial]. Retrieved from http://academicguides.waldenu.edu/researchcenter/resources/Design

Wang, D. C., Strosky, D., & Fletes, A. (2014). Secondary and vicarious trauma: Implications for faith and clinical practice. *Journal of Psychology and Christianity, 33*(3), 281.

Wozniak, J. D., Caudle, H. E., Harding, K., Vieselmeyer, J., & Mezulis, A. H. (2020). The effect of trauma proximity and ruminative response styles on posttraumatic

stress and posttraumatic growth following a university shooting. *Psychological Trauma: Theory, Research, Practice, and Policy, 12*(3), 227.

Wu, X., Kaminga, A. C., Dai, W., Deng, J., Wang, Z., Pan, X., & Liu, A. (2019). The prevalence of moderate-to-high posttraumatic growth: A systematic review and meta-analysis. Journal of affective disorders, 243, 408-415.

Younggren, J. N., Gottlieb, M. C., & Boness, C. L. (2020). Forensic consultation. In C. A. Falender & E. P. Shafranske (Eds.), Consultation in psychology: A competency-based approach (p. 239–251). American Psychological Association. https://doi.org/10.1037/0000153-014

Appendix A: Interview Questions

1. How old are you?
2. How do you define your role as a mental health professional? (Counselor, social worker, psychologist)?
3. How many years have you worked in the field of trauma?
4. Please define your client population.
5. How many weekly hours of services do you provide to your clients?
6. What topics are discussed while providing those services?
7. What type of training have you had to prepare you for working with the clients you serve?
8. Are you aware of the concept of vicarious traumatization?
    1. If yes, proceed to ask question #9.
    2. If no, define vicarious traumatization as the phenomenon which describes the cumulative negative effects of trauma and providing trauma therapy, upon the worldview, schema, and efficacy of the empathetically engaged therapist (Pearlman & McCann, 1990). Proceed to question #9
9. Have you received training on vicarious traumatization?
10. Vicarious trauma could include symptoms of intrusion, avoidance, hyper arousal, and negative changes to cognitions, etc. Can you describe your experiences with these types of symptoms?
11. How would you describe your ability to minimize the risk of vicarious traumatization?

12. What skills or techniques were effective to help you minimize your risk of vicarious traumatization? Why?
13. What skills or techniques were ineffective to minimize your risk of vicarious traumatization? Why?
14. Can you describe any personal support systems that you use in your personal life, gym, yoga, personal therapy, etc., to manage vicarious trauma? (Follow up). Can you describe how these systems help you to manage vicarious trauma?
15. Can you describe any support systems that are in place at your place of employment, such as individual supervision, group supervision, peer support groups, training, etc.? (Follow up) Can you describe how your experiences with support, training, supervision, etc. in the workplace has affected your ability to manage vicarious trauma?
16. Have you heard any one comment about your work-life balance? If yes, what do you think of those comments?

Permission to use some of these questions has been generously given by Tambria Hunt PhD and James Adams PhD.

Appendix B: Data Analysis Round 2 – The Raw Numbers

Demographics

14/15 participants identified as Caucasian.

11/15 were over 40, 4/15 were under 40,

11/15 treat primarily Mid-High SES, 4/15 treated primarily Low SES,

10/15 treated primarily adolescent through young adult males

10/15 treat primarily a monocultural and ethnographic population

8/15 highest education was a Masters, 7/15 had Doctorates

9/15 treated mostly CSA

RQ1-Lived Experience of VT

13/15 of therapists reported that they never having received specific training for VT.

10/15 of the male trauma therapists reported high levels of avoidance.

8/9 of the CSA therapists reported symptoms of Avoidance

8/15 of the male trauma therapists reported high levels of intrusion.

5/9 of the CSA therapists reported symptoms of Intrusion

5/9 of the CSA therapists reported symptoms of Detachment

4/9 of the CSA therapists reported symptoms of Hyperarousal

RQ2-Coping Mechanisms of Male Therapists

14/15 of therapists said they are "Good" or "Very Good" at being able to manage VT.

14/15 engage in some sort of **Supervision** either individual or with a group.

14/15 **create personal space**, **forget the world**, **separate from treating Trauma**.

9/15 said **spirituality** helped them manage VT, provided *purpose, meaning, space*

8/15 undergo **Personal Therapy** distinct from Supervision.

8/15 said they utilize **physical exercise** to help manage.

Appendix C: Synthesis of Meaning Units

Themes

I noted some major themes through the results of this study. Some of them were about the way male therapists experienced VT in their personal and professional life. But most of the insights and themes were more apparent regarding their methods and strategies for managing and preventing VT.

Lived Experience of VT

Interpersonal vs Intrapersonal

1. The majority of the therapists reported involuntarily "**bringing home"** their clients trauma stories and being disturbed by that (despite actively trying not to):
    a. "A lot of Intrusion, Intrusion is very big for me. I do have bothersome thoughts of clients and their stories and have a lot of vivid imagery of graphic scenes disclosed during therapy, and infrequent I have difficulty sleeping"
    b. "the second thing is that a lot of the descriptions of what the guys tell me are pretty horrific, I def had nights having a hard time falling asleep because of what I heard. Intrusion, really sad and uncomfortable thoughts about."
    c. "Like one time I had a young mother whose 3 yr old drowned, and I thought of my own child, the details of the case, how the child changed from warm to cold and blue. That description bothered me for days, I had dreams. I imagined it as my own child and I could feel my child's skin becoming cold…"
    d. "Sometimes I think about client stories especially when they were particularly horrible."
2. Most of the male trauma therapists reported high levels of "**avoidance"** (10/15). Therapists who treated CSA had the highest levels of Avoidance (8/9).
    a. "Disassociation, which is the enemy of treatment, but you need it in order to disentangle what they are telling you,
    Detachment"
    b. "Also I became used to it, it was more shocking and hard to sit with in the beginning, but then I learnt my limits and that thinking about it doesn't help, you kinda desensitize. Depersonalize."
    c. "Avoidance, sometimes I feel myself being a little burnt out, feeling relieved when the client cancels. I don't think that's related to trauma, as much as it is burnout from the work. I think I am affected by my clients,

s/t the work can burn me out. Its not from their stories or their trauma. but if we look at how their trauma"

- **d.** "Biggest one for me is avoidance. (Follow up) more from other people, the more intense my week is with trauma, the less inclined I am to hang out with friends, to feel the free-spiritedness of sending out funny texts, it pushes me to hibernate, my resources, and become more judgmental, of the way I hear that non-trauma focused people talking about situations of trauma, they are too superficial, I get mad that they are missing the point"
- **e.** "fatigue, when people call me to discuss a case, I feel fatigue, I already dealt with that the whole day and I don't have the energy to deal with it."
- **f.** "I thought I wasn't cut out for therapy, I felt bad that I wasn't able to help my client, or other clients"
- **g.** "I had a client OD, that was a terrible time for me, I had doubts about my inability to prevent it, I felt guilt for not paying enough attention to the client and his struggle, or doing enough to help him. It generated a great fear of my incompetence, made me question myself as a therapist."
- **h.** "Dissociation, bored less focused, less empathically intuned. More distracted, less fully intuned, maybe even a subtle resistance to affect, I notice these subtle shifts, I notice that I am getting more bored, wanting to distract myself, I think its more about the amount of hours I work, it doesn't help that all I hear is human tragedy and suffering all day, every day."

3. A few therapists, especially those in private practice without the benefit of peers working with them, reported a deep feeling of isolation.
   - **a.** "When you see more then 5 ppl a day, in very personal and intense ways of giving empathetically, it concretizes a feeling of isolation."
   - **b.** My family doesn't require the same level of empathy. Bec that's not the human way. I have been caught up
   - **c.** isolation, private practice can be called isolated practice, this work is very isolating, a very large chunk of that is no doubt due to VT.
   - **d.** Going from the intensity of a session, to everyday life is an adjustment
   - **e.** Become a junkie for honest communication, get put off by insincere communication

<u>VT Management</u>

1. A Major Themes is that **almost every therapist does something to; create some sort of personal space, forget the world, and/or separation from treating Trauma**

"I am very very good at containment, my practice is a drama free zone, We very much communicate to patients, our message is "you got this" very rarely having emergencies, we create a sense of calm and perseverance, contain intensity levels, help contain even relevant stakeholders to stay focused w/o being dramatic, keeps things grounded"

"I take long baths"

2. Almost every therapist said that they **make a separation between themselves and the clients/the clients stories,** sometimes even consciously trying to **depersonalize as a prevention and protection measure.**
   - "Disassociation, which is the enemy of treatment, but you need it in order to disentangle what they are telling you" and
   - "I identify the projection, mostly I recognize that its just my projection of what happened/ happening"
   - "There a certain things, such as shutting off at times, and consciously distracting, and setting very strong boundaries in terms of when I work, how how many clients I see, have all been very important."
   - "Detachment, I find it easier to avoid the other symptoms by just detaching."
   - "For me it's a story, it may be true or not, but it's a reality I could live with when I'm with you."
   - "I am very good at noticing and accepting my own feelings But if and when I am empathetically engaged with a client, I do feel it, there is some activation, with/from the clients, and when I am aware of that I take some time to analyze and process some space for my self, at the end of the day before I go home (I wish I could do it between clients)."

Some of them feel that separation is a goal, an ideal, something that they actively strive for;

- "As I become older an experienced it becomes more of a job then a calling, a separation, which is healthy, there's something about passion that can ruin therapists".

- "I do rituals to create a space between me and my clients, during therapy I carry an item or rock, ornament to hold their feelings, where the energy goes there instead of towards me and I also

visualize myself being shielded with a white light before I meet them."

- "I try to depersonalize, to work the problem, because its really easy to get sucked into the story. I try to think of the structure of the problem, instead of the content. Through my training, which is to; "work the problem, not the story".

- I think I am way above average, in terms of capacity, not necessarily always in the ideal form, I have very strong defenses to be able to turn inwards to handle stress, difficulty, but in a little of a, a very powerful ability to put up a wall. Much less likely then many of my colleagues to have nightmares, and burst into crying, feel overwhelmed, given that ability, There is a greater capacity for, a trend for "pulling away" form that fully empathically engaged connection, I feel less likely to be pulled into complete empathetic engagement.

3. **Personal therapy is seen as super helpful, if not super critical for effective VT management.**
    - **a.** I started my own therapy, helps work out things that are getting to me
    - **b.** I had to reduce my caseload, I noticed that I was constantly adding self care practices, I started personal therapy only 2 years ago, I should have started earlier…

4. **Most report needing SPACE to process or decompress. This can be accomplished by physical exercise or just scheduling a day or time off.**
    - **a.** 8/15 utilize physical exercise to help manage. Some have described the physical exercise as a way to just let go, to "run away from the clients stories";
        i. "I exercise every day, I run 5 miles, I put my headphones on and just go, I forget everything I just heard"
        ii. "I do 10 pushups in between each client."
        iii. "It takes you out of your own mind and see it objectively for what's going on. I take a day of every week to hike…"
    - **b.** Schedule Breaks:

i. "I shifted from being a purely trauma therapist so that it isn't so intense. I give my self breaks. I days or parts of days, that I can do non trauma or not therapy related."

5. **8/15 of therapists said spirituality helped them manage VT. They said that spirituality and religion provided them with purpose, support, and meaning.**
    a. **Purpose**
        i. "Spirituality is also important, knowing that there is a reason. someone once told me "God gave you to me" and I thought about it and it makes sense to me, its kinda helpful to use spirituality. I believe there is a higher reason for why this happens,"
        ii. "religion is very important, religious servicers and activities, give my life a lot of meaning and purpose. I identify as orthodox jew, learning Torah, I give a shiur which is very important and meaning, orthodoxy is about growth mindset and its hard but meaningful and gives me purpose. Its not all about work, there's other things that give my life purpose and meaning. A lot of my worldview as a therapist is influenced by my religious view and Torah (Bible) learning, I know that I get tools for helping people based on my Judaic knowledge and ppl comment about me being an orthodox jew, using that to connect with clients, even those who aren't religious, universal themes of religion and how it helps people."
    b. **Support**
        i. "praying, meditating, I meditate while I pray. Sometimes I feel like God talks to me through the texts, there is a mystical connection I get with the text and with God that are very meaningful for me. [**How does this learning and praying/connection with God help you prevent or manage VT?**] It helps me to trust myself, my intuition and my internal processes."
        ii. "I do find religious practice to be a support"
        iii. "I do energy stuff, I do rituals to create a space between me and my clients"
    c. **Meaning, like a sense of depth, richness of life. [see more below]**

i. “I also give shiurim (sermons), which helps mitigate my VT bec I get to talk about my clients and turn what they are going through into s/t meaningful”
ii. “I try to use a religious spiritual frame to ease perspective give meaning and purpose to what clients are going through and my role.”

6. **Many said that finding meaning is very important for them. In 2 different kinds of context;**
    - **a.** one was **finding meaning in their clients stories and pain**,
        - **i.** “its kinda helpful to use spirituality. I believe there is a higher reason for why this happens”
        - **ii.** “I also give shiurim (sermons), which helps mitigate my VT bec I get to talk about my clients and turn what they are going through into s/t meaningful”.
    - **b.** the other was to **find meaning in their own life independent of therapy**;
        - **i.** “Its not all about work, there’s other things that give my life purpose and meaning”