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Vicarious Traumatization and Vicarious Resilience in Mental Health Professionals: An Investigation of Group Differences

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Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

Marie Demchak

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Walden University
2021

Abstract

Vicarious Traumatization and Vicarious Resilience in Mental Health Professionals: An Investigation of Group Differences

by

Marie Ann Demchak-Buotte

MA, Marist College, 2013

BS, Marist College, 2011

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

Walden University

May 2021

Abstract

The purpose of this study was to investigate individual differences between mental health professionals with varied levels of clinical experience and their personal levels of vicarious trauma (VT) and vicarious resilience (VR) as measured by the Secondary Traumatic Stress Scale (STSS) and the Connor-Davidson Resilience Scale (CD-RISC), respectively. A sample of 161 mental health professionals in New York State completed the scales and separate one-way between-subjects ANOVA tests examined the relationship between variables. A test for the moderating effect of the percentage of trauma clients on the clinician's caseloads was also conducted between experience level of the clinician and their own levels of VT and VR. This study built upon existing research that suggested that working with trauma clients can precipitate VT and/or VR in the therapist. The data of this study revealed a significant difference between mental health professionals at difference levels of clinical experience with regard to their personal levels of VT and VR; clinicians with less experience had a higher trauma score than those with 5+ years' experience, The data did not support that the percentage of trauma clients on a clinician's caseload moderated this relationship. This study can lead to positive social change by bringing awareness to the potential for VT in clinicians, thereby demonstrating the need for support programs and trainings for said clinicians.

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Dedication

"A river cuts through a rock not because of its power, but its persistence." –Jim Watkins

This dissertation is lovingly dedicated to those closest to me who supported and encouraged me through this educational journey. To my father, who instilled in me the importance of academia at a young age and continued to support me through to my highest academic accomplishment. To my mother, whose strength and determination in her own life served as light to guide me through this journey to see its end. To my husband Nick, who continued to push me to write even when I was exhausted and who has never stopped believing in me and my dream. And to my daughter Colette, who teaches me every day to celebrate life's little triumphs, and inspires me to keep striving to always be the best version of myself.

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Chapter 1: Introduction to the Study

Introduction

Therapeutic work with traumatized individuals is a challenging task and is not without potential hazards to those professionals who endeavor to provide them with therapeutic support (Harrison & Westwood, 2009). Research has shown that in repeatedly listening to the traumatic events that their clients have experienced, therapists can begin to experience their own personal feelings of anxiety, pain, suffering, and being exhausted, similar to those feelings of their client (Bartoskova, 2015). This phenomenon is not uncommon for those working with traumatized clients. Sodeke-Gregson et al. (2013) stated that a vast majority of therapists are at an increased risk for experiencing some level of secondary traumatic stress or vicarious trauma (VT) from working with traumatized clients. Being that the nature of trauma work is so intense, therapists are more vulnerable to developing impairments such as compassion fatigue, burnout, and countertransference (Williams et al., 2012). These impairments can lead to psychological distress in the clinician and a subsequent loss of therapeutic integrity (McCormack & Adams, 2016). Vicarious resilience (VR) is a newer concept that has been described as a therapist being positively affected by the resilience of trauma clients, alterations of perspectives on the therapist's own life, and valuing the therapy work performed (Hernández et al., 2007). The experience of VR results in growth and the transformation of the therapist consequent to client growth and resilience during trauma recovery (Hernández, et al., 2010). VT is a significant risk that should be taken into account when working with trauma clients; however, there is much potential for positive outcomes of

working with trauma clients. The concepts of VT and VR are not dichotomous in nature, rather they exist simultaneously and are of equal importance in terms of their exploration through research.

The purpose of this chapter is to introduce the study. The following section contains background information on the topic, including an overview of related research literature. The second section includes the research problem and the gap in the existing literature that I addressed in this study. Sections 4 through 6 contain the purpose statement, research questions and hypotheses, and an overview of the theoretical foundation for the study. Section 7 includes a rationale for the study design chosen, description of the variables in the study, and a brief summary of the methodology. The final sections contain detailed definitions of variables and other important terms, study assumptions, scope and delimitations, limitations, and significance of the study.

Background

Traumatic events affect not only those who are directly involved in the event but also those who attempt to provide support to the survivors. Howlett and Collins (2014), examined support workers who work with survivors of trauma, demonstrated the importance the mental health professional role, and highlighted the risks that come with the exposure of the support workers to the experiences of numerous trauma survivors and the explicit accounts of those experiences. This exposure can lead to an increased risk for the development of vicarious trauma in the support worker. These crisis volunteer support workers are similar to many other mental health professionals who provide support to those who have experienced trauma. These *crisis interventionists* as I

called them in this study, experienced short-term exposure to many similar accounts of violence, in this case intimate-partner violence. Upon conducting one-on-one in-depth interviews of the crisis interventionists in their study, Howlett and Collins (2014) found that for some of the support workers, the traumatic experiences of those individuals with whom they worked were not easily forgotten. The researchers found that the majority of support workers discussed the emotional burden that came with listening to the client's traumatic experiences repeatedly. Many of the support workers reported experiencing feelings of anger, frustration, annoyance, and confusion (Howlett and Collins, 2014). Other support workers reported feelings of unpreparedness to deal with these trauma survivors, subsequently developing feelings of anxiety and being overwhelmed. The importance of recognizing the onset of symptoms related to vicarious traumatization to avoid or manage personal changes that occur due to this trauma was noted by the researchers. Howlett and Collins (2014) indicated that those who work with trauma survivors must be aware of their own levels of VT to remain effective in their work. Understanding the signs and symptoms, maintaining boundaries, and a moderate case load were all suggestions in how crisis support workers would be able to maintain personal mental health as well as an effective helping relationship with the victims with whom they were working.

In their study, Ben-Porat and Itzhaky (2009) discussed the negative and positive implications for therapists working with victims of family violence. This study included information on the possible implications of working with victims of family violence in terms of secondary traumatization, VT, and growth. Further, investigation of the positive

and negative changes that may occur in therapists in terms of their own personal well-being, personal lives, and family life was provided by the researchers. Ben-Porat and Itzhaky (2009) described the effects of working with traumatized clients in terms of the therapist becoming "infected" by the victim and experiencing symptoms similar to the post-traumatic stress that is experienced by the client. This particular research focused on the potential negative and positive outcomes for mental health professionals working with trauma victims. It also included information regarding the potential for growth in the mental health professionals who work with these types of clients. Results of this study also indicated that mental health professionals working with trauma clients experienced a negative shift in their spousal relationships and change of worldview (Ben-Porat & Itzhaky, 2009). They did, however, experience positive changes in the areas of interpersonal communication, spousal awareness, and parenting. The study conducted by Ben-Porat and Itzhaky (2009) brings to light the potential for positive changes to be experienced by the mental health professional in working with trauma clients; however, the fact that negative outcomes are also a real possibility for these professionals cannot be ignored.

Harrison and Westwood (2009) conducted a study in which they explored preventative practices. They provided an in-depth look at some of the protective practices that might mitigate the risks of VT in mental health professionals. The researchers recruited individuals for the study who were trained at the masters or doctoral level, had a minimum of 10 years of experience working with traumatized clients, and had self-identified as having managed well in their work. Narrative data was collected through

interviews that occurred in three phases. Part of the interview process involved asking the participants how they managed to sustain their personal and professional well-being, despite their work with traumatized clients over many years. The results provided the researchers with a wealth of information regarding the preventative practices that the clinicians engaged in in order to mitigate the risks of VT. A total of nine major themes were revealed which included: countering isolation, developing mindful self-awareness, consciously expanding perspective to embrace complexity, active optimism, holistic self-care, maintaining clear boundaries and honoring limits, exquisite empathy, professional satisfaction, and creating meaning (Harrison & Westwood, 2009).

Knight (2013) explored indirect trauma and the implications for self-care, supervision, the organization, and the academic institution in his study. Knight (2013) identified the emotional, psychological, and cognitive effects that working with trauma survivors, specifically those who are adult survivors of childhood physical and sexual abuse, has upon those who provide clinical services to these individuals. Like Harrison and Westwood (2009), he too identified factors that may mitigate the risk of experiencing VT. He also investigated factors that might increase this risk. Knight (2013) stated that a common problem among trauma survivors is their distorted perceptions of self and others. Practitioners who work with these trauma survivors are also likely to experience changes in their own views about themselves and the world around them. The risks of vicarious traumatization are often higher for those professionals who have less education as well as those who have less experience working with trauma survivors (Knight, 2013). Individuals who are not prepared through their educational program to deal with this

population of clients will have a more difficult time in handling the repeated exposure to traumatic stories in therapy sessions. Students also seem to be at a higher risk of developing vicarious trauma (Knight, 2013). In terms of mitigating the potential risks of vicarious trauma, Knight (2013) stated that organizational support can be helpful. Individuals who feel that they could not talk to their supervisors are at a greater risk of developing different types of secondary trauma. The value of an "affective check-in" during which as supervisor is asking the supervisee about their emotional responses is immeasurable (Knight, 2013). Being proactive about the potential risks of VT is extremely important. This requires that the clinician engage in some form of self-care to maintain their own mental health on a daily basis. Knight moves on to discuss the critical role that the employing organization can play in student and staff members' experiences with indirect trauma. A supportive work environment can mitigate the effects of indirect trauma, while an unsupportive work environment can make things more challenging for the clinician. Further, the importance of addressing the manifestations of indirect trauma in the classroom was indicated. The educational program should be providing students with information regarding the risks of indirect trauma and ideas for preventative practices that could mitigate these risks.

Ivicic and Motta (2017) conducted one of the most recent studies on VT among mental health professionals. Eighty-eight psychologists, social workers, mental health therapists, and creative arts therapists were asked to complete the modified Stroop procedure. They also completed the Secondary Traumatic Stress Scale, the Life Events Checklist, the Job Satisfaction Survey, and a demographics questionnaire. A multiple

regression was conducted to determine whether there was a relationship between exposure, as defined by the number of hours spent with trauma clients and number of years employed as a mental health professional, and secondary traumatic stress, as measured by response latencies on the modified Stroop procedure. A multiple regression analysis was also used to determine whether or not those who have higher levels of job satisfaction and quality supervision would have lower secondary trauma symptoms than those who are less satisfied at their job. Finally, a hierarchical regression was conducted to determine the relative contribution of demographic variables and personal trauma history, as measured by the Life Events Checklist (Ivicic and Motta, 2017). The results of this study revealed that between 23 and 27% of respondents were positive for secondary traumatization (Ivicic & Motta, 2017). Overall, results indicated a relatively high level of secondary trauma among mental health professionals.

Another important area that has been investigated with regard to VT in mental health professionals is personal growth and VR as a result of VT. Bartoskova (2015) conducted a critical literature review that summarized existing literature on post-traumatic growth in therapists that have experienced VT. Much literature has focused on the negative effects that mental health professionals experience as a result of VT. More recently, research has begun to focus on the positive outcomes that are experienced by some individuals as a result of VT. These outcomes were termed *post-traumatic growth* and VR. In terms of this study, there were key research questions that Bartoskova (2015) was hoping to answer: “Do trauma therapists experience post-traumatic growth?” and “What are the key factors that predict post-traumatic growth in trauma therapists?”

Bartoskova (2015) examined a synthesis of resources in order to answer these research questions. Bartoskova (2015) found that post-traumatic growth in trauma therapists is a highly promising feature for counseling psychologists, with a need to move away from the stereotype of purely negative outcomes being associated with trauma work.

I discussed these studies regarding VR in mental health professionals because it is a newer aspect of VT research and an important topic to be aware of. Many mental health professionals across organizations are at risk for developing VT. It is important to also be aware of the potential for clinicians to experience positive outcomes as a result of trauma work. These positive outcomes can be experienced if the clinician develops the ability to cope with diversity and utilize different strategies to keep their own mental health in check. Resiliency is powerful and can change the way that a clinician approaches therapy, subsequently enhancing the therapeutic relationship and setting the example for growth and positivity.

All of the studies discussed, and those that I will discuss in detail in Chapter 2, present a wealth of information with regard to VT and the mental health professional. Although preliminary research in the area of VT has explored the risks of VT, the way in which VT manifests in the mental health professional, preventative practices to mitigate these risks, the potential for post-traumatic growth/VR, and implications for the therapeutic relationship, what has yet to be established in the literature is how the percentage of trauma clients on a clinician's caseload affects the relationship between the clinician's experience level in the field and their personal level of VT.

In this study, I intended to provide further information to those working in the helping professions with regard to the potential for VT and VR occurrence in clinicians at different levels of practice as well as the potential effects that the percentage of traumatized clients on one's caseload may have on the level of VT and VR experienced by the individual. By doing so, my goal is to raise a further level of awareness of the potential for VT in clinicians and the need for proper training on VT before, and during the time when professionals enter into therapeutic relationships with clients who have experienced trauma. My other goal was to bring awareness for the potential of VR in mental health professionals and what foundation or protective factors are needed to develop this state of being.

This research also fills a gap in understanding by focusing specifically on the relationship between a clinician's time/experience in the field and their level of vicarious trauma and how the percentage of traumatized clients on the clinician's caseload affects this relationship. This study is unique in that I addressed a very specific area of VT and VR research not yet investigated thoroughly. Prior researchers (e.g. Iqbal, 2015; Knight, 2013; Zarach & Shalev, 2015) have focused on the effects of VT, both positive and negative, as well as strategies that are utilized by therapists to cope with VT; however, thus far limited research is available regarding the levels of VT and VR specific to therapists across different levels of clinical experience and the effect that the percentage of traumatized clients on the clinician's caseload might have upon that relationship. Insights from this study may facilitate positive social change in a number of ways. The results of this study may aid professionals in the field of psychology in understanding the

potential for VT as well as VR in mental health clinicians. In addition, insights gained from this study may bring awareness to professional and educational organizations with regard to the necessity for the development and/or maintenance of proper programs/trainings that can be provided to clinicians prior to and during their work with traumatized clients. Insights may also aid in providing information to those in the field with regard to how the percentage of traumatized clients on an individual's caseload may have an effect upon their levels of VT and VR.

Problem Statement

Mental health professionals who work with clients who have experienced a trauma are potentially at risk for adverse effects (Harrison & Westwood, 2009). Repeatedly listening to the personal traumatic accounts of their clients can bring on feelings of negativity, distrust, fear, and suffering in the therapist (Bartoskova, 2015). This is not an uncommon occurrence in clinicians who work with this population. Researchers have demonstrated that a large percentage of clinicians are at an increased risk of experiencing VT or secondary traumatic stress as a result of working with clients who have experienced their own trauma (Sodeke-Gregson et al., 2013). Williams et al. (2012), stated that trauma therapy can be very intense, not only for the client, but for the clinician, increasing their vulnerability to develop impairments such as burnout and compassion fatigue, in their professional and personal lives. These impairments can lead to psychological distress in the clinician and a subsequent loss of therapeutic integrity (McCormack & Adams, 2016).

Nature of the Study

The purpose of this quantitative study, in which I used a nonexperimental design, was to investigate individual differences between mental health professionals with varied levels of clinical experience and their personal levels of VT and VR. I also investigated whether the percentage of traumatized clients on a therapist's caseload moderated the relationship between the clinician's experience level and the level of VT/VR experienced by the therapist. My goal was to understand the levels of VT and VR that are experienced by mental health professionals at levels of training, novice, and seasoned practice. The purpose was of the study was to understand whether a difference existed between groups with regard to the level of VT and VR in working with patients who have experienced trauma and whether the percentage of traumatized clients on a clinician's caseload had an effect on the level of VT and/or VR experienced.

I used a nonexperimental, correlational design for this quantitative study. My goal was to collect statistical data to evaluate the differences in mental health professionals in terms of their levels of VT and VR. I compared the levels of VT and VR of mental health professionals at first year, novice, and seasoned levels of experience in the mental health field. I also conducted a test for the moderating effect of the third variable, percentage of traumatized clients on the clinician's caseload. My reason for using the moderating variable was to understand if the percentage of traumatized clients on a clinician's caseload impacted the relationship between the clinician's level of experience and his/her level of VT and/or VR. The experience level of the clinician acted as the independent variable. I separated experience into three categories: first year clinicians, novice

clinicians, and seasoned clinicians. First year clinicians were those individuals who had completed approximately 1,750 hours of full-time supervised experience as described by the New York State Office of the Professions requirements for licensure/certification and were just beginning their career independently. Novice clinicians were defined as professionals who have under 5 years of experience in the field (as defined by the New York State Psychological Association). Seasoned professionals were defined as those professionals who have 5 years or more of experience in the mental health field. The term *mental health professional* included clinical psychologists, clinical social workers, licensed professional counselors, mental health counselors, and psychiatric or mental health nurses. The dependent variables for this study were the level of vicarious trauma/vicarious resilience as reported by the mental health professionals. Finally, the percentage of traumatized clients on the clinician's caseload served as a moderating variable. Traumatized clients were defined as any individual who had the unique individual experience, associated with an event or enduring conditions, in which (a) the individual's ability to integrate affective experience is overwhelmed or (b) the individual experiences a threat to life or bodily integrity (Pearlman & Saakvitne, 1995).

Research Questions and Hypotheses

I derived the research questions from my review of existing literature in the area of VT, VR and mental health professionals.

Research Question 1 (RQ1): Is there a significant difference in the level of vicarious traumatization in mental health professionals depending upon experience level?

Null Hypothesis ($H_0$1): There is no difference in the level of vicarious traumatization in mental health professionals depending upon experience level as assessed by the Secondary Traumatic Stress Scale.

Alternative Hypothesis (H_a1): There is a difference in the level of vicarious traumatization in mental health professionals depending on experience level as assessed by the Secondary Traumatic Stress Scale.

Research Question 2 (RQ2): Is there a significant difference in the level of vicarious resilience in mental health professionals depending on experience level?

Null Hypothesis ($H_0$2): There is no difference in the level of vicarious resilience in mental health professionals depending on experience level as assessed by the Connor Davidson Resilience Scale.

Alternative Hypothesis (H_a2): There is a difference in the level of vicarious resilience in mental health professionals depending on experience level as assessed by the Connor-Davidson Resilience Scale.

Research Question 3 (RQ3): What effect does the percentage of traumatized clients on a clinician's caseload have upon the relationship between their experience in the field and their level of vicarious trauma?

Null Hypothesis ($H_0$3): The percentage of traumatized clients on a clinician's caseload does not have an effect the relationship between their experience in the field and their level of vicarious trauma.

Alternative Hypothesis (H_a3): The percentage of traumatized clients on a clinician's caseload does affect the relationship between their experience in the field and their level of vicarious trauma.

Research Question 4 (RQ4): What effect does the percentage of traumatized clients on a clinician's caseload have upon the relationship between their experience in the field and their level of vicarious resilience?

Null Hypothesis ($H_0 4$): The percentage of traumatized clients on a clinician's caseload does not have an effect the relationship between their experience in the field and their level of vicarious resilience.

Alternative Hypothesis ($H_a 4$): The percentage of traumatized clients on a clinician's caseload does affect the relationship between their experience in the field and their level of vicarious resilience.

Rational for the Study

I selected this design for several reasons. A nonexperimental design lacks the manipulation of the independent variable (Creswell, 2003). I chose this design because I did not plan to manipulate the independent variable. I used this design for relatively short, shallow data collection via survey methods. I collected data as the participants completed the surveys. This type of data collection eliminated the need for multiple individuals to be involved in the data collection, as the surveys were self-explanatory and did not need to be administered to the participants. Costs are minimal when utilizing a non-experimental design and survey methods for data collection (Ponto, 2015). Most importantly, this design was noninvasive. No treatment or experimentation was applied, removing the risk

of interference of normal function, safety, and/or peace of mind of the participants involved.

Commonly, non-experimental studies are utilized in the field of psychology and are purely observational and the results intended to be purely descriptive (Thompson & Panacek, 2007). A review of the literature demonstrates that numerous previous studies related to vicarious trauma and/or vicarious resilience utilized a non-experimental approach, as the studies were either reviewing prior research (Baum, 2016) or collecting and describing information regarding what has already occurred with regard to mental health professionals and VT and/or VR (Howlett & Collins, 2014). The present study remained in line with prior research in this area by utilizing a non-experimental design. Thompson and Panacek (2007) described multiple non-experimental designs, including the use of surveys and questionnaires. There are a number of different non-experimental designs that have been described by Thompson and Panacek (2007). The use of surveys and/or questionnaires allows the researcher to query the research question(s) directly and collate the answers. I used surveys/questionnaires in this study to gain information from the participants to answer the research questions. The independent variable (IV) for this proposed study was categorical. The purpose was to categorize the data into groups based on the literature. For this study, the IV groups were the experience level of the clinicians. Experience level was operationally defined as the following three categories: first year clinicians, novice clinicians, and seasoned clinicians. First year clinicians were those individuals who had completed approximately 1,750 hours of full-time supervised experience as described by the New York State Office of the Professions requirements

for licensure/certification and are just beginning their career independently. Novice clinicians were defined as professionals who had under 5 years of experience in the field (as defined by the New York State Psychological Association). Seasoned professionals were defined as those professionals who had 5 years or more of experience in the mental health field. The term "mental health professional" included clinical psychologists, school psychologists, clinical social workers, licensed professional counselors, mental health counselors, and psychiatric or mental health nurses. The dependent variables for this study were the participant's levels of vicarious trauma and vicarious resilience. Finally, a moderating variable of "percentage of traumatized clients on the clinician's caseload" was used.

The sample consisted of information provided by mental health professionals who work with individuals who have experienced a trauma. Demographic forms gathered information regarding the mental health professional's level of clinical experience (i.e. years in the field), and percentage of traumatized clients on their caseload. For this study, data was collected from mental health professionals between 2020 and 2021. Data collected included information regarding the levels of VT and VR, as well as the demographic information of the mental health professionals in the study and their reported percentage of traumatized clients on their caseloads.

Statistical power refers to the probability of accurately rejecting the null hypothesis when it is false (Wetherbee & Achenbach, 2002). I conducted a power analysis for ANOVA with three levels and one dependent variable in G-POWER to determine the minimum number of participants needed to achieve sufficient power for

this study. Based on a power size of .80, (alpha of $p < .05$), and a medium effect size ($f2 = 0.25$), the minimum sample size needed was 159 (Faul et al., 2008). It is of note that the dependent variables (VT, VR) were to be run separately using a one-way ANOVA.

Theoretical Framework

The theoretical framework of this dissertation was rooted in Pearlman and Saakvitne's (1995) constructivist self-development theory (CSDT). This theory is based upon a constructivist foundation, postulating that individuals construct personal realities based upon the complex cognitive schemas used to interpret and make sense of life experiences (Williams et al., 2012). This approach suggests that an individual's unique personal history influences his or her experience of traumatic events (McCann & Pearlman, 1992). Much like the experience of a primary trauma for a client, the impact of VT on a clinician's psychological functioning and worldview can result in intra and interpersonal difficulties. VT demoralizes the clinician's sense of safety in the world, leaving him or her feeling as though they cannot trust the world around them (Williams, Helm, & Clemens, 2012). These feelings can have serious implications for clinical practice.

The Constructivist Self-Development Theory (CSDT) provides a basis for understanding the psychological, interpersonal, and transpersonal impact of traumatic events upon an individual. This theory also provides a framework for understanding the impact that trauma work may have upon the therapist (Pearlman & Saakvitne, 1995). This theory was originally cited by McCann and Pearlman (1990) but has continued to develop and evolve over the years. Pearlman and Saakvitne (1995)

expanded upon the original concept by providing information with regard to the specific areas in which the gradual process of internal change for an individual occurs due to a traumatic event. For the purposes of this present study, the version of the theory that will be discussed in detail is rooted in Pearlman and Saakvitne's (1995) explanation and understanding of CSDT. It is important to note that when trauma is discussed in reference to the CSDT it is defined as the unique, individual experience, associated with an event or enduring conditions, in which the individual's ability to integrate affective experience is overwhelmed or the individual experiences a threat to life or bodily integrity (Pearlman & Saakvitne, 1995).

CSDT, as Pearlman and Saakvitne (1995) described it, places a strong emphasis on integration, meaning, and adaptation. In terms of the therapeutic relationship, this theory requires the clinician to view the client as a unique individual who is actively trying to manage a particular set of life circumstances rather than viewing the client as a collection of symptoms (Pearlman & Saakvitne, 1995). This theory places significant emphasis upon an individual's strength and will to survive, as well as acknowledges the importance of an interactive therapeutic relationship. CSDT posits that individuals construct their own realities based upon their own unique experiences within the world (Pearlman & Saakvitne, 1995). These unique experiences can also encompass traumatic events that occur in an individual's life. As clinicians, we cannot assume that we will be able to truly grasp the experiences of the client. Rather, we must be mindful of the diversity that each individual brings to the therapeutic relationship, which includes his or her own exclusive set of life experiences. These exclusive sets of life experiences may

include traumatic events, making it imperative for clinicians to understand that each individual who experiences trauma makes sense of it in his or her own unique way. The magnitude of the effects of trauma cannot be assumed to be experienced the same way across clients (Pearlman & Saakvitne, 1995). Similarly, the way in which mental health professionals experience and make sense of the traumatic stories that they hear is unique to the individual. The way in which each clinician experiences VT is based upon their own unique life and prior experiences. To truly understand the experience of the effects of trauma on clients and VT on clinicians, a further detailed explanation of the CSDT is necessary. This explanation is provided in Chapter 2 of this dissertation.

The CSDT was chosen for this present study as it describes in detail the potential for an individual to become altered by traumatic experience in such a way that it affects those individuals around them, namely, the therapist providing support to them. This theory describes the negative effects that trauma can have upon an individual, including a change in the individual themselves as a reaction to said trauma. In the same vein, vicarious trauma profoundly changes core aspects of the therapist's self (Iqbal, 2015) These changes alter the dimensions of their being and, subsequently, may alter their perception of others, placing the therapeutic relationship in jeopardy. This theory relates to the current study as it aided in the understanding of how different circumstances, unique to the individual, may contribute to their experience of vicarious trauma. In this study I attempted to investigate different circumstances of the therapist (e.g. level of experience in the field and percentage of trauma clients assigned to them) and how those circumstances related to their personal experience of VT. The research questions in the

present study built upon the existing theory by providing information regarding specific circumstances in which an individual's level of VT may be affected.

Definitions of Terms

First year clinicians are individuals who have completed approximately 1,750 hours of full-time supervised experience (New York State Office of the Professions, 2017).

Mental health professional is clinical psychologists, clinical social workers, licensed professional counselors, mental health counselors, and psychiatric or mental health nurses (National Alliance on Mental Illness, 2017).

Novice clinicians are professionals who have under 5 years of experience in the field (New York State Office of the Professions, 2017)

Seasoned clinicians are professionals who have 5 years or more of experience in the mental health field (New York State Office of the Professions, 2017).

Traumatized clients are any individual who had the unique individual experience, associated with an event or enduring conditions, in which (a) the individual's ability to integrate affective experience is overwhelmed or (b) the individual experiences a threat to life or bodily integrity (Pearlman & Saakvitne, 1995).

Vicarious resilience is a therapist being *positively* affected by the resilience of trauma clients, alterations of perspectives on the therapist's own life, and valuing the therapy work performed (Hernández et al., 2007).

Vicarious traumatization is the cumulative transformative effects upon therapists resulting from empathetic engagement with traumatized clients (McCann & Pearlman, 1990).

Assumptions

There were several assumptions for this study, including those involving external variables that could influence the data. I assumed that participants answered the statements on the questionnaires in an honest and candid manner. In order to have assurance that the participants answered honestly, anonymity and confidentiality were preserved. The participants were volunteers and were able to remove themselves from the study at any point in time without penalty. I assumed that participants had a sincere interest in participating in this research. I assumed that the data from this study would permit generalizations to mental health professionals in other locations but such generalizations were made with caution. These assumptions were necessary because it would take a considerable amount of time to validate every single response of every single participant so it was assumed that they were answering honestly and candidly. An assumption that the participants had a sincere interest in the research was necessary for the belief that they would participate fully and honestly. I assumed that the surveys I used for this study were measuring the constructs they were meant to measure and that they were valid measures for collecting the data on the variables in the study.

Scope and Delimitations

In this study I investigated the levels of VT and VR as it related to mental health professionals and their level of experience in the field as well as the percentage of

traumatized clients on their caseload. Mental health professionals from within the 6 surrounding counties of the researcher's home residence were to be the focus group for this study. This focus was chosen due to convenience of sampling the population.

Through this study I aimed to understand the levels of VT and VR that are experienced by mental health professionals at levels of training, novice, and seasoned practice. The purpose was to understand whether a difference exists between groups with regard to the level of VT and VR in working with patients who have experienced trauma and whether the percentage of traumatized clients on a clinician's caseload had an effect on the level of VT and/or VR experienced. I excluded other factors related to the development of VT or VR in mental health professionals as it was not feasible to investigate *all* potential contributing factors. To do this, many more scales/questionnaires, time, capital etc. would have been needed. Other populations, such as physicians who work with those who have experienced trauma were excluded from this research as given their work scheduling and demanding profession it would have been more difficult to gain participation.

Limitations

There were several limitations for this study. One limitation was related to the selected pool of participants. The participants for this study were selected from local counties to this researcher. Using a convenience sample such as this may not be able to be generally applied to the entire population of mental health professionals. Another limitation was time. The current study was due to run a span of a few months. This was a "snapshot" in time dependent on the conditions occurring at that time. Another limitation

was related to the selected instrument to collect the data. Surveys, while inexpensive and able to be sent out in mass quantities, can be problematic for professionals who already struggle with time constraints. These professionals may be less likely to participate because they simply feel as though they do not have the time. Participants who also may need clarification regarding how to fill out the survey will not be able to gain the clarification as easy as they would in a face to face interview situation. In order to address the limitations regarding the instrument itself, I provided contact information for participants to utilize if necessary. I made myself available to answer any and all questions that the participants may have had regarding the study.

Issues of Internal and External Validity

Creswell (2003) identified several types of threats to validity that can interfere with the ability of a researcher to draw inferences from the data collected in a study. Potential threats to the internal validity of the current study included history and mortality. Being that the true duration of this study was unknown and the data collection was to continue until the appropriate number of responses was reached, there was potential for events to occur during the data collection process that may or may not have influenced the outcomes of the study. For example, a participant's percentage of traumatized clients on their caseload may have changed, they may have begun a self-care regimen, either of which events may have altered their original levels of perceived vicarious trauma/vicarious resilience. Being that participation in the current study was voluntary, participants may have chosen to remove themselves at any time. If this occurred, the questionnaire responses of those participants would have been unknown

and therefore, would not have been able to be considered in the study. Participants may also have simply chosen to refrain from filling out the questionnaires after they received them.

Potential threats to the external validity of the current study included selection of participants, and history. The sample used in this study came from mental health clinics, schools, hospitals within the southeast region of New York State. Because most of the participants lived in one regional area, a threat is posed to the validity of generalizing results from this study to mental health professionals who live in other areas of the country. In addition, because the results of the current study were going to be collected within a certain time frame, the results could not be generalized to any past or future situations.

Significance

Through this research I intended to provide further information to those working in the helping professions with regard to the potential for VT occurrence in clinicians at different levels of practice as well as the potential effects that the percentage of traumatized clients on one's caseload may have on the level of VT experienced by the individual. By doing so, the ultimate hope was to raise a further level of awareness of the potential for VT in clinicians and the need for proper training on VT before, and during the time when professionals enter into therapeutic relationships with clients who have experienced trauma. I also intended to fill a gap in understanding by focusing specifically on the relationship between a clinician's time/experience in the field and their level of vicarious trauma and how the percentage of traumatized clients on the clinician's

caseload affects this relationship. This study was unique in that I addressed a very specific area of VT research not yet investigated thoroughly. Prior studies (Iqbal, 2015; Knight, 2013; Zarach & Shalev, 2015) have focused on the effects of VT, both positive and negative, as well as strategies that are utilized by therapists to cope with VT; however, thus far limited research is available regarding the levels of VT specific to therapists across different levels of clinical experience and the effect that the percentage of traumatized clients on the clinician's caseload might have upon that relationship. Insights from this study may facilitate positive social change in a number of ways. The results of this study would aid professionals in the field of psychology in understanding the potential for VT in mental health clinicians. In addition, insights gained from this study would bring awareness to professional and educational organizations with regard to the necessity for the development and/or maintenance of proper programs/trainings that can be provided to clinicians prior to and during their work with traumatized clients. Insights would also aid in providing information to those in the field with regard to how the percentage of traumatized clients on one's caseload may have an effect upon their levels of VT.

Summary

Working with traumatized individuals can be a difficult undertaking for the mental health professional. These professionals are at risk for developing vicarious VT from being exposed repeatedly to the horrific stories of their clients. Researchers have suggested that mental health professionals can also experience VR and positive outcomes from working with traumatized clients. The aim of this current study was to expand upon

existing research on VT and VR and to investigate the differences in mental health professionals with regard to their own personal levels of VT and/or VR. The ultimate goal was to bring further awareness to the mental health professional community about the potential for the negative and positive effects of working with trauma clients.

In Chapter 2 I will review the pertinent research and provide an in-depth discussion of the Constructivist Self-Development Theory (Pearlman & Saakvitne, 1995), the theoretical basis for this study, as it relates to VT and VR in mental health professionals. Previous literature on VT and VR will also be reviewed. The chapter will end with implications of past research and its influence on this present research.

Chapter 2: Literature Review

Introduction

In this literature review, I establish the need for continued research about VT and VR in mental health professionals. Traumatized individuals are a difficult population to work with and the work is not without risks to those who provide these individuals with therapeutic support (Harrison & Westwood, 2009). Research has shown that in listening to the traumatic life experiences of their clients, therapists can begin to experience their own personal feelings of anxiety, pain, distress, and feelings of being overwhelmed, similar to those feelings of their client (Bartoskova, 2015). This is not an uncommon occurrence for those working with traumatized clients. Sodeke-Gregson et al. (2013), stated that a large majority of therapists are at an increased risk for experiencing some level of secondary traumatic stress or VT from working with traumatized clients. Due to the intense nature of trauma work, therapists are more vulnerable to developing impairments such as compassion fatigue, burnout, and countertransference (Williams et al., 2012). These impairments can lead to psychological distress in the clinician and a subsequent loss of therapeutic integrity (McCormack & Adams, 2016). Individuals who engage in trauma work can experience patterns of intrusion, avoidance, and hyperarousal similar to the experiences of their clients. The repeated exposure to the traumatic stories told by their clients can lead to intrusive thoughts and psychological distress for the mental health professional (McCormack & Adams, 2016). Similar to their clients, clinicians may begin to make a conscious effort to avoid their own thoughts, feelings, and activities that may remind them of the events that were described to them by a client in

therapy (Baum, 2016). Feelings of hyperarousal can lead to sleep disturbances, a heightened startle reflex, difficulty concentrating, irritability, and hypervigilance. In addition to psychological disturbances, mental health professionals have reported somatic symptoms related to secondary traumatic stress and VT. Gastrointestinal problems and heart palpitations have been some of the somatic symptoms reported by clinicians who were experiencing secondary traumatic stress and/or VT.

VR is a newer concept that has been described as a therapist being positively affected by the resilience of trauma clients, alterations of perspectives on the therapist's own life, and valuing the therapy work performed (Hernández et al., 2007). The experience of VR results in growth and the transformation of the therapist consequent to client growth and resilience during trauma recovery (Hernández et al., 2010). VT is a significant risk that should be taken into account when working with trauma clients; however, there is much potential for positive outcomes of working with trauma clients. The concepts of VT and VR are not dichotomous in nature, rather they exist simultaneously and are of equal importance in terms of their exploration through research.

McCann and Pearlman (1990) first defined VT as the cumulative transformative effects upon therapists resulting from empathetic engagement with traumatized clients. These transformative effects can often have a significant negative impact upon the individual, including personal and professional changes within their lives (Welsh, 2014). In recent years, increased attention has been given to the topic of VT and the perspective

of those clinicians who work with individuals who have experienced trauma. Overall, the emphasis has been placed upon the implications for therapy, as well as the potential effects that VT may have on the clinician (Ben-Porat & Itzhaky, 2009). A large majority of the research on VT thus far has focused upon the manifestations of VT in the therapist and the potential impact that this condition may have upon them, both personally and professionally. Further research focusing on the actual levels of VT in relation to the clinician's experience in the field, as well as the percentage of traumatized clients on the clinician's caseload and how it relates to those levels of VT is warranted (Baum, 2016). Being that the concept of VR is rather new to the literature, limited studies that are quantitative in nature have attempted to measure this variable. Further research in this area is also warranted. Through the current research I intended to help fill the gap in the literature by providing a more comprehensive understanding of the levels of VT and VR that clinicians experience at different stages of clinical practice (i.e. first year clinicians, novice clinicians, and seasoned clinicians), as well as how the percentage of traumatized clients that a practitioner has contact with regularly has an effect on the relationship between the practitioner's experience in the field and their level of VT and VR.

The purpose of this study was to investigate individual differences between mental health professionals in varied levels of clinical experience and their personal levels of VT and VR. Through this study I aimed to investigate whether the percentage of traumatized clients on a therapist's caseload moderates the relationship between the clinician's experience level and the level of VT experienced by the therapist. I aimed to understand the levels of VT and VR that are experienced by mental health

professionals at levels of training, novice, and seasoned practice. I aimed to understand whether a difference exists between groups with regard to the level of VT and VR in working with patients who have experienced trauma and whether the percentage of traumatized clients on a clinician's caseload has an effect on the level of VT and/or VR experienced.

In this chapter I will include the literature search strategy utilized for this study, an in-depth review of the theoretical foundation that the study is rooted in, and a review of the literature related to key variables and/or concepts within the present study. The chapter will culminate with a summary of, and conclusions about, the literature review.

Literature Search Strategy

Empirical research in the area of vicarious traumatization appears in both newer peer-reviewed journals as well as long-standing psychological journals and textbooks. A search of literature was conducted digitally through electronic psychology databases such as PsycINFO, PsycARTICLES, multidisciplinary databases such as ProQuest Central and Thoreau Multi-Database Search, as well as a search of completed dissertations and thesis' that investigated topics similar to those in the current study. In order to ensure that the literature that was used for this current study was relatively recent, I completed a search of literature to include articles published only between the years 2009–2017. Further, over 50% of the articles included in the present literature review were obtained from between the years 2013 and 2017. I included a small number of literature sources from the 1990s because they were original contributors to the theory and concepts that this present study is rooted in. The list of search terms that I used to conduct the literature

search included: *vicarious trauma, vicarious traumatization, vicarious resilience, therapist, therapy, mental health professional, and clinician.* The sources of articles that I obtained and reviewed for this study were primarily obtained digitally; however, some materials that I obtained traditionally through existing print versions of professional journals. I also obtained a book that provided a wealth of information with regard to the topic of this study in relation to the therapist, as well as the theory in which this study is rooted.

Theoretical Foundation

The theoretical framework of this dissertation was rooted in Pearlman and Saakvitne's (1995) constructivist self-development theory (CSDT). This theory is based upon a constructivist foundation, postulating that individuals construct personal realities based upon the complex cognitive schemas used to interpret and make sense of life experiences (Williams et al., 2012). This approach posits that an individual's unique history shapes their experience of traumatic events (McCann & Pearlman, 1992). Much like the experience of a primary trauma for a client, the impact of VT on a clinician's psychological functioning and worldview can result in intra- and interpersonal difficulties. VT undermines the clinician's sense of safety in the world, leaving him or her with a sense of cynicism and mistrust for the world around them (Williams et al., 2012). These feelings can have serious implications for clinical practice.

Constructivist Self-Development Theory

There is a theoretical complexity that exists within the therapeutic process. Clinicians must utilize theory to engage in the interactive journey of therapy.

Clinicians must also often apply theory in an attempt to understand our clients. CSDT provides a basis for understanding the psychological, interpersonal, and transpersonal impact of traumatic events upon an individual. This theory also provides a framework for understanding the impact that trauma work may have upon the therapist (Pearlman & Saakvitne, 1995). This theory was originally cited by McCann and Pearlman (1990) but has continued to develop and evolve over the years. Pearlman and Saakvitne (1995) expanded upon the original concept by providing information with regard to the specific areas in which the gradual process of internal change for an individual occurs due to a traumatic event. For the purposes of this present study, the version of the theory that will be discussed in detail is rooted in Pearlman and Saakvitne's (1995) explanation and understanding of CSDT. When trauma is discussed in reference to the CSDT it is defined as the unique, individual experience, associated with an event or enduring conditions, in which the individual's ability to integrate affective experience is overwhelmed or the individual experiences a threat to life or bodily integrity (Pearlman & Saakvitne, 1995).

CSDT, as Pearlman and Saakvitne (1995) describe it, places a strong emphasis on integration, meaning, and adaptation. In terms of the therapeutic relationship, this theory requires the clinician to view the client as a unique individual who is actively trying to manage a particular set of life circumstances rather than viewing the client as a collection of symptoms (Pearlman & Saakvitne, 1995). This theory places significant emphasis upon an individual's strength and will to survive, as well as acknowledges the importance of an interactive therapeutic relationship. CSDT posits that individuals construct their own realities based upon their own unique experiences within the world

(Pearlman & Saakvitne, 1995). These unique experiences can also encompass traumatic events that occur in an individual's life. Clinicians cannot assume that they will be able to truly grasp the experiences of the client. Rather, clinicians must be mindful of the diversity that each individual brings to the therapeutic relationship, which includes his or her own exclusive set of life experiences. These exclusive sets of life experiences may include traumatic events, making it imperative for clinicians to understand that each individual who experiences trauma makes sense of it in his or her own unique way. The magnitude of the effects of trauma cannot be assumed to be experienced the same way across clients (Pearlman & Saakvitne, 1995). Similarly, the way in which mental health professionals experience and make sense of the traumatic stories that they hear is unique to the individual. The way in which each clinician experiences VT is based upon their own unique life and prior experiences. To truly understand the experience of the effects of trauma on clients and VT on clinicians, a further detailed explanation of the CSDT is necessary.

Based upon the CSDT, the experience of trauma can disrupt numerous aspects of the self, including one's frame of reference, self-capacities, ego resources, psychological needs, cognitive schemas, and memory system (Pearlman & Saakvitne, 1995). These potential disruptions have been described in the literature to provide a more comprehensive understanding of the inter and intrapersonal impact of trauma upon an individual.

An individual's frame of reference is the framework through which they interpret experiences. This framework of beliefs includes one's worldview, one's identity, and

one's spirituality (Pearlman & Saakvitne, 1995). A person's worldview includes their attitudes about other individuals, as well as their beliefs about the world around them (Pearlman & Saakvitne, 1995). The experience of trauma may distort an individual's worldview dramatically. An individual who was once trusting of those around them and held the belief that the world was benevolent in nature may experience feelings of skepticism of the world and general mistrust for others following a traumatic event. A once seemingly safe place may transform into a perilous environment if an individual's worldview is altered by a traumatic event. A person's identity refers to their sense of self across time, situations, and across physiological, cognitive, and emotional states (Pearlman & Saakvitne, 1995). An individual may begin to question their sense of self and/or lose certain aspects of themselves if this portion of their frame of reference is disrupted due to trauma. An individual who was once confident may find themselves questioning who they are if a traumatic event has caused a distortion in this area. Spirituality is where an individual's identity and their worldview converge (Pearlman & Saakvitne, 1995). Spirituality is related to the creation of meaning about the self in the world. For some individuals, spirituality is based upon the self's connection to a higher being or power. For others, it is a connection to nature, community, humanity, or some other entity larger than oneself (Pearlman & Saakvitne, 1995). That connection may diminish, or be lost altogether when a traumatic event is experienced and this aspect of an individual's frame of reference is disrupted.

Self-capacities relate to abilities that an individual has that allow that individual to maintain a sense of self across different situations. There are three specific self-capacities

that are identified in CSDT are: the ability to tolerate strong affect, the ability to maintain a positive sense of self, and the ability to maintain an inner sense of connection with others (Pearlman & Saakvitne, 1995). These self-capacities develop at a young age through interpersonal experiences. Positive experiences help individuals to develop a sense of self-worth and belief that they are worthy of being loved by others. Negative experiences or trauma may cause an individual to develop feelings of worthlessness.

Ego resources are abilities that allow the individual to meet psychological needs and to relate to others (Pearlman & Saavitne, 1995). These resources can include intelligence, willpower, and initiative. They also include a person's abilities to be introspective and understand things from different perspectives. These abilities allow an individual to foresee consequences, establish relationships with others, and establish boundaries. Individuals' ego resources develop through interactions with others and attempting to receive positive reinforcement through those interactions (Pearlman & Saakvitne, 1995).

Basic psychological needs motivate people's behaviors and, in turn, affect their relationships with others. These basic needs, much like self-capacities, are developed through early life experiences. These needs continue to develop over time and become more fixed and unchangeable as a person grows and matures. CSDT focuses on five specific psychological needs: safety, trust/dependency, esteem, intimacy, and control (Pearlman & Saakvitne, 1995). These needs are variable in terms of importance between individuals and are based upon the experiences that shape them. Often, when trauma occurs, an individual's five psychological needs are affected. Safety describes an

individual's need to feel secure and safe from harm in the world. Trauma may cause an individual to begin to view their world as unsafe. Trust and dependency can be related to a healthy dependency upon others or the self in which one trusts their own judgment and perceptions. An individual's trust may be affected due to a traumatic event, leaving them without trust for themselves or those around them. Esteem is related to valuing and holding oneself and/or others in positive regard. Many times, those who have experienced trauma begin to rethink what could have been done differently and begin to criticize themselves for not acting in that way (Pearlman & Saakvitne, 1995). Trauma can also lead an individual experience a damaged view of others based upon the perpetrator's actions. The individual may begin to lump all individuals into categories which are malevolent in nature.

Intimacy involves caring for oneself and others in a kind and loving way. When this basic need is disrupted, the individual will find it difficult to have love for oneself as well as to demonstrate love for others. Control is related to one's need to feel in control of one's thoughts, feelings and behaviors. Control can also relate to the need to control others in much the same way (Pearlman & Saakvitne, 1995). Often, individuals are involved in traumatic experiences in which they were not in control of their own feelings, thoughts, body, etc. These experiences may result in the individual attempting to control everything in their world at all times and not allowing their thoughts, feelings, emotions, etc. to flow freely through their conscious mind (Pearlman & Saakvitne, 1995).

Connected deeply with psychological needs are one's cognitive schemas. In terms of CSDT, the use of the term *cognitive schemas* refers to the conscious and unconscious

beliefs and expectations that an individual has about themselves and others. These schemas are organized based upon the previously mentioned five psychological needs. The cognitive schemas that are most affected by traumatic experiences are connected to an individual's highest psychological need areas (Pearlman & Saakvitne, 1995).

In terms of one's memory system, CSDT is very descriptive. It posits that traumatic memory often involves the fragmentation or dissociation of aspects of the individual's experience. There are five aspects that Pearlman and Saakvitne (1995) describe which are as follows: verbal memory, imagery, affect, somatic memory, and interpersonal memory. When an individual who has experienced a trauma can access these different pieces of their memory, they may be able to understand what happened fully and work through the traumatic event. When aspects of the memory are missing or distorted, the individual will have difficulty in processing the event with clarity.

Understanding the different aspects of the self that may become disrupted due to trauma is an important piece of CSDT and can be useful when attempting to comprehend how individuals construct their own beliefs and worldviews based upon their own experiences of trauma. The same theory can be applied to clinicians who may experience trauma vicariously through their clients.

In order to truly understand the concept of VT in this context, other concepts must be discussed. *Burnout* is a common term that is used to define the emotional and physical exhaustion that is often the result of being overloaded by one's profession. *Countertransference* is rooted in psychodynamic theory and refers to the

counselor's reaction to the client as a result of the counselor's own personal life experience, emotional processes, and defenses. *Compassion fatigue* is the consequence of being exposed to and showing empathy toward clients who have experienced traumatic events (Howlett & Collins, 2014). These terms are often used interchangeably; however, an important difference exists between these other states of being and vicarious traumatization. While an individual who is providing support to people who have had traumatic experiences may become "burned out", have reactions toward their clients based upon their own experiences, or experience and overwhelming sense of fatigue from consistently providing emotional support, VT *changes* an individual. A once trusting person who viewed the world as a safe and just place in which to live can be altered in terms of their belief system and perceptions of the world around them. These changes in the mental health professional can have serious implications for therapy. Having a comprehensive understanding of the literature regarding the potential for VT, how it affects the individual and, subsequently, the therapeutic relationship is imperative in order to progress forward toward making a positive social change.

The CSDT was chosen for this present study as it describes in detail the potential for an individual to become altered by traumatic experience in such a way that it affects those individuals around them, namely, the therapist providing support to them. This theory describes the negative effects that trauma can have upon an individual, including a change in the individual themselves as a reaction to said trauma. In the same vein, vicarious trauma profoundly changes core aspects of the therapist's self (Iqbal, 2015) These changes alter the dimensions of their being and, subsequently, may alter their

perception of others, placing the therapeutic relationship in jeopardy. This theory relates to the current study as it aids in the understanding of how different circumstances, unique to the individual, may contribute to their experience of VT. Through this study I will attempt to investigate different circumstances of the therapist (e.g. level of experience in the field and percentage of trauma clients assigned to them) and how those circumstances relate to their personal experience of vicarious traumatization. Through my research questions in the present study I will build upon the existing theory by providing information regarding specific circumstances in which an individual's level of VT may be affected.

Literature Review Related to Key Variables and/or Concepts

As mentioned previously, traumatic events affect not only those who are directly involved in the event but also those who attempt to provide support to the survivors. There are many areas all over the world in which access to public mental healthcare is limited; however, these are often the areas in which violence is commonplace and trauma survivors are many. For these areas, an importance of crisis support volunteers has been expressed (Howlett & Collins, 2014). Research conducted by Howlett and Collins (2014) into these support workers has demonstrated the importance of the position and also highlights the risks that come with the exposure of the support workers to the experiences of numerous trauma survivors and the explicit accounts of those experiences. This exposure can lead to an increased risk for the development of VT in the support worker. These crisis volunteer support workers are similar to many other mental health professionals who provide support to those who have experienced trauma. These *crisis*

interventionists as they were so named for this study, experienced short-term exposure to many similar accounts of violence, in this case intimate-partner violence. Upon conducting one-on-one in-depth interviews of the crisis interventionists in their study, Howlett and Collins (2014) found that for some of the support workers, the traumatic experiences of those individuals with whom they worked were not easily forgotten. The researchers found that the overall majority of support workers discussed the emotional burden that came with listening to the client's traumatic experiences repeatedly. Many of the support workers reported experiencing feelings of anger, frustration, annoyance, and confusion. Other support workers reported feelings of unpreparedness to deal with these trauma survivors, subsequently developing feelings of anxiety and being overwhelmed. The importance of recognizing the onset of symptoms related to VT to avoid or manage personal changes that occur due to this trauma was noted. Howlett and Collins (2014) indicated that those who work with trauma survivors must be aware of their own levels of VT to remain effective in their work. Understanding the signs and symptoms, maintaining boundaries, and a moderate case load were all suggestions in how crisis support workers would be able to maintain personal mental health as well as an effective helping relationship with the victims with whom they were working. Suggestions for future research included conducting the study with other populations of support workers in order to enhance the generalizability of the study.

Vicarious Traumatization and Gender

Baum (2016) investigated potential gender differences in mental health professionals with regard to levels of secondary traumatic stress (STS)

and VT. This research reiterated the fact that mental health professionals who work with clients who have experienced trauma are at a risk for experiencing secondary traumatic stress and VT. While there is potential for any mental health professional working with trauma clients to develop these difficulties, Baum's (2016) study reviewed prior research and the specifics regarding differences in gender when it came to secondary traumatic stress and VT. Baum's (2016) findings revealed mixed results in terms of STS and gender. Baum (2016) found in some of the studies that were reviewed, females were more susceptible to STS, while in other studies, males were the more susceptible gender. Further yet, Baum's (2016) review of other studies found no difference between genders at all. It was highlighted however, that in certain studies, information regarding the amount of traumatized clients on the mental health professionals' caseloads as well as the amount of time spent with these clients (frequency) was not accounted for, creating some questions regarding the results (Baum, 2016). One of the key takeaways from this research was that while gender is an important aspect to investigate when it comes to secondary traumatic stress or VT, other components to the mental health professional must also be investigated. There is potential for issues to arise while working with traumatized clients, making it imperative to have information about other factors and how those factors may contribute to or increase the risk of a clinician experiencing some level of secondary traumatic stress and/or VT. Future research that gave gender a more central position, than the marginal position it is typically given, was suggested. It was also recommended that future research that provides more information on the clinicians' exposure to traumatized clients be conducted. This literature provided information with

regard to a specific variable that may be influential on the development of VT in mental health professionals.

Vicarious Trauma and Therapist Outcomes

In their study, Ben-Porat and Itzhaky (2009) discussed the negative and positive implications for therapists working with victims of family violence. The researchers provided more information on the possible implications of working with victims of family violence in terms of secondary traumatization, VT, and growth. Further, investigation of the positive and negative changes that may occur in therapists in terms of their own personal well-being, personal lives, and family life was provided. The researchers touched upon what working with victims of family violence often entails. These clients are often victims of ongoing trauma, not a singular event. As the trauma continues for these individuals, so do the stories that the clients share with the mental health professional. As mentioned previously, this continuous exposure to such stories can have negative behavioral, emotional, and social implications for the therapist. Ben-Porat and Itzhaky (2009) described the effects of working with traumatized clients in terms of the therapist becoming "infected" by the victim and experiencing symptoms similar to the post-traumatic stress that is experienced by the client. This particular research focused on the potential negative and positive outcomes for mental health professionals working with trauma victims. It also included information regarding the potential for growth in the mental health professionals who work with these types of clients. In their review of the literature, Ben-Porat and Itzhaky (2009) found that therapists can sometimes experience an increased appreciation for life and personal

growth. In their particular study however, an increase in growth was seen more in those mental health professionals that did not work with trauma clients than those who did, suggesting that the work with trauma clients may create a hindrance surrounding the personal growth of the mental health professional. Results of this study also indicated that mental health professionals working with trauma clients experienced a negative shift in their spousal relationships and change of worldview (Ben-Porat & Itzhaky, 2009). They did however experience positive changes in the areas of interpersonal communication, spousal awareness, and parenting. The researchers bring to light the potential for positive changes to be experienced by the mental health professional in working with trauma clients; however, the fact that negative outcomes are also a real possibility for these professionals cannot be ignored.

Theoretical Explanations for Vicarious Trauma

A review of literature conducted by Chouliara et al. (2009), aligns with much of the previous literature discussed thus far. In addition to many of the topics covered, the authors discuss a number of theoretical explanations that are often used to understand why mental health professionals might develop VT. Cognitive theories suggest that a mental health professional's key beliefs about one's self and about the world around them may become distorted as a result of the repeated exposure to their client's trauma (Janoff-Bulman, 1985). McCann and Pearlman's (1990) theory suggested that the exposure to their client's narratives about the abuse of trust, powerlessness, and lack of safety may be assimilated and incorporated into the therapist's own personal cognitive schemas causing them to view the people around them and the world in

which they live in a negative light. The findings of Chouliara et al. (2009) indicated that overall, psychological disruption was reported in mental health professionals working with trauma clients in a broad range of settings (Chouliara et al., 2009). This psychological disruption is similar to that of the disruption of the aspects of self in the CSDT that the present study is rooted in.

Chouliara et al. (2009), reviewed a number of studies that revealed symptomatology in mental health professionals consistent with post-traumatic stress disorder (PTSD) as well as high levels of disruption in one's belief system. The PTSD symptoms included behaviors related to avoidance and intrusion while the disruptions in beliefs included trust, intimacy, and safety. Interestingly, the mental health professional's own previous experiences of maltreatment, victimization, sexual violence, and/or childhood sexual abuse contributed to the VT experienced (Chouliara et al., 2009). These results align with Pearlman and Saakvitne's (1995) description of the CSDT in which an individual's experience of trauma or VT is based upon their own unique history. A number of studies included in the review of the literature conducted by Chouliara et al. (2009) compared mental health professionals working with survivors of sexual violence/childhood sexual abuse and those who worked with other client groups. The findings revealed that no significant difference existed between the groups with regard to VT and belief disruption. Other factors considered when investigating VT in mental health professionals included demographics, level of exposure to sexual trauma work, professional experience, personal history of sexual violence or childhood sexual abuse, and general levels of distress and coping. The researchers found that demographics

were not associated with VT; however, higher levels of exposure to the sexual trauma work as well as less professional experience were associated with greater levels of VT (Chouliara et al., 2009). The researchers recommended that future research address a clear development of operational definitions of constructs that can be used by all researchers as was the use of other populations (e.g. volunteer counselors) in the research.

Research has investigated the experiences of mental health professionals across different settings. Culver et al. (2011) utilized a mixed methods study to explore VT as experienced by mental health professionals in the post-Hurricane Katrina New Orleans region. The study also examined the impact of VT on the personal and professional functioning of the mental health professionals via interviews with the agency directors. The authors developed the Vicarious Traumatization Questionnaire (VTQ) to assess a mental health professional's self-reported experiences of VT in an anonymous way. The questionnaire was sent via email to mental health agency directors in five selected parishes in the New Orleans area. The directors were instructed to distribute the questionnaire to the mental health professionals employed at their agencies. The directors were then asked via email if they would take part in an interview. Structured interviews, 60-minutes in duration were conducted and videotaped for record. The results of this study revealed notable levels of VT in the mental health professionals within this specific area. The clinicians who worked with trauma victims reported many adverse psychological symptoms which included anxiety, suspiciousness, and increased feelings of vulnerability (Culver et al., 2011). These participants also reported that their sense of

personal safety as well as their frame of reference, one of the aspects of the self previously mentioned, were disrupted due to working with trauma victims. Overall, a significant correlation was found between the mental health professionals working with trauma clients and their own level of VT (Culver et al., 2011). The interviews conducted with the agency directors revealed common themes, one in which recognized that mental health professional's perceptions of others and worldview are often affected due to their work with trauma clients (Culver et al., 2011). The researchers suggested that future research surrounding the development of prevention and treatment regimens to mitigate some of the effects of VT is warranted.

Harrison and Westwood (2009) conducted a study in which some preventative practices were explored. They provided an in-depth look at some of the protective practices that might mitigate the risks of VT in mental health professionals. Harrison and Westwood (2009) investigated practices that might be put in place to prevent or ameliorate the harmful effects of VT. The researchers recruited individuals for the study who were trained at the masters or doctoral level, had a minimum of 10 years of experience working with traumatized clients, and had self-identified as having managed well in their work. Narrative data was collected through interviews that occurred in three phases. Part of the interview process involved asking the participants how they managed to sustain their personal and professional well-being, despite their work with traumatized clients over many years. The results provided the researchers with a wealth of information regarding the preventative practices that the clinicians engaged in in order to mitigate the risks of VT. A total of nine major themes were revealed which included:

countering isolation, developing mindful self-awareness, consciously expanding perspective to embrace complexity, active optimism, holistic self-care, maintaining clear boundaries and honoring limits, exquisite empathy, professional satisfaction, and creating meaning (Harrison & Westwood, 2009). The clinicians interviewed revealed that they dealt with any feelings of isolation that may occur in their work by drawing upon continuity in relationships. These relationships were in all realms that are at risk of being affected in a negative way by their work. These individuals expressed the importance of supervision and how it helps to decrease feelings of isolation and reinforces their commitment to engage in self-care practices. Peer supervision also provided these individuals with an opportunity to connect with others and share different strategies on how to address VT (Harrison & Westwood, 2009). Participants emphasized the importance of proper training on VT as well as the importance of strong, supportive interpersonal relationships outside of the work setting. The practice of mindfulness was also emphasized as an important tool in protecting oneself from the harmful effects of VT. The participants shared with Harrison and Westwood that part of their preventative practices often involve challenging negative cognitions in order to expand their perspective when they become caught up in negativity (Harrison & Westwood, 2009). They actively encourage themselves to view the positive side of things and to not allow their worldview to become negatively impacted as a result of the challenging work that they do. The clinicians interviewed took a holistic approach to self-care, which they considered to be imperative in maintaining their personal and professional well-being. Maintaining clear boundaries and honoring limits allowed for these clinicians to maintain

an appropriate therapeutic relationship with their clients as well as to recognize that as the clinicians they are not responsible for making change in the clients lives but rather a facilitator for that change (Harrison & Westwood, 2009). By engaging in empathetic engagement with their clients, these clinicians were able to experience true satisfaction in their work, fueling their desire to help and to maintain a positive therapeutic relationship. All of the clinicians interviewed expressed that they feel much satisfaction when they are effective in their work. All of the preventative practices that were discussed aids in their ability to be effective, in turn solidifying the need for continued engagement in these preventative practices (Harrison & Westwood, 2009). Further research investigating the differences between clinicians who are managing well in their work versus those who are not was suggested as this study only looked at a small group of individuals who self-reported that they were managing quite well in their work.

Knight (2013) went on to further explain indirect trauma and the implications for self-care, supervision, the organization, and the academic institution in his study. Knight (2013) identified the emotional, psychological, and cognitive effects that working with trauma survivors, specifically those who are adult survivors of childhood physical and sexual abuse, has upon those who provide clinical services to these individuals. Like Harrison and Westwood (2009), he too identified factors that may mitigate the risk of experiencing VT. He also investigated factors that might increase this risk. Knight (2013) stated that a common problem among trauma survivors is their distorted perceptions of self and others. Practitioners who work with these trauma survivors are also likely to experience changes in their own views about themselves and the world around them. The

risks of VT are often higher for those professionals who have less education as well as those who have less experience working with trauma survivors (Knight, 2013). Individuals who are not prepared through their educational program to deal with this population of clients will have a more difficult time in handling the repeated exposure to traumatic stories in therapy sessions. Students also seem to be at a higher risk of developing VT (Knight, 2013). In terms of mitigating the potential risks of VT, Knight (2013) stated that organizational support can be helpful. Individuals who feel that they could not talk to their supervisors are at a greater risk of developing different types of secondary trauma. The value of an "affective check-in" during which as supervisor is asking the supervisee about their emotional responses is immeasurable (Knight, 2013). Being proactive about the potential risks of VT is extremely important. This requires that the clinician engage in some form of self-care to maintain their own mental health on a daily basis. Knight moves on to discuss the critical role that the employing organization can play in student and staff members' experiences with indirect trauma. A supportive work environment can mitigate the effects of indirect trauma, while an unsupportive work environment can make things more challenging for the clinician. Further, the importance of addressing the manifestations of indirect trauma in the classroom was indicated. The educational program should be providing students with information regarding the risks of indirect trauma and ideas for preventative practices that could mitigate these risks. Knight emphasized the need for further research to examine ways in which to create supervisory, academic, and organizational climates that are supportive to clinicians and students in appropriate ways.

Vicarious Traumatization, Job Turnover and Burnout

Understanding VT and the impact that it may have upon mental health professionals is imperative for many reasons; one of which includes high rates of turnover at mental health agencies. Middleton and Potter (2015) outlined the relationship between VT and turnover among child welfare professionals in their study. Child welfare professionals work with maltreated children and their families on a daily basis. They are often exposed to the most severe forms of child abuse and trauma, including sexual abuse and physical abuse, resulting in the death of a child. The child welfare professional often works within very unpredictable environments, including crime scenes and severely neglectful homes (Middleton & Potter, 2015). The nature of this work places these professionals at risk of experiencing a negative impact upon their own emotional well-being. This negative impact may manifest in a shift in trust for others, a sense that one has lost control, issues with intimacy, social withdrawal, etc. This negative impact can limit the professional's ability to perform the duties of their role effectively, leading to a decrease in the quality of service provided to those in need and potentially contributing to overall workforce capacity issues (Middleton & Potter, 2015). Child welfare organizations often experience difficulties in having enough service providers for the heavy caseloads which can lead to burnout and, subsequently, a high rate of turnover in this field. The high rate of turnover in this field is of large concern as these services are desperately needed in many communities. This concern led to the investigation of the relationship between VT and turnover among child welfare professionals. Results of this study indicated that approximately 30% of participants experienced some level of VT.

63% of the participants reported observing a coworker experiencing negative effects due to the nature of the job (Middleton & Potter, 2015). It was reported that 50% of the participants reported thinking of leaving their organization at one point or another and 25% reported actual plans to leave their organization in the next 12 months and are actively seeking employment (Middleton & Potter, 2015). The researchers emphasized the importance of the relationship between VT and turnover in these organizations because it has many implications for the future. Suggestions for future research included expanding the study to other agencies so that the results are more readily generalizable as well as to examine potential mediators and interventions that might be used to mitigate some of the risks as well as the negative impacts that VT can have upon mental health professionals.

In their study, Sodeke-Gregson et al. (2013) assessed the prevalence of, compassion satisfaction, burnout, and secondary traumatic stress in a group of therapists within the United Kingdom. While this particular study was not directly and specifically investigating VT, it is important to understand the predictors of these other potential hazards of working with trauma survivors as they many times relate to one another and/or lead to VT. Sodeke-Gregson et al. (2013) found that while the majority of the participants scored within the average range for compassion satisfaction and burnout, 70% of the therapists' scores indicated that they were at a high risk for secondary traumatic stress. In terms of predictor variables, it was found that age, time spent in research and development activities, perceived management support, and perceived supervision support were significant positive indicators of compassion satisfaction (Sodeke-Gregson

et al., 2013). Perceived management support and age were significant negative predictors of burnout. The more an individual perceived support, the less their risk became in terms of experiencing burnout. Finally, the time spent in supervision and time spent engaged in self-care were significant positive predictors for secondary traumatic stress if the individual had themselves experienced a traumatic event at one point in their lives (Sodeke-Gregson et al., 2013). This study, similar to others, found that the more supportive the work environment and the more professional development and supervision take place, the less the risk is of VT or secondary traumatic stress in the professional. While this study found that a supportive work environment and supervision helped to lessen the risk of VT for clinicians, there has been evidence to the contrary. Further research to explore the positive and negative experiences of therapists working with trauma clients was suggested in order to build upon the existing knowledge in this area.

Williams et al. (2012) utilized path analytic procedures to assess a comprehensive theoretical vicarious traumatization model based upon the CSDT, the same theory that the present study is rooted in. The researchers used a comprehensive CSDT-based model to examine the relationships between and the combined impact of childhood trauma, personal wellness, supervisory working alliance, and organizational factors. Similar to the study conducted by Sodeke-Gregson et al. (2013), this study investigated the support of the clinician's organization and the supervisory relationship, as well as some additional variables. Sodeke-Gregson et al. (2013), predicted that a supportive organizational culture, personal wellness, and a positive supervisory relationship would increase a mental health professional's resilience toward developing VT. They also

predicted that a mental health professional's workload and own personal history of trauma would result in an increased vulnerability toward developing VT. The participants used for this study included mental health professionals working full time in community health organizations. Surveys were used to investigate the different variables in the study. The researchers found that personal wellness mediated the relationship between childhood trauma and VT. Contrary to the findings in the study conducted by Sodeke-Gregson et al. (2013), the researchers found that the supervisory working alliance did not have an effect on VT in mental health professionals. Further, the hypothesis that organizational culture would have a negative direct effect on VT was not supported. Finally, the hypothesis that workload would have a positive direct effect on VT was not supported (Williams et al., 2012). These findings suggested that overall, personal wellness is an important factor in lowering a mental health professional's risk of developing VT. While supervisory alliance and organizational factors have been suggested by others to help mitigate some of the risk for VT in mental health professionals, those notions are not supported by this particular study. Williams et al. (2012) suggested that future research include the assessment of the relevance of the CSDT to the development of VT by testing other models. Assessing a similar CSDT using a larger sample size was also suggested.

Ivicic and Motta (2017) conducted one of the most recent studies on VT among mental health professionals. Eighty-eight psychologists, social workers, mental health therapists, and creative arts therapists were asked to complete the modified Stroop procedure. They also completed the Secondary Traumatic Stress Scale, the Life Events

Checklist, the Job Satisfaction Survey, and a demographics questionnaire. A multiple regression was conducted to determine whether there was a relationship between exposure, as defined by the number of hours spent with trauma clients and number of years employed as a mental health professional, and secondary traumatic stress, as measured by response latencies on the modified Stroop procedure. A multiple regression analysis was also used to determine whether or not those who have higher levels of job satisfaction and quality supervision would have lower secondary trauma symptoms than those who are less satisfied at their job. Finally, a hierarchical regression was conducted to determine the relative contribution of demographic variables and personal trauma history, as measured by the Life Events Checklist (Ivicic and Motta, 2017). The results of this study revealed that between 23 and 27% of respondents were positive for secondary traumatization (Ivicic & Motta, 2017). Overall, results indicated a relatively high level of secondary trauma among mental health professionals.

Vicarious Resilience and Personal Growth

Another important area that has been investigated with regard to VT in mental health professionals that is mentionable is personal growth and VR as a result of VT. Bartoskova (2015) conducted a critical literature review that summarized existing literature on post-traumatic growth in therapists that have experienced vicarious traumatization. Much literature has focused on the negative effects that mental health professionals experience as a result of VT. More recently, research has begun to focus on the positive outcomes that are experienced by some individuals as a result of VT. These outcomes were termed “post-traumatic growth” and VR. In terms of this study, there

were key research questions that the author was hoping to answer: 'Do trauma therapists experience post-traumatic growth?', and 'What are the key factors that predict post-traumatic growth in trauma therapists?'. The author examined a synthesis of resources in order to answer these research questions.

In his literature review, Bartoskova (2015) defined post-traumatic growth as an experience of psychological change that occurs after the challenge of a traumatic event as a result of enduring psychological struggle. Unlike the typical negative effects that manifest in an individual when they experience VT, post-traumatic growth alters the individual's perception of others and the world around them to be viewed through a more *positive* lens. These individuals often experience an increased appreciation for life, enhanced personal growth, better interpersonal relationships, etc. The concept of post-traumatic growth has been around for many years. In fact, this concept goes back to the early writings of ancient Hebrews, Greeks, and Christians. There has long been an idea that trauma can incite positive change in an individual's life and allow for growth to take place (Bartoskova, 2015); however, this concept has just recently been investigated in depth with regard to VT in mental health professionals.

How therapists achieve post-traumatic growth has been debated for some time. It has been suggested by some that in order for an individual to experience post-traumatic growth, they must already have a sense of personal control over life. Having this sense of control allows for the individual to handle the uncontrollable nature of traumatic events better than those individuals who do not already have a strong sense of life control. It has also been suggested that the way in which clients depict their stories of heroic struggle

and survival can enable the therapist to experience growth (Pearlman & Saakvitne, 1995). Hearing these stories of trauma, perseverance, and triumph can encourage the mental health professional to take on their own personal struggles in a different way, resulting in more positive outcomes. Witnessing a client's determination to move past traumatic experiences can result in a renewed sense of positivity and inspiration for the therapist working with them. This literature review emphasized that working with trauma clients can cause a shift in the perspective of the therapist in which they begin to reprioritize their life in terms of what is truly important and experience post-traumatic growth or VR (Bartoskova, 2015). This study concluded with multiple suggestions for future research, one of which was the further investigation of key occupational and psychological factors that enable therapists to experience post-traumatic growth.

A study that Pack (2013) conducted also investigated VT and VR in mental health professionals. The author of this article wanted to discuss VR in the context of self-care for clinicians working with survivors of sexual violence. VR was described as a concept that suggests that mental health professionals actively evolve positive processes and strategies to maintain their therapeutic effectiveness when dealing with the traumatic disclosures of their clients (Pack, 2013). The stories of trauma do not impede the therapist; rather, the stories influence the therapist to remain strong for their clients. Similar to post-traumatic growth, VR is related to the positive outcomes related to the experience of vicarious trauma. These positive outcomes are more likely if the clinician engages in a number of protective factors. Similar to the results of other studies, Pack (2013) suggested that clinicians who utilize social and organizational supports, maintain a

certain level of optimism, involve themselves in their community in order to gain a sense of connectedness to others, engage in enjoyable hobbies and leisure time, and have a level of spirituality tend to be able to be able to handle their work with trauma clients in a better way (Pack, 2013). These clinicians are more resilient even though the nature of their work is stressful and difficult at times. Pack (2013) suggested that in addition to the protective factors, trauma-informed models of clinical supervision are one of the most important resources for the mental health professional who works with trauma clients. The author suggested that future research into the implications of a spiritual dimension for practice was necessary. Pack (2013) also stated that another area in which further research is needed is how mental health professionals see themselves as a resource for survivors of sexual violence for whom religion and spirituality are important guiding factors in managing their lives.

In the same vein, Welsh (2014) conducted a qualitative descriptive study in which she explored clinicians' experience of VT and/or VR in working with refugee clients. The purpose of this study was to gain a better understanding of VT and the ways in which VT affects clinicians. Welsh (2014) also looked to determine whether or not clinicians experience VR in working with the refugee population and if that VR has an impact on the clinician's approach to treatment, practice style, and personal life. Welsh (2014) defined VR as the potential positive effects of engaging with a client's traumatic experience in a therapeutic setting on clinicians working with trauma survivors (Welsh, 2014). Most of the participants interviewed reported positive clinical and personal changes after working with the refugee population. The participants were able to identify

successful ways of coping that they engaged in intentionally. Some participants reported that they spoke with their spouses or friends in the field about the trauma in order to mentally process the cases. Other participants reported that they discussed the difficult cases with supervisors who were experienced in this area. Self-care was also utilized as a tool among the participants to handle any emotional impact that they may have experienced in working with trauma survivors. Other participants reported engaging in ritualistic techniques that they had established to deal with trauma (i.e. making a mental note that "when I cross through this doorway, I leave my work behind") (Welsh, 2014). Although participants reported being affected by the stories of their clients both personally and professionally, all of them were able to identify positive ways in which they coped with their trauma work. These positive coping strategies have been suggested to lead to VR in mental health professionals (Welsh, 2014). This study proposed several areas for future research. Welsh (2014) suggested expanding upon the present research by including clinicians in other agencies that work with refugee survivors in order to increase generalizability. The impact of supervision, specifically qualities of supervision, upon the levels of VT and VR was also a recommendation for future exploration.

Frey et al. (2016) investigated VR in sexual assault and domestic violence advocates. Their intent was to investigate predictors of VR in the individuals who participated in the study. Frey et al. (2016) found that increased experience of personal trauma and peer relational quality predicted increased VR in the participants. While personal trauma is a significant risk factor for VT, it simultaneously has the potential to stimulate personal growth in therapists (Linley & Joseph, 2007). The findings of the

study conducted by Frey et al. (2016) suggest that mental health professionals who have their own personal trauma history may benefit from their work with trauma clients. Suggestions for future research included a replication of the study in order to increase its validity.

Edelkott et al. (2016) conducted a qualitative study in which they explored the concept of VR in thirteen therapists working with clients who had been tortured. Semi structured interviews were given to the participants which focused on the participant's background, their knowledge of VT, and their own personal experience with VR (Edelkott et al. 2016). Analysis of the interviews revealed four major themes that were discussed: change in the therapists' self-perception and their general outlook on the world, altered spirituality, modified thoughts about self-care, and new views on trauma work and connecting with clients. The results of the study conducted by Edelkott et al. (2016) suggested that VR can significantly influence therapists' personal lives as well as their therapeutic work. The researchers suggested that future research investigate varying influences on VR. It was also suggested that future research investigate VR even further in other populations as this is a relatively new topic.

These studies that investigated VR in mental health professionals were discussed because it is a newer aspect of VT research and an important topic to be aware of. Many mental health professionals across organizations are at risk for developing VT. It is important to also be aware of the potential for clinicians to experience positive outcomes as a result of trauma work. These positive outcomes can be experienced if the clinician develops the ability to cope with diversity and utilize different strategies to keep their

own mental health in check. Resiliency is powerful and can change the way that a clinician approaches therapy, subsequently enhancing the therapeutic relationship and setting the example for growth and positivity.

Summary and Conclusions

All of the studies discussed present a wealth of information with regard to VT and the mental health professional. Although preliminary research in the area of VT has explored the risks of VT, the way in which VT manifests in the mental health professional, preventative practices to mitigate these risks, the potential for post-traumatic growth/VR, and implications for the therapeutic relationship, what has yet to be established in the literature is how the percentage of trauma clients on a clinician's caseload affects the relationship between the clinician's experience level in the field and their personal level of VT. The design for the present study was chosen based upon a judicious review of existing psychological literature in the areas of VT in the mental health professional. The next chapter discusses the methodology, setting, sample, instrumentation, and analysis that will be used to conduct the study.

Chapter 3: Research Method

Introduction

This chapter includes a description of the present study's design, sample, instrumentation, data analysis, and ethical considerations. An overview of the present study's design will include a rationale for why I selected this particular design. I will present the sample characteristics and size as well as a description of the instrumentation that was used. I will also discuss the data collection process and analysis in this chapter.

Purpose of the Study

The purpose of this quantitative study, using a nonexperimental design, was to investigate individual differences between mental health professionals with varied levels of clinical experience and their personal levels of VT and VR. Through this study I also aimed to investigate whether the percentage of traumatized clients on a therapist's caseload moderated the relationship between the clinician's experience level and the level of vicarious trauma/vicarious resilience experienced by the therapist. I aimed to understand the levels of VT and VR that were experienced by mental health professionals at levels of training, novice, and seasoned practice. The purpose of the study was to understand whether a difference existed between groups with regard to the level of VT and VR in working with patients who have experienced trauma and whether the percentage of traumatized clients on a clinician's caseload had an effect on the level of VT and/or VR experienced.

Research Design and Approach

In this quantitative study I employed a nonexperimental, correlational design. My goal was to collect statistical data to evaluate the differences in mental health professionals in terms of their levels of VT and VR. I compared the levels of VT and VR of mental health professionals at first year, novice, and seasoned levels of experience in the mental health field. I also conducted a test for the moderating effect of the third variable, percentage of traumatized clients on the clinician's caseload. My reason for using the moderating variable was to understand if the percentage of traumatized clients on a clinician's caseload impacted the relationship between the clinician's level of experience and his/her level of vicarious trauma and/or vicarious resilience. The experience level of the clinician acted as the independent variable. I separated experience into three categories: first year clinicians, novice clinicians, and seasoned clinicians. First year clinicians were those individuals who had completed approximately 1,750 hours of full-time supervised experience as described by the New York State Office of the Professions requirements for licensure/certification and were just beginning their career independently. I defined novice clinicians as professionals who have under 5 years of experience in the field (as defined by the New York State Psychological Association). Seasoned professionals were defined as those professionals who have 5 years or more of experience in the mental health field. The term *mental health professional* included clinical psychologists, clinical social workers, licensed professional counselors, mental health counselors, and psychiatric or mental health nurses. The dependent variables for this study were the level of vicarious trauma/vicarious resilience as reported by the

mental health professionals. Finally, the percentage of traumatized clients on the clinician's caseload served as a moderating variable. I defined traumatized clients as any individual who had the unique individual experience, associated with an event or enduring conditions, in which (a) the individual's ability to integrate affective experience is overwhelmed or (b) the individual experiences a threat to life or bodily integrity (Pearlman & Saakvitne, 1995).

For the current study, I used a one-way, between subjects analysis of variance (ANOVA) to compare outcome means of the different groups in the study. I selected a quantitative, nonexperimental, correlational design for the present study for several reasons. Quantitative research is empirical, using numerical, and quantifiable data. Any conclusions made are based upon experimentation and objective and systematic observations (Belli, 2008). Nonexperimental research is based upon variables that already exist (Belli, 2008). As opposed to experimental research in which variables are manipulated, nonexperimental research does not manipulate variables. Being that the present study involved the investigation of existing variables, a nonexperimental design was most appropriate. Creswell (2009) described survey research as a type of quantitative, nonexperimental research that provides a description of trends, attitudes, or opinions of a population by studying a sample of that population. I chose this type of research because it aligns with the objective of the study; gaining a description of the attitudes and experiences of mental health professionals who work with individuals who have experienced trauma. Using a survey design allows for easy data collection of a

larger sample and is cost effective because it is not necessary for the survey to be administered by the researcher or other trained professional.

For the current study, I assessed the levels of vicarious traumatization using the Secondary Traumatic Stress Scale (STSS; Bride, Robinson, Yegidis, & Figley, 2004). I utilized this17-item self-report measure of secondary trauma to measure the dependent variable of level of vicarious trauma in mental health professionals. In order to assess the level of VR in the mental health professionals in this study, I used the the Connor-Davidson Resilience Scale (CD-RISC; Connor & Davidson, 2003).

Design Justification

I selected this design for several reasons. A nonexperimental design lacks the manipulation of the independent variable (Creswell, 2003). I chose this design because no such manipulation is to take place. This design allows for relatively short, shallow data collection via survey methods. This kind of data collection within this design allows for the researcher to provide the surveys to the participants and collect the data as the surveys are completed. This type of data collection eliminates the need for multiple individuals to be involved in the data collection, as the surveys are self-explanatory and do not need to be administered to the participants (Becker, 2018). Costs were minimal due to the nature of this study. Most importantly, this design was noninvasive. No treatment or experimentation was applied, removing the risk of interference of normal function, safety, and/or peace of mind of the participants involved.

Commonly, nonexperimental studies are used in the field of psychology and are purely observational and the results intended to be purely descriptive (Thompson &

Panacek, 2007). The review of the literature I conducted demonstrated that numerous previous studies related to VT and/or VR utilized a nonexperimental approach, as the studies were either reviewing prior research (Baum, 2016) or collecting and describing information regarding what has already occurred with regard to mental health professionals and VT and/or VR (Howlett & Collins, 2014). The present study results align with prior research in this area by utilizing a non-experimental design. Thompson and Panacek (2007) described multiple nonexperimental designs, including the use of surveys and questionnaires. There are a number of different non-experimental designs that have been described by Thompson and Panacek (2007). The use of surveys and/or questionnaires allows the researcher to query the research question(s) directly and collate the answers. Through the present study I sought to utilize surveys/questionnaires to gain information from the participants to answer the research questions.

Sampling and Sampling Procedures

The sample I collected for this study was from local mental health agencies in the southeast area of New York State, including but not limited to, hospitals, in-patient clinics, outpatient clinics, etc. Any organization that specialized in providing services to individuals who have experienced trauma were included in the sample.

I used this convenience sample from local mental health agencies/organizations to obtain the data necessary to study the proposed research question. However, using data from a single area of New York State may have limited the generalizability of conclusions based upon the data. Using a convenience sample is low cost; however, there is a chance of bias and an over or under-representation of groups.

The sample consisted of information provided by mental health professionals who work with individuals who have experienced a trauma. I used demographic forms to gather information regarding the mental health professional's level of clinical experience (i.e. years in the field), and percentage of traumatized clients on their caseload. For this study, I collected data from the agencies between 2020 and 2021. The data I collected included information regarding the levels of VT and VR, as well as the demographic information of the mental health professionals in the study and their reported percentage of traumatized clients on their caseloads.

Statistical power refers to the probability of accurately rejecting the null hypothesis when it is false (Wetherbee & Achenbach, 2002). I conducted a power analysis for ANOVA with three levels and one dependent variable in G-POWER to determine the minimum number of participants needed to achieve sufficient power for this study. Based on a power size of .80, (alpha of $p < .05$), and a medium effect size ($f2 = 0.25$), the minimum sample size needed for the study to have sufficient power was 159 (Faul et al., 2008). It is of note that I ran the dependent variables (VT, VR) separately using ANOVA.

Instrumentation and Operationalization of Constructs

Instrument for the Independent Variable

Purpose

The independent variable (IV) for this study was categorical. The purpose was to categorize the data into groups based on the literature. For this study, the IV groups were the experience level of the clinicians. I operationally defined experience level as the following three categories: first year clinicians, novice clinicians, and seasoned clinicians. First year clinicians were those individuals who had completed approximately 1,750 hours of full-time supervised experience as described by the New York State Office of the Professions requirements for licensure/certification and were just beginning their career independently. Novice clinicians were defined as professionals who had under 5 years of experience in the field (as defined by the New York State Psychological Association). Seasoned professionals were defined as those professionals who had 5 years or more of experience in the mental health field. The term *mental health professional* included clinical psychologists, school psychologists, clinical social workers, licensed professional counselors, mental health counselors, and psychiatric or mental health nurses.

Procedures

To categorize the data into these groups, I collected data from the demographic section of the questionnaire that the participants were asked to fill out. Each category of experience was provided and operationally defined on the demographic information sheet in order to ensure that the participants chose their level of experience correctly and based

upon the definitions provided. I used the data to categorize each participant into one of the three groups previously mentioned. These groups were mutually exclusive, so that a participant could only belong to one of the three groups.

Instrument for Dependent Variable(s)

Connor-Davidson Resiliency Scale (CD-RISC)

The Connor-Davidson Resiliency Scale (CD-RISC) is a standardized, self-report form designed to assist in assessing stress coping abilities and psychological resilience (Connor & Davidson, 2003). The CD-RISC has been developed and tested as (a) a measure of degree of resilience, (b) as a predictor of outcome to treatment with medication or psychotherapy, stress management and resilience-building; (c) as a marker of progress during treatment; (d) as a marker of biological (i.e. physical) changes in the brain. The scale also has promise as a method to screen people for high, intermediate, or low resilience (Connor & Davidson, 2003). I obtained permission from the CD-RISC author to use the instrument in this dissertation (see permission letter in appendix).

Procedures

The CD-RISC is a paper-and-pencil instrument that contains 25 items, each rated on a 5-point scale (0–4), with higher scores reflecting greater resilience. The CD-RISC is designed to be self-administered. Along with the demographic information form, participants also received a copy of the CD-RISC to complete. Respondents rated each item on a scale of 0–4, where 0 equals *not true at all*, 1 equals *rarely true*, 2 equals sometimes true, 3 equals *often true*, and 4 equals *true nearly all of the time*, with higher scores reflecting greater a greater level of resilience (Connor & Davidson, 2003). For this

study, participants completed this instrument along with another instrument during work or leisure time.

Scoring

Scoring of the CD-RISC is based on the summation of all 25 items, each of which is scored form 0–4. For the CD-RISC-25, the full range is therefore from 0–100, with higher scores reflecting greater resilience (Connor & Davidson, 2003).

Statistical Parametric

Norms for the CD-RISC are based on a national sample of 577 participants (Connor & Davidson, 2003). The median score was 82 with Q1, Q2, Q3, and Q4 being 0–73, 74–82, 83–90, 91–100. Given that, a score of 55, for example, would place the subject in the lowest 25% of the general population, and a score of 89 would fall in the 50–75% percentile, of third quartile: 25% would have a higher score than this (Connor & Davidson, 2003).

Connor and Davidson showed acceptable test-retest reliability for the full CD-RISC (r=0.87). Khoshouei showed test-retest good reliability for the four factors in a factor analysis (r=0.78 to r=0.88) (Khoshouei, 2009). As noted, Ito et al. (2009) showed good test-retest reliability in Japanese students. Test-retest reliability was reported by Giesbrecht et al. (2009), who noted mean scores of 66.4 (10.8) at Time 1, and 66.3 (9.8) at Time 2, 4 months later. In Steinhardt's study (2008), the wait-list control group showed no change in the CD-RISC over 4 weeks (70.5(12.3) and 70.6 (11.7)). Baek et al. (2010) reported a test-retest reliability coefficient of r=0.70 in Korean subjects. A correlation of r=0.732 was obtained for test- retest reliability on the CD-RISC 10 in

Spanish undergraduates (Notario- Pacheco et al, 2011). Patients undergoing rehabilitation after spinal cord injury showed consistent scores in the CD-RISC (82.2, 81.9 and 82.6) across a 2–3-month period (White et al, 2010).

Several types of data on validity are presented in the manual for the CD-RISC. Construct validity comes from a study by Roberts et al. (2007), which showed that among 252 veterans of Iraq or Afghanistan, those with higher resilience were less likely to develop PTSD (OR = 0.11, 95% CI = 0.06–0.21), and of those who did have PTSD, resiliency was uniquely associated with decreased PTSD severity after accounting for demographic variables and combat severity (β = -.0.37, $p<0.001$). Roy et al. (2007) showed that the CD-RISC score was lower in substance abusers with a history of attempted suicide than in those with no such history, and that in a logistic regression, the risk of suicide attempt was predicted by the CD-RISC but not the Childhood Trauma Questionnaire (CTQ) score for either emotional or physical abuse. In a second report by the same group, the authors found that CD-RISC score, but not Beck Depression Inventory, predicted suicide attempt (Roy et al., 2007). Likewise, Nrugham et al. (2010) reported that resilience moderated the association between a lifetime history of violence and attempted suicide even in the presence of antecedent depression.

A later report by Roy et al. (2011) found a protective effect for resilience against suicide in those who had experienced childhood trauma in two separate samples: prisoners (*n*=332) and substance abuse patients (*n*=40). Similar results were found by Youssef et al. (2013a, 2013b) in two samples of OIF/OEF veterans. Baseline CD-RISC score predicted suicidality at three-year follow-up to a greater extent than did PTSD or

alcohol use, and opined that the assessment of resilience and childhood trauma can contribute to their clinical status regarding depression and suicidal ideation (Connor & Davidson, 2003). Concurrent (convergent) validity is demonstrated by showing that the scale correlates with like measures, either of resilience itself or related measures such as stress coping, self-esteem, optimism, symptoms of depression or anxiety, etc. Three Chinese studies have assessed the convergent validity of the CD-RISC. In one (Yu and Zhang, 2007a), the CD-RISC correlated with the Rosenberg Self-Esteem Scale ($r=0.49$, $p<0.01$), the Life Satisfaction Index A ($r=0.48$, $p<0.01$), and all five factors if the NEO-FFI (i.e., neuroticism, $r=-0.47$; extraversion, $r=0.43$; openness, $r=0.27$; agreeableness, $r=0.36$; conscientiousness, $r=0.64$ – all $p<001$). In another study (Yu and Zhang, 2007b), the CD-RISC and Ego Resiliency Scale (ERS) were evaluated and the CD-RISC proved superior in comparison to the ERS in respect of correlations against the NEO, self-esteem and life satisfaction scales, six out of seven of which were significant for the CD-RISC (ranges $r=-0.39$ to 0.54), and only one of which was significant for the ERS (ranges $r=-0.13$ to 0.19). In a third report of adolescents, the CD-RISC and nearly all of its five factors correlated significantly in expected directions with the Children's Depression Inventory, the Screen for Child Anxiety Related Emotional Disorders and the Multidimensional Scale of Perceived Social Support. Only in factor 5, which contains 2 items, were correlations non- significant for depression and anxiety (Yu et al, 2011).

Secondary Traumatic Stress Scale (STSS)

Purpose

The Secondary Traumatic Stress Scale (STSS) is a 17-item instrument designed to measure intrusion, avoidance, and arousal symptoms associated with indirect exposure to **traumatic** events via one's professional relationships with traumatized clients (Bride et al., 2004). An initial pool of items based on the DSM-IV Criteria B (intrusion), C (avoidance), and D (arousal) for PTSD was developed using the domain-sampling model described by Nunnally and Bernstein (1994). Permission was obtained from the STSS author to use the instrument in this dissertation (see permission letter in appendix).

Procedures

The STSS is a 17-item, pencil-and-paper, self- report instrument designed to assess the frequency of intrusion, avoidance, and arousal symptoms associated with secondary traumatic stress. Respondents are instructed to read each item and indicate how frequently the item was true for them in the past 7 days using a five- choice, Likert-type response format ranging from 1 to 5, where 1 equals never, 2 equals rarely, 3 equals occasionally, 4 equals often, and 5 equals very often, with higher scores reflecting greater a greater level of vicarious trauma . The STSS is comprised of three subscales: Intrusion (items 2, 3, 6, 10, 13), Avoidance (items 1, 5, 7, 9, 12, 14, 17), and Arousal (items 4, 8, 11, 15, 16). Scores for the full STSS (all items) and each subscale are obtained by summing the items assigned to each (Bride et al., 2004). For this study, participants completed this instrument along with the CD-RISC instrument.

Scoring

Scoring of the STSS is based on the summation of all 17 items, each of which is scored from 1-5, with higher numbers indicating higher levels of vicarious traumatization. Three subscales in addition to a total score can be obtained through the STSS. The three subscales are listed as the following: Intrusion, Avoidance, Arousal. In order to gain a total score the three subscales are added together (Bride et al., 2004).

Statistical Parametric

A list of master's-level social workers licensed in one state located in the southeastern United States was obtained from the state licensing board. From that list, 600 social workers were randomly selected to be included in the sample for the study that was investigating the reliability and validity of the final version of the STSS (Bride et al., 2004). Coefficient alpha was used to assess internal consistency of the STSS. Means, standard deviations, and alpha levels for the STSS and its subscales were as follows: Full STSS (M = 29.49, SD = 10.76, α = .93), Intrusion (M = 8.11, SD = 3.03, α = .80), Avoidance (M = 12.49, SD = 5.00, α = .87), and Arousal (M = 8.89, SD = 3.57, α = .83) (Bride et al., 2004).

A total of 28 correlations were planned in examination of convergent and discriminant validity, setting α = .05 for each correlation would result in an inflated Type I error risk. Therefore, the Bonferroni technique was used to set the family-wise error rate at α = .05, resulting in a per comparison alpha level of .00179 (.05/ 28). significant correlations were obtained between the STSS and its subscales and each of the convergent variables, although significant correlations were not found between the STSS

and its subscales and each of the discriminant variables. Thus, claims for the convergent and discriminant validity of the STSS and its subscales appear to be supported (Bride et al., 2004).

Procedures for Recruitment, Participation, and Data Collection

This nonexperimental study was guided by research questions and a set of hypotheses. These are restated below.

Restatement of the Research Questions and Hypotheses

Research Question 1 (RQ1): Is there a significant difference in the level of vicarious traumatization in mental health professionals depending upon experience level?

Null Hypothesis ($H_0$1): There is no difference in the level of vicarious traumatization in mental health professionals depending upon experience level as assessed by the Secondary Traumatic Stress Scale.

Alternative Hypothesis (H_a1): There is a difference in the level of vicarious traumatization in mental health professionals depending on experience level as assessed by the Secondary Traumatic Stress Scale.

Research Question 2 (RQ2): Is there a significant difference in the level of vicarious resilience in mental health professionals depending on experience level?

Null Hypothesis ($H_0$2): There is no difference in the level of vicarious resilience in mental health professionals depending on experience level as assessed by the Connor Davidson Resilience Scale.

Alternative Hypothesis (H_a2): There is a difference in the level of vicarious resilience in mental health professionals depending on experience level as assessed by the Connor-Davidson Resilience Scale.

Research Question 3 (RQ3): What effect does the percentage of traumatized clients on a clinician's caseload have upon the relationship between their experience in the field and their level of vicarious trauma?

Null Hypothesis ($H_0 3$): The percentage of traumatized clients on a clinician's caseload does not have an effect the relationship between their experience in the field and their level of vicarious trauma.

Alternative Hypothesis ($H_a 3$): The percentage of traumatized clients on a clinician's caseload does affect the relationship between their experience in the field and their level of vicarious trauma.

Research Question 4 (RQ4): What effect does the percentage of traumatized clients on a clinician's caseload have upon the relationship between their experience in the field and their level of vicarious resilience?

Null Hypothesis ($H_0 4$): The percentage of traumatized clients on a clinician's caseload does not have an effect the relationship between their experience in the field and their level of vicarious resilience.

Alternative Hypothesis ($H_a 4$): The percentage of traumatized clients on a clinician's caseload does affect the relationship between their experience in the field and their level of vicarious resilience.

Data Collection

Data was collected from local mental health agencies including private practices and other mental health practices in which clinical psychologists, school psychologists, clinical social workers, licensed professional counselors, mental health counselors, and psychiatric or mental health nurses were employed. Approval was obtained from the Walden University Institutional Review Board (IRB) on February 18, 2020 (approval # 02-18-20-0489795).

Agencies were located utilizing a web search of programs within Orange, Ulster, Rockland, Sullivan, Westchester, and Dutchess counties located on the eastern region of New York State. Once prospective participants were identified, information regarding the current study was provided to each potential participant and they were provided with my email address and personal phone number in the event that they had any further concerns or questions. Questionnaires were provided to the participants via email with a Google Form attachment.

Any data I obtained from the STSS, along with data I obtained from the CD-RISC, was collected via email submission of the Google Form and entered into a Microsoft Excel chart to organize responses. Any demographic information, including the clinician's length of time in the field and percentage of traumatized clients on the individual's caseload was collected and organized along with the submission of the questionnaires.

Confidentiality was of utmost concern to this researcher and measures were taken to safeguard the privacy and confidentiality of the data. Participants were not required to

provide their name. This information was not relevant to the study. Participants were only required to provide information regarding their level of experience, percentage of traumatized clients on their caseload and the two measures.

Data Analysis

I conducted the data analysis using the computer software program SPSS. Descriptive demographic data was provided for each of the three groups as well as for the overall sample. A one-way analysis of variance (ANOVA) was used to evaluate reported vicarious trauma as well as reported vicarious resilience of the participants. Each set of results (VT, VR) was run separately. An ANOVA allows for the comparison between the results of the three different groups to be made in terms of their levels of VT and VR to determine if there is a significant difference between the groups. Results of the omnibus tests were reported, using a .05 alpha level as the standard for significance. Following the ANOVAs, I conducted a test for the moderating effect of the percentage of traumatized clients on the clinician's caseloads in order to determine if that percentage moderated the relationship between experience level of the clinician and their own levels of vicarious trauma and vicarious resilience. Zaiontz (2018) listed 5 statistical assumptions underlying a one-way ANOVA. The first assumption is that each group sample is drawn from a normally distributed population. The second assumption is that all populations have a common variance. The third assumption is that all samples are drawn independently from each other. The fourth assumption is that within each sample the observations are sampled randomly and independently of each other. Finally, the fifth assumption is that factor effects are additive (Zaiontz, 2018). The data was tested against each of these

assumptions, and appropriate adjustments were made in the event any of the assumptions were violated.

Threats to Validity

Creswell (2003) identified several types of threats to validity that can interfere with the ability of a researcher to draw inferences from the data collected in a study. For the purposes of the current study, this section will discuss potential internal and external threats to validity.

Internal validity threats are experimental procedures, treatments, or experiences of the participants that threaten the researcher's ability to draw correct inferences from the data about the population in an experiment (Creswell, 2003). Potential threats to the internal validity of the current study included history and mortality. History is described as time passing during a study and events occurring that unduly influence the outcome of the study (Creswell, 2003). Being that the true duration of this study was unknown and the data collection was to continue until the appropriate number of responses was reached, there was potential for events to occur during the data collection process that may or may not have influenced the outcomes of the study. For example, a participant's percentage of traumatized clients on their caseload may have changed, they may have begun a self-care regimen, either of which events may have altered their original levels of perceived vicarious trauma/vicarious resilience. Mortality is described by Creswell (2003) as participants dropping out during a study, making the outcomes for those participants unknown. Being that participation in the current study was voluntary, participants may have chosen to remove themselves at any time. If that had occurred, the

questionnaire responses of those participants would have been unknown and therefore, would not have been able to be considered in the study. Participants may also have simply chosen to refrain from filling out the questionnaires after they received them.

External validity threats arise when experimenters draw incorrect inferences from the sample data to other persons, other settings, and part of future situations (Creswell, 2003). Potential threats to the external validity of the current study included selection of participants, and history. The sample used in this proposed study came from mental health clinics, schools, hospitals within the southeast region of New York State. Because most of the participants lived in one regional area, a threat is posed to the validity of generalizing results from this study to mental health professionals who live in other areas of the country. In addition, because the results of the current study were collected within a certain time frame, the results could not be generalized to any past or future situations.

Protection of Participants' Rights

Participants have a right to privacy that should not be violated without informed consent. Any identifying information, including names, initials, addresses of workplaces, was not published in any written descriptions of the present study. Nonessential identifying information was omitted from the formal write up of the present study. Informed consent was gained from the participants prior to conducting the study and was stored in a secure location.

Ethical Concerns

Due to the voluntary nature of this study, the ethical concerns were few. Participants were able to choose to participate or decline to participate in the current

study. They were also able to withdraw from the study at any time without penalty. Potential participants were informed fully regarding the nature of the current study before they chose to participate.

Summary

For this quantitative study I used a nonexperimental design to investigate individual differences between mental health professionals in varied levels of clinical experience and their personal levels of VT and VR. I also aimed to investigate whether the percentage of traumatized clients on a therapist's caseload moderated the relationship between the clinician's experience level and the level of VT and/or VR experienced by the therapist.

I collected data from local mental health agencies in New York State. Any clinics that specialized in providing services to individuals who have experienced trauma were included in the sample. Data regarding VT was collected using the STSS (Bride et al., 2004). Data regarding VR was collected using the CD-RISC (Connor & Davidson, 2003). I used a one-way ANOVA procedure to run the dependent variables as well as a test for the moderating effect of percentage of traumatized clients on a clinician's caseload in order to answer the research questions and test the hypotheses.

Chapter 4: Results

Introduction

The purpose of this quantitative non-experimental correlational study was to investigate individual differences between mental health professionals with varied levels of clinical experience and their personal levels of VT and VR. I also aimed to investigate whether the percentage of traumatized clients on a therapist's caseload moderated the relationship between the clinician's experience level and the level of VT/VR experienced by the therapist. This chapter includes the following sections: changes from original study, research setting, demographics, data collection, data analysis, study results, evidence of trustworthiness, and summary.

Research Questions and Hypotheses

I derived the following research questions from the review of existing literature in the area of VT, VR and mental health professionals.

Research Question 1 (RQ1): Is there a significant difference in the level of vicarious traumatization in mental health professionals depending upon experience level?

Null Hypothesis ($H_0$1): There is no difference in the level of vicarious traumatization in mental health professionals depending upon experience level as assessed by the Secondary Traumatic Stress Scale.

Alternative Hypothesis (H_a1): There is a difference in the level of vicarious traumatization in mental health professionals depending on experience level as assessed by the Secondary Traumatic Stress Scale.

Research Question 2 (RQ2): Is there a significant difference in the level of vicarious resilience in mental health professionals depending on experience level?

Null Hypothesis ($H_0$2): There is no difference in the level of vicarious resilience in mental health professionals depending on experience level as assessed by the Connor Davidson Resilience Scale.

Alternative Hypothesis (H_a2): There is a difference in the level of vicarious resilience in mental health professionals depending on experience level as assessed by the Connor-Davidson Resilience Scale.

Research Question 3 (RQ3): What effect does the percentage of traumatized clients on a clinician's caseload have upon the relationship between their experience in the field and their level of vicarious trauma?

Null Hypothesis ($H_0$3): The percentage of traumatized clients on a clinician's caseload does not have an effect the relationship between their experience in the field and their level of vicarious trauma.

Alternative Hypothesis (H_a3): The percentage of traumatized clients on a clinician's caseload does affect the relationship between their experience in the field and their level of vicarious trauma.

Research Question 4 (RQ4): What effect does the percentage of traumatized clients on a clinician's caseload have upon the relationship between their experience in the field and their level of vicarious resilience?

Null Hypothesis ($H_0$4): The percentage of traumatized clients on a clinician's caseload does not have an effect the relationship between their experience in the field and their level of vicarious resilience.

Alternative Hypothesis (H_a4): The percentage of traumatized clients on a clinician's caseload does affect the relationship between their experience in the field and their level of vicarious resilience.

Changes Made to Original Study

I made a number of minor changes to this study due to unforeseen difficulties in data collection. The sample for the proposed study was to be collected from local mental health agencies in the Southeast area of New York State, including but not limited to, outpatient clinics, schools, private practice settings, etc. Any organization that specialized in providing services to individuals who had experienced trauma was to be included in the sample. I made numerous attempts to collect data from this specified sample from February 18, 2020 to August 26th 2020. I found it difficult to collect the data during this time frame as the United States was in the midst of the COVID-19 pandemic. New York State was among one of states most effected by the pandemic. Many businesses and organizations, including mental health practices, were not operating under normal circumstances. Many organizations were forced to close temporarily, have their employees work from home, or close altogether. COVID-19 cases in the United States were reported to be over 30 million with over one million in New York State alone during the time data collection for this study was to take place (Centers for Disease Control, 2019). Subsequently, attempting to make contact with mental health clinicians at

this time and getting them to participate in the current study was very difficult. At the later date, I submitted a request of change in procedures form to the Institutional Review Board to open up the sample to mental health professionals outside of New York State. Recruiting participants from outside of New York State would not impact the results of the study as location was not a variable for the current study. This request was approved on August 26th, 2020 and then I began to collect data from all states, including New York State.

The recruitment technique for potential participants was to be via internet search of mental health professionals along with internet searches of agencies and organizations providing outpatient support to clients. I submitted a request for change in procedures form to the Institutional Review Board to recruit potential participants utilizing social media outlets in addition to the original methods of internet web searches that was approved by the IRB prior to the start of the study. This request was approved on August 26, 2020.

I planned to conduct the data analysis for this study using the computer software program SPSS. Descriptive demographic data were to be provided for each of the three groups as well as for the overall sample. A one-way analysis of variance (ANOVA) was to be used to evaluate reported VT as well as reported VR of the participants. Each set of results (VT, VR) were to be ran separately. When I collected all of the necessary data, it came to my attention that data was only collected from two out of the three subgroups intended to be used. Zero participants in the group entitled “first year clinician” responded to the surveys. This lack in responses made it necessary to change the data

analysis technique from a one-way analysis of variance (ANOVA) to an independent samples *t*-test. An independent samples *t*-test allows for the comparison of means between two independent groups (Abbott, 2016).

Demographic Characteristics

The sample for this study consisted of 161 mental health professionals practicing in various areas across the United States. Over an 11-month period, from February 2020 to January 2021, I recruited 161 mental health professionals practicing within the United State via emails and social media postings. Inclusion criteria required participants to be mental health professionals practicing in settings where some form of trauma treatment was being given. The participants (N=161) identified themselves as mental health professionals having either 1–5 years experience in the fields (n=36) or over 5-years experience in the field (n=125). As part of the demographic information, I asked participants to provide the percentage of traumatized clients currently on their caseload. Answers ranged from 1% to 100%. The caseload distribution indicated that seven (4%) of the clinicians had a caseload that was comprised of 1% trauma clients, one clinician (.62%) had 3% trauma clients, three clinicians (1%) had 5% trauma clients, one clinician (.62%) had 7% trauma clients, 13 clinicians (8%) had 10% trauma clients, one clinician (.62%) had 12% trauma clients, four clinicians (2%) had 15% trauma clients. Further, 17 clinicians (11%) had 20% trauma clients, one clinician (.62%) had 21% trauma clients, 15 clinicians (9%) had 25% trauma clients, two clinicians (1%) had 27% trauma clients, one clinician (.62%) had 29% trauma clients, nine clinicians (6%) had 30 % trauma clients, two clinicians (1%) had 33% trauma clients, one clinician (.62%) had 35%

trauma clients, four clinicians (2%) had 40% trauma clients, one clinician (.62%) had 43% trauma clients. Additionally, one clinician (.62%) had 45% trauma clients, 33 clinicians (20%) had 50% trauma clients, three clinicians (1%) had 55% trauma clients, two clinicians (1%) had 65% trauma clients, three clinicians (1%) had 70% trauma clients, 21 clinicians (13%) had 75% trauma clients, six clinicians (3.7%) had 80% trauma clients, one clinician (.62%) had 85% trauma clients, four clinicians (2.5%) had 90% trauma clients, and four clinicians (2.5%) had 100% trauma clients on their caseload.

Table 1 indicates demographic data for the 161 mental health professionals.

Table 1
Demographic Characteristics of Study Sample

Characteristic	*n*	Percent
Years in the Field		
1-5 years	36	22.0
Over 5 years	125	78.0
Percentage of Trauma Clients	7.0	1.0
	1.0	3.0
	3.0	5.0
	1.0	7.0
	13.0	10.0
	1.0	12.0
	4.0	15.0
	17.0	20.0
	1.0	21.0
	15.0	25.0
	2.0	27.0
	1.0	29.0
	9.0	30.0
	2.0	33.0
	1.0	35.0
	4.0	40.0
	1.0	43.0
	1.0	45.0
	33.0	50.0

3.0	55.0
2.0	65.0
3.0	70.0
21.0	75.0
6.0	80.0
1.0	85.0
4.0	90.0
4.0	100.0

Evaluation of Statistical Assumptions

Laerd Statistics (2018) listed 6 statistical assumptions underlying an independent samples *t*-test. The conclusions of an independent samples *t*-test can be trusted if the following three assumptions are met. The first assumption is that the dependent variable is measured on a continuous scale. The dependent variables for this study were the clinician's levels of VT and VR. I assessed these levels via a Likert Scale questionnaire, making the category of measurement that they fell into considered to be interval data. The second assumption of the independent samples *t*-test is that the independent variable should consist of two categorical, independent groups. The independent variable for this study, experience level of the clinician, consisted of two categorial groups: 1–5 years in the field and over 5 years in the field. The third assumption for the independent samples *t*-test is there should be independence of observations, meaning that there should be no relationship between the observations in each group or between the groups themselves. The two groups of mental health professionals, 1–5 years in the field and over 5 years in the field are mutually exclusive, as mental health professionals can fall into only one group, or the other. There was no overlap in groups.

Statistical Analysis Findings

For Research Question 1 (RQ1), I asked the following: Is there a significant difference in the level of vicarious traumatization in mental health professionals depending upon experience level? To test the hypothesis that clinicians with 1–5 years of experience in the field and clinicians with over 5 years of experience in the field were associated with a statistically significant difference in levels of VT, I performed an independent samples *t*-test. Descriptive statistics are represented in Table 2. The results indicated a significant difference in the scores between mental health professionals with 1–5 years in the field (M=35.25, SD= 11.60) and over 5 years in the field (M=30.42, SD=11.36). The independent samples *t*-test was associated with a statistically significant effect, $t(159)=2.24$, $p=0.027$. Thus, clinicians with 1–5 years in the field were associated with a statistically significantly higher mean score on the Secondary Traumatic Stress Scale than the clinicians with over 5 years of experience in the field. Cohen's *d* was estimated at .423, which is a medium effect size based on Cohen's (1992) guidelines. Table 3 indicates the statistically significant results of the independent samples *t*-test.

Table 2

Descriptive Statistics

	N	Mean	Std. Deviation
1-5 years in the field	36	35.25	11.60
Over 5 years in the field	125	30.42	11.36

Table 3

Independent Samples Test

		F	Sig.	t	df	Sig. (2-tailed)
STSSTotal	Equal variances assumed	.032	.858	2.235	159	.027

For Research Question 2 (RQ2), I asked the following: Is there a significant difference in the level of vicarious resilience in mental health professionals depending on experience level? To test the hypothesis that clinicians with 1–5 years of experience in the field and clinicians with over 5 years of experience in the field were associated with a statistically significant difference in levels of VR, an independent samples *t*-test was performed. Descriptive statistics are represented in Table 4. The results indicated a significant difference in the scores between mental health professionals with 1–5 years in the field (M=69.33, SD= 14.76) and over 5 years in the field (M=75.49, SD=12.79). The independent samples *t*-test was associated with a statistically significant effect, $t(159)=-2.46$, $p=0.015$. Thus, clinicians with 1–5 years in the field were associated with a statistically significantly lower mean score on the Connor Davidson Resilience Scale than the clinicians with over 5 years of experience in the field. Cohen's *d* was estimated at -.465, which is a medium effect size based on Cohen's (1992) guidelines. Table 5 indicates the statistically significant results of the independent samples *t*-test.

Table 4

Descriptive Statistics

	N	Mean	Std. Deviation
1-5 years in the field	36	69.33	14.76
Over 5 years in the field	125	75.49	12.79

Table 5

Independent Samples Test

		F	Sig.	t	df	Sig. (2-tailed)
CDRISCTotal	Equal variances assumed	2.65	.105	-2.456	159	.015

For Research Question 3 (RQ3), I asked the following: What effect does the percentage of traumatized clients on a clinician's caseload have upon the relationship between their experience in the field and their level of VT? To test the hypothesis that the percentage of traumatized clients on a clinician's caseload does have an effect on the relationship between their experience in the field and their level of vicarious trauma, I performed a linear regression analysis. I examined percentage of traumatized clients as a moderator of the relation between a clinician's years in the field and their level of VT. The results indicated that the percentage of trauma clients on a clinician's caseload did not have a statistically significant effect on the existing relationship of the clinician's level of experience in the field and their level of VT, p=.951. Results of the linear regression analysis are indicated in Table 6.

Table 6

Linear Regression Analysis

Model	Unstandardized Coefficients B	Std. Error	Standard Coefficients Beta	t	Sig.
(Constant)	35.998	7.175		5.017	.000
Years in Field	-4.583	3.941	-.166	-1.163	.247
Trauma Clients	.096	.143	.220	.669	.505
Interaction	-.005	.079	-.021	-.061	.951

a. Dependent Variable STSSTotal

For Research Question 4 (RQ4), I asked the following: What effect does the percentage of traumatized clients on a clinician's caseload have upon the relationship between their experience in the field and their level of VR? To test the hypothesis that the percentage of traumatized clients on a clinician's caseload does have an effect on the relationship between their experience in the field and their level of VR, a linear regression analysis was performed. I examined percentage of traumatized clients as a moderator of the relation between a clinician's years in the field and their level of VR. The results indicated that the percentage of trauma clients on a clinician's caseload did not have a statistically significant effect on the existing relationship of the clinician's level of experience in the field and their level of vicarious resilience, p=.272. Results of the linear regression analysis are indicated in Table 7.

Table 7

Linear Regression Analysis

Model	Unstandardized B	Coefficients Std. Error	Standard Coefficients Beta	t	Sig.
(Constant)	53.454	8.430		6.341	.000
Years in Field	10.471	4.631	.325	2.261	.025
Trauma Clients	.230	.168	.455	1.369	.173
Interaction	-.102	.093	-.389	-.389	.272

a. Dependent Variable CDRISCTotal

Summary

The purpose of this quantitative non-experimental correlational study was to investigate individual differences between mental health professionals with varied levels of clinical experience and their personal levels of VT and VR. I also aimed to investigate whether the percentage of traumatized clients on a therapist's caseload moderates the relationship between the clinician's experience level and the level of VT/VR experienced by the therapist. The results for research question one indicated that there was a statistically significant difference in the levels of vicarious trauma between clinicians with 1–5 years of experience in the field and those with over 5 years of experience in the field. An independent samples *t*-test indicated that clinicians with 1–5 years of experience in the field reported higher levels of VT than those clinicians with over 5 years in the field. The results for research question two indicated that there is a statistically significant difference in the levels of VR between clinicians with 1–5 years of experience in the field and those clinicians with over 5 years in the field. An independent samples *t*-test indicated that clinicians with over 5 years of experience in the field reported having

higher levels of VR than those clinicians with 1–5 years of experience in the field. The results for research question 3 did not indicate that the percentage of traumatized clients on a clinician's caseload had a statistically significant effect on the relationship between the clinician's level of experience in the field and their levels of VT. The results for research question 4 did not indicate that the percentage of traumatized clients on a clinician's caseload had a statistically significant effect on the relationship between the clinician's level of experience in the field and their levels of VR.

In chapter five I will elaborate further on other aspects of the study that are associated with the results, address limitations of the study, and reference implications for social change. The chapter will conclude with how the results from the present study might be applied to future research.

Chapter 5: Summary, Conclusions, and Recommendations

Introduction

The purpose of this nonexperimental quantitative study was to investigate individual differences between mental health professionals with varied levels of clinical experience and their personal levels of VT and VR. I also aimed to investigate whether the percentage of traumatized clients on a therapist's caseload moderated the relationship between the clinician's experience level and the level of vicarious trauma/vicarious resilience experienced by the therapist. The objective of this study was to understand the levels of VT and VR that are experienced by mental health professionals at levels of training, novice, and seasoned practice.

To determine if there was a significant difference in mental health professionals in terms of their personal levels of vicarious trauma, an independent samples *t*-test was used. The results of this analysis determined that there was a significant difference between mental health professionals at different levels of clinical experience in terms of their personal levels of vicarious trauma. To determine if there was a significant difference in mental health professionals in terms of their personal levels of VR, an independent samples *t*-test was used. Results of this analysis determined that there was a significant difference between mental health professionals at different levels of clinical experience and their personal levels of VR. To determine if the percentage of traumatized clients on a clinician's caseload had a moderating effect on the existing relationship of level of experience and level of VT, I used a linear regression test. I determined from the results of this analysis that the percentage of trauma clients on a clinician's caseload did

not have a significant effect on the existing relationship of level of experience and level of VT. To determine if the percentage of traumatized clients on a clinician's caseload had a moderating effect on the existing relationship of level of experience and level of vicarious resilience, I used a linear regression test. I determined from the results of this analysis that the percentage of trauma clients on a clinician's caseload did not have a significant effect on the existing relationship of level of experience and level of VR. In this chapter, I will discuss the interpretations of the results, limitations of the study, and suggestions for future research. The chapter concludes with comments regarding implications for social change and recommendations for both action and further studies.

Interpretation of Findings

The goal of this study was to determine if a significant difference existed between mental health counselors of different levels of experience and their personal levels of VT and VR. The goal was also to determine if the percentage of trauma clients on a clinician's caseload moderated the relationship between their level of experience and levels of VT and VR. In the following subsections, I will investigate these variables as they relate to literature previously presented in Chapter 2.

A sample of 161 mental health professionals from within the United States completed the STSS and the CD-RISC. I used the collected data to test the hypotheses and answer the research questions. In this section I provide an interpretation of the research findings for each research question.

The study results indicate that clinicians with 1–5 years in the field were associated with a statistically significantly higher mean score on the Secondary

Traumatic Stress Scale than the clinicians with over 5 years of experience in the field, suggesting that clinicians with less time in the field, experience higher levels of VT. These results align with previous research and its indications of the existence of vicarious trauma in mental health professionals. Harrison and Westwood (2009) stated that traumatized individuals are a difficult population to work with and not without risks to the clinician. Sodeke-Gregson et al. (2013) stated that a large majority of therapists are at an increased risk for experiencing some level of secondary traumatic stress or VT from working with traumatized clients. Due to the intense nature of trauma work, therapists are more vulnerable to developing impairments such as compassion fatigue, burnout, and countertransference (Williams et al., 2012). Through the current study I confirmed that there are in fact risks to the clinician in working with traumatized individuals. The results of the current study demonstrated that clinicians who work with traumatized individuals experience impairments such as burnout and VT.

The study results indicate that clinicians with 1–5 years in the field were associated with a statistically significantly lower mean score on the CD-RISC than the clinicians with over 5 years of experience in the field, suggesting that clinicians with less experience in the field have lower levels of VR than those clinicians with more experience in the field. These results align with previous research and its indications for the potential for VR in mental health professionals. Research has described VR as a therapist being positively affected by the resilience of trauma clients, alterations of perspectives on the therapist's own life, and valuing the therapy work performed (Hernández et al., 2007). The experience of VR results in growth and the transformation

of the therapist consequent to client growth and resilience during trauma recovery (Hernández et al., 2010). A number of studies have examined how work with trauma survivors had the potential to affect and transform the therapist in a positive way (Hernández et al., 2010). The results of these studies indicate that therapists were able to identify positive effects within themselves from interaction with clients who had overcome adversity. Such positive effects included a change in their attitudes, emotions, and behaviors (Hernández et al., 2010). In addition, professional counselors who provided services to those affected by Hurricanes Katrina and Rita reported higher levels of posttraumatic growth and VR as a result of their work with the survivors (Lambert & Lawson, 2013).

I used Research question 3 (RQ3) to assess if the percentage of traumatized clients on a clinician's caseload had an effect on the existing relationship of the clinician's experience in the field and their personal levels of VT. The results of this study indicated that the existing relationship of the clinician's experience in the field and their personal levels of VT was not affected by the percentage of traumatized clients on the clinician's caseload. These results did not align with prior research that revealed that the total number of hours providing trauma-focused therapy was a predictor of secondary traumatic stress symptoms (Gottesman, 2008).

I used Research question 4 (RQ4) to assess if the percentage of traumatized clients on a clinician's caseload had an effect on the existing relationship of the clinician's experience in the field and their personal levels of VR. While existing research supports the potential for the development of VR in mental health professionals, limited

studies specifically address the percentage of trauma clients on a clinician's caseload and their level of VR. Many studies have indicated that VR is developed by the clinician when working with trauma clients. Reports of enhanced hope, a change in clinical expectations, and a confirmation of personal values has been described by counselors working with a population that has experienced significant trauma (Welsh, 2014).

Current Study and Theoretical Framework

The theoretical framework of this dissertation is rooted in Pearlman and Saakvitne's (1995) CSDT. This theory is based upon a constructivist foundation, postulating that individuals construct personal realities based upon the complex cognitive schemas used to interpret and make sense of life experiences (Williams et al., 2012). This approach suggests that an individual's unique personal history influences his or her experience of traumatic events (McCann & Pearlman, 1992). Much like the experience of a primary trauma for a client, the impact of VT on a clinician's psychological functioning and worldview can result in intra- and interpersonal difficulties. Similarly, witnessing a client's perseverance and strength during difficult times, can influence a clinician's own experiences, resulting in VR. An important part of CSDT as it relates to this study is the idea that cognitive schemas, which are a mental structure used to organize knowledge and guide cognitive processes and behavior, evolve over an individual's lifetime. These cognitive schemas can be influenced heavily by experience, for example a clinician's work with trauma clients (Branson et al., 2014). As mental health clinicians listen to client's accounts of trauma, the clinicians create their own internal understanding of the event. Subsequently, the mental health clinician's view of the world and self may be

altered as their cognitive schemas are negatively affected by their client's stories of trauma (Branson et al., 2014). Conversely, cognitive schemas can be altered in a positive way, involving beliefs that the world is reasonably safe, and people are generally good and honest. As counselors bear witness to their client's attitudes of hope, their strength and resilience when facing a trauma, they are more likely to see their own strengths as human beings and healers. Thus, the positive effects of the therapeutic process have the potential to be bidirectional. Counselors who are involved in the therapeutic process with clients not only foster positive effects for their clients but also can be on the receiving end of those positive effects (Silveira & Boyer, 2015).

The results of the current study support this theory of change in cognitive schemas as they are influenced both positively and negatively over time as clinicians with more experience in the field reported higher levels of VR (positive schema change) and lower levels of VT. Conversely, clinicians with less experience in the field reported higher levels of VT (negative cognitive schema change) and lower levels of VR. Clinician's cognitive schemas were found to be influenced positively or negatively through their work with trauma clients, depending on experience level.

Limitations

All research studies naturally come with their limitations, often related to the design itself and/or the approach of the researcher (Creswell, 2009). Although the results of this research may help to develop programs for graduate students and novice mental health professionals to better prepare them for their work, it is important to note the limitations of the study. First, the pool of participants was opened up to the entire United

States. There was no way to determine whether or not the respondents that completed the surveys represented each area of the United States equally. It is possible that more respondents on the East Coast participated than on the West Coast, or more in Central United States making it difficult to determine if the sample is truly generalizable to the entire population of mental health professionals. Secondly, while the data collection for this study was over 11 months, this is still a limited view in time that is dependent upon the conditions occurring at that time. If the surveys were taken at a different time, different results may have been yielded.

Additionally, the selected instrument for the data collection in this study has limitations. Surveys, while inexpensive and able to be sent out in mass quantities, can be problematic for professionals who already struggle with time constraints. These professionals may be less likely to participate because they simply feel as though they do not have the time. Participants who also may need clarification regarding how to fill out the survey will not be able to gain the clarification as easy as they would in a face-to-face interview situation. Further, survey research cannot capture the complexity and depth of in-person interviews. It is difficult to understand the meaning behind the responses of a survey (Morris, 1991).

Finally, the lack of respondents for the original first category of mental health professionals (first year clinicians) which subsequently caused a change in procedures to the original study is a limitation of this current research. I hypothesized that there were zero respondents for this group because the wording could have been clearer on the demographic section of the questionnaire. Mental health clinicians typically complete a

full year internship before they can meet requirements for graduation, meaning that once they graduate, they would already have a year of experience in the field. If the potential respondents were counting that year, they would likely have chosen to respond in the 1–5 years of experience group. More respondents for the In my first year group may have been collected if this researched specified that category to say AFTER graduation. I may have been able to provide more insight into the levels of vicarious trauma and vicarious resilience of mental health professionals in different levels of experience if that group did not need to be omitted.

Recommendations for Further Research

As mentioned in the limitations section, there are several areas that could be a good starting point for further research. First, future researchers might repeat this research and recruit participants intentionally and equally in different areas across the United States. Future researchers may also attempt to replicate this original study, utilizing a convenience sample of a specific area as was originally intended to seek better response rates. Future researchers may also want to repeat this study using a qualitative approach, through which they can interview mental health clinicians at different levels of clinical experience. An interview approach may offer more depth in responses from each participant and gain more meaningful information with regard to the participant's actual experiences. Finally, further research to include mental health clinicians that fall into the category of first year clinicians is needed. Additionally, it will be important to more clearly define who fits into the first year clinicians category. Indicating that first year clinicians includes those mental health professionals who are working in the field for the

first year AFTER graduation will be necessary. It is likely that because the definition of first year clinicians was not clear enough in the demographics section of the questionnaires for this current study no respondents were acquired for this group. Despite this oversight, this is an important group to investigate with regard to their levels of vicarious trauma and vicarious resilience as this group would likely be more vulnerable to vicarious trauma and less prepared to experience vicarious resilience, as the present study suggests.

Implications for Positive Social Change

The current study's implications for social change are many. The results of this study might be used to aid professionals in the field of psychology in understanding the potential for the development of VT in mental health clinicians. This research brings to light potential for the experience of negative and positive effects of working with trauma clients. It may educate those working in the helping professions with regard to the potential for VT occurrence in clinicians at different levels of practice as well as the potential for growth and vicarious resilience. With awareness and education comes change and preventative measures.

In addition, insights gained from this study might bring awareness to professional and educational organizations with regard to the necessity for the development and/or maintenance of proper programs/trainings that can be provided to clinicians prior to and during their work with traumatized clients. The ultimate hope through this education is to raise a further level of awareness of the potential for VT in clinicians and the need for proper training on VT before, and during the time when professionals enter into

therapeutic relationships with clients who have experienced trauma. The hope is also to prompt professionals in the field of psychology to include trainings within their education programs for clinicians to help foster their self-care and resiliency, to lessen the potential for vicarious trauma and burnout. The results of putting these programs/trainings into place may be more preparedness on the part of the clinician in terms of their own awareness of personal mental health vulnerabilities and strengths, subsequently making them more effective clinicians.

Conclusion

Therapeutic work with traumatized individuals is a challenging task and is not without potential hazards to those professionals who endeavor to provide them with therapeutic support (Harrison & Westwood, 2009). Being that the nature of trauma work is so intense, therapists are more vulnerable to developing impairments such as compassion fatigue, burnout, and countertransference (Williams, Helm, & Clemens, 2012). In addition, the experience of VR results in growth and the transformation of the therapist consequent to client growth and resilience during trauma recovery (Hernández et al., 2010).

VT is a significant risk that should be taken into account when working with trauma clients; however, there is much potential for positive outcomes of working with trauma clients. The concepts of VT and VR are not dichotomous in nature, rather they exist simultaneously and are of equal importance in terms of their exploration through research.

The results of this study revealed that a significant difference exists between mental health professionals with regard to their personal levels of VT and VR. In fact, clinicians with less time in the field reported higher levels of VT and lower levels of VR than those clinicians with more time and experience in the field, solidifying the need to prepare said clinicians for their work in the field before they experience any negative effects, potentially rendering them less effective in their work as clinicians.

In summary, these study results aligned with existing literature which indicated the potential for both VT and VR to develop in mental health clinicians that work with trauma clients. These results strongly point to the need for programs and trainings for mental health clinicians before and during their professional work to educate them on the potential for the negative effects of working with trauma clients as well as to foster self-care and resiliency in these same clinicians. Most mental health clinicians enter into the field to help others through their most difficult moments. A good therapeutic relationship is paramount to successful treatment for the client and the foundation of this success begins with the mental health of the clinician.

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Appendix A: Informed Consent Form and Permissions to Use Scales

CONSENT FORM

You are invited to take part in a research study about Vicarious Traumatization and Vicarious Resilience in mental health professionals. The purpose of this study is to investigate individual differences between mental health professionals with varied levels of clinical experience and their personal levels of vicarious trauma (VT) and vicarious resilience (VR). This researcher is inviting local mental health professionals in the southeast area of New York State, including but not limited to, in-patient clinics, outpatient clinics, schools, etc. Any organization that specializes in providing services to individuals who have experienced trauma will be included in the study. I obtained your name/contact information via an internet search of the mental health organizations/providers in the southeast region of New York State. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Marie Demchak, who is a doctoral student at Walden University.

Background Information:

The purpose of this study is to investigate individual differences between mental health professionals with varied levels of clinical experience and their personal levels of vicarious trauma (VT) and vicarious resilience (VR). This study also aims to investigate whether the percentage of traumatized clients on a therapist's caseload affects the relationship between the clinician's experience level and the level of vicarious trauma/vicarious resilience experienced. This study aims to understand the levels of VT and VR that are experienced by mental health professionals at levels of training, novice, and seasoned practice. The purpose is to understand whether or not a difference exists between groups with regard to the level of VT and VR and whether or not the percentage of traumatized clients on a clinician's caseload has an effect on the level of vicarious trauma and/or vicarious resilience experienced.

Procedures:

If you agree to be in this study, you will be asked to:

- Fill out a form to indicate how many years you have in the field of mental health, and to indicate the percentage of trauma clients on your caseload (this will take about a minute)
- Fill out a 25-item likert scale about resilience (CD-RISC) (this may take up to ten minutes)
- Fill out a 17-item likert scale about the impact of trauma clients on clinicians (STSS) (this may take up to ten minutes)

Here are some sample questions:

- I am able to adapt when changes occur.
- I have at least one close and secure relationship that helps me when I am stressed.
- I felt emotionally numb
- I have at least one close and secure relationship that helps me when I am stressed

Voluntary Nature of the Study:

This study is voluntary. You are free to accept or turn down the invitation. If you decide to be in the study now, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study:

Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as fatigue, stress, or becoming upset. Being in this study would not pose risk to your safety or wellbeing. I have made contact with a mental health professional local to the area if you feel at any time during the study that you need mental health support. I will provide this contact information to you if needed.

This research intends to provide further information to those working in the helping professions with regard to the potential for VT occurrence in clinicians at different levels of practice as well as the potential effects that the percentage of traumatized clients on one's caseload may have on the level of VT experienced by the individual. By doing so, the ultimate hope is to raise a further level of awareness of the potential for VT in clinicians and the need for proper training on VT before, and during the time when professionals enter into therapeutic relationships with clients who have experienced trauma. Insights from this study would facilitate positive social change in a number of ways. The results of this study would aid professionals in the field of psychology in understanding the potential for vicarious trauma in mental health clinicians. In addition, insights gained from this study would bring awareness to professional and educational organizations with regard to the necessity for the development and/or maintenance of proper programs/trainings that can be provided to clinicians prior to, and during their work with traumatized clients.

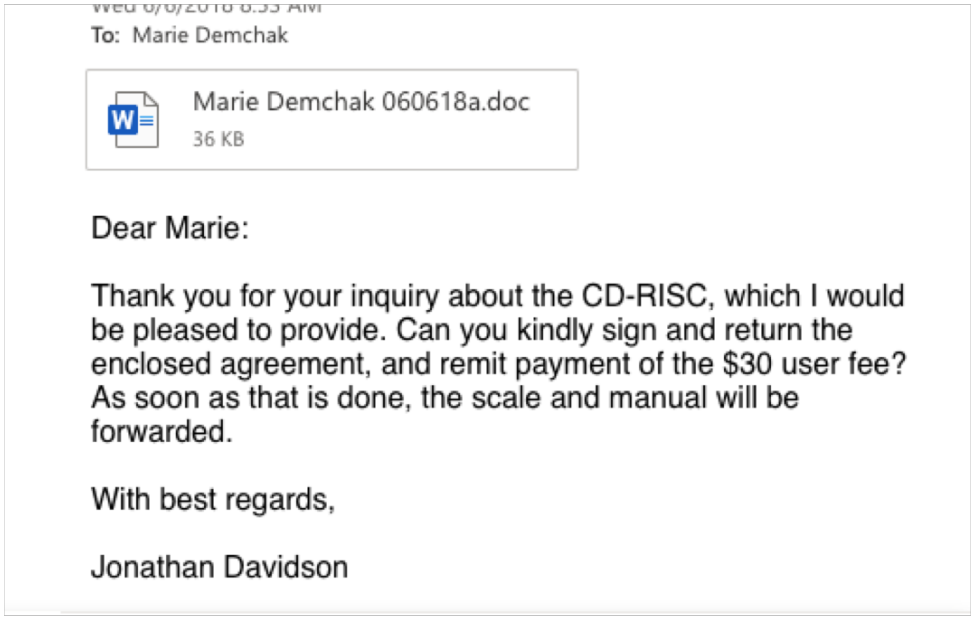
Payment:
No payment, gifts, or reimbursements will be provided in return for participation in this study.
Privacy:

Reports coming out of this study will not share the identities of individual participants. Details that might identify participants, such as the location of the study, also will not be shared. The researcher will not use your personal information for any purpose outside of this research project. Data will be kept secure by storing the data within a password protected computer and encrypted emails. Data will be kept for a period of at least 5 years, as required by the university.

Walden University's approval number for this study is 02-18-20-0489795 and it expires on February 17, 2021.

Please print or save this consent form for your records. Obtaining Your Consent

If you feel you understand the study well enough to make a decision about it and you consent to participate, please complete the demographic information and surveys that follow this informed consent form.



To: Marie Demchak

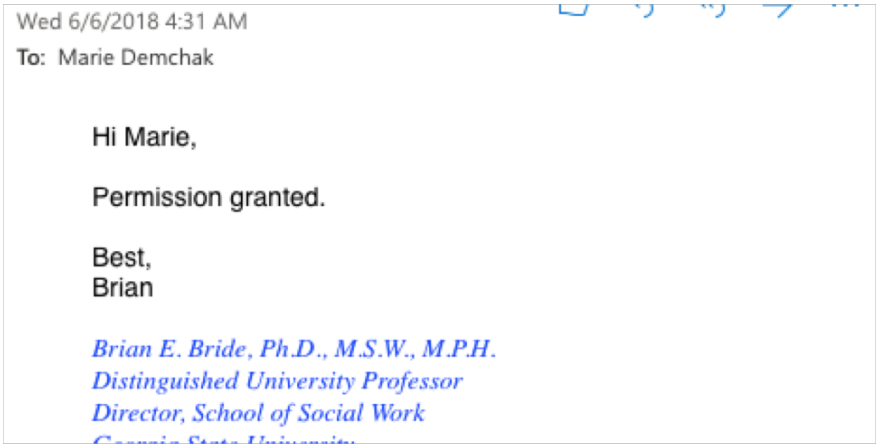
Marie Demchak 060618a.doc
36 KB

Dear Marie:

Thank you for your inquiry about the CD-RISC, which I would be pleased to provide. Can you kindly sign and return the enclosed agreement, and remit payment of the $30 user fee? As soon as that is done, the scale and manual will be forwarded.

With best regards,

Jonathan Davidson



Wed 6/6/2018 4:31 AM

To: Marie Demchak

Hi Marie,

Permission granted.

Best,
Brian

Brian E. Bride, Ph.D., M.S.W., M.P.H.
Distinguished University Professor
Director, School of Social Work
Georgia State University

Hi Marie,

Permission is granted for you to use the STSS in Survey Monkey, Google Form, or a similar format.

Best,
Brian

Brian E. Bride, Ph.D., M.S.W., M.P.H.
Distinguished University Professor