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Human Service Professionals' Experience With Vicarious Trauma

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This is to certify that the doctoral dissertation by

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Abstract

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MA, Liberty University, 2008

BS, Liberty University, 2006

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

The purpose of this generic qualitative study was to explore the vicarious trauma (VT) experiences of nonlicensed human service professionals (HSPs) between the ages of 30 and 65 from Central Texas who work with male intimate partner violence (IPV) victims. The conceptual framework that guided this study was the constructivist self-development theory. A purposive sample of 11 HSPs who experienced VT because of working with male IPV victims was obtained through flyers posted on social media. Huberman and Miles's approach to thematic analysis was used to analyze the data and create codes, categories, and themes. The 13 themes that were identified were (a) emotions enable vicarious trauma vulnerability, (b) lack of awareness leads to poor diagnosis, (c) work experience plays a role in associated risks, (d) stigma prevents the professional from seeking help, (e) vicarious trauma impacts mental and physical health, (f) vicarious trauma affects the professional's productivity, (g) vicarious trauma improves self-care and services offered, (h) preventive strategies minimize risks associated with vicarious trauma, (i) coping strategies limit the symptoms related to vicarious trauma, (j) ineffective coping strategies cause challenges among professionals, (k) availability of employer-sponsored professional support systems, (l) challenges helping professionals faced with employer-funded support systems, and (m) rewards related to utilizing professional support systems. Social change implications include bringing awareness of the impact of VT in HSPs' personal and professional environments, which may lead to increased availability of work support services and may improve the number of HSPs who seek and participate in employment-offered professional assistance programs.

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Dedication

I dedicate this dissertation first to my God; thank You for never leaving me or forsaking me and covering me! I dedicate this study to my late Uncle Edward, who did not see me complete this journey, but had faith and confidence that I would, and for that I thank you. My two best friends, Selma and Rebecca, who are now my heavenly angels, I miss you every day, but am so very grateful for the time God allowed you both to be my ride-or-die blessings. Lastly, I dedicate this dissertation to my young adult Tyahija (Tie-jah), who never wavered in belief that I would one day complete this journey. Thanks for being my person! I love you to the moon and beyond, infinity!

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Chapter 1: Introduction to the Study

Introduction

Intimate partner violence (IPV) is a prevalent public health and economic issue worldwide. IPV was defined by Yang et al. (2019) as perpetrated abusive physical, sexual, emotional, economic, or psychological behavior inflicted by an intimate partner or family member against another. Whether mental or physical, the intent to cause harm to someone is considered abuse. IPV is a life-changing experience that manifests in various forms of victimization, such as sexual, physical, and emotional assault, as well as stalking (Ameral et al., 2020). Not only does IPV present far-reaching economic and social problems, but it can also cause significant health issues for the victims. Individuals who have been exposed to IPV most often require medical care because of the physical injuries sustained from the abuse (Bosch et al., 2017). Prolonged exposure to IPV increases the potential for long-term health conditions for the victims. These individuals may suffer from frequent headaches, chronic pain, insomnia, gastrointestinal problems, cardiovascular disease, diabetes, asthma, and overall poor quality of health (Patra et al., 2018). The long-term effects of trauma experienced from IPV, according to Curry et al. (2018), can also result in mental health issues such as depression, posttraumatic stress disorder (PTSD), anxiety disorders, eating disorders, substance abuse, and suicidal behavior. According to Mendonça and Ludermir (2018), mental health issues are common among victims of IPV and can cause them to have symptoms of insomnia, fatigue, isolation, inability to work, irritability, forgetfulness, difficulty concentrating, somatic complaints, depression, and anxiety, increasing the demand for health and social

service support. Victims of IPV are often so traumatized that they trust no one, feel trapped, and are afraid to seek help. For some victims, the struggle to overcome the effects of IPV becomes even more challenging when they do not seek professional support services.

Human service professionals (HSPs) play a role in helping victims of IPV who have experienced significant trauma in regaining their independence and reclaiming their lives. Choi (2017) stated that HSPs who work with trauma victims on a regular basis will, over time, eventually be affected by recounts of trauma by their clients. As a consequence of working with this population, helping professionals are exposed to graphic details of varying scenarios and degrees of abuse, which can result in the helping professional developing vicarious trauma (VT; Kanno & Giddings, 2017). HSPs may, over time, experience the effects of VT from exposure to client recounts of trauma. Secondary traumatic stress (STS), compassion fatigue (CF), and VT are three of the major constructs that commonly affect helping professionals working with victims of trauma (Rauvola et al., 2019). Although these constructs are often used interchangeably, Cuarter and Campos-Vidal (2019) posited that they impact helping professionals differently. Response to same or similar situation experiences may vary dependent on severity and length of exposure, as well as the individual.

In this study, I explored the gap in literature focused on the experiences of HSPs with VT after working with male victims of IPV. In Chapter 1, I provide a brief background on IPV, male victims of IPV, and HSPs' experiences with VT, as well as the study's problem statement, purpose, research question, conceptual framework, and

nature. I also define key terms, assumptions, scope and delimitations, potential limitations, and the significance of this study, which addressed the research gap in understanding HSPs' experience with VT after working with male victims of IPV.

Background

HSPs have a significant function within the health and human services network. They are pivotal in helping secure support services for individuals, families, groups, and communities (Alvarez et al., 2017). Without their vital role in the delivery of services, there would not be a link between providers and clients, and continuity of care would be lost (Salsberg et al., 2017). Although there are no specific data available on the number of counselors in the United States who specialize in IPV counseling, the U.S. Bureau of Labor Statics (2016) provided a breakout of overall U.S. HSP statistics, which indicated that there were approximately 764,272 counselors of whom approximately 552,000 were mental health counselors. Even with these numbers, there is still an increased demand for HSPs with the special knowledge and skills needed to service those who have experienced extreme trauma such as IPV.

HSPs who provide psychosocial services to individuals impacted by IPV are exposed on a consistent basis to the aversive details of traumatic events. This exposure places them in positions of higher risk of suffering some type of secondary trauma from the exposure (Jones et al., 2018). All HSPs who work with trauma victims on a weekly basis will eventually be affected by recounts of trauma by their clients (Salsberg et al., 2017). Kanno and Giddings (2017) noted that HSPs who do not effectively manage and/or resolve their issues are at a higher risk of experiencing VT, CF, and burnout. VT

refers to culmination of trauma-related accounts that transfer to the helping professional internally because of empathetic feelings regarding the client's trauma (Cummings et al., 2018). The impact of VT has the potential to last for months to several years, depending on the severity and length of exposure (Rauvola et al., 2019). Although the physical wounds will most likely heal and fade away, the emotional scars sustained from prolonged abuse can remain with victims, causing them to relive the trauma all over again.

There are stringent ethical guidelines that individuals who work in the field of human and social services must adhere to in their profession. The American Counseling Association (ACA, 2014a) Code of Ethics outlined the professional and ethical responsibilities of helping professionals by asserting that it is the helping professionals' responsibility to recognize and monitor any changes in their behavior that would impair their mental, emotional, and physical ability to effectively render services to their clients. According to Denne (2019), approximately 40% to 85% of helping professionals who work with trauma clients experience some form of secondary trauma from that work. HSPs who have unresolved VT experience emotional distancing from clients, avoidance, anxiety, and dissociation, rendering the HSP unable to provide continued empathy and objectiveness toward clients (Butler et al., 2017). Tarshis and Baird (2019) further pointed out that HSPs who do not appropriately handle unresolved VT place themselves at risk of experiencing loss of empathy, anger toward the client, chastising, and blaming the victim for their abuse. This can damage the helping professional–client alliance and collaboration, thus damaging whatever trust that was established between the helping

professional and their client. It is vital that helping professionals are equipped with the appropriate tools for identifying VT and the negative impact it can have on the quality of providing services to their clients and overall quality of life.

Problem Statement

VT is a term used to describe the emotional impact on helping professionals who work with individuals who have experienced traumatic events in their lives. VT is often experienced by HSPs, who work with victims of IPV. VT was initially defined by McCann and Pearlman (1990a) as the aggregated change that helping professionals undergo after multiple encounters with trauma clients over time. VT has the potential, according to Kanno and Giddings (2017), to have an impact on the physical, mental, and emotional posture of the helping professional by presenting similar symptoms of trauma clients. VT is the experience of trauma through listening to the experiences of individuals who have experienced the trauma (Molnar et al., 2017). Further, Kelly (2020) noted that helping professionals who are unable to reconcile VT tend to lose their ability to establish and maintain trust, alliance, and collaboration with their clients. HSPs are at a higher risk of experiencing, over time, VT after working with clients who have experienced traumatic events, which affects their ability to provide effective service to their clients because of their own psychological struggle with VT.

IPV among male victims is becoming more prevalent across the United States. In the United States, as noted by the National Coalition Against Domestic Violence (2020), it was estimated that 1 in 4 men have experienced physical abuse by an intimate partner; 1 in 7 men have been severely abused by an intimate partner. The Centers for Disease

Control and Prevention (CDC, 2020b) also reported that 1 in 18 men have been stalked by an intimate partner; 1 in 25 men have been injured by an intimate partner; and 29% of men in the United States have experienced rape by an intimate partner in their lifetime. Although there is much less data available on male IPV victims than female victims, males are victims of IPV, and the number of male IPV victims is steadily rising (Ponce-Garcia et al., 2016). Jones et al. (2018) wrote that the psychological and emotional impact of IPV can remain long after the IPV ends. IPV, not addressed properly, has the potential to result in long-term negative consequences for the victim both physically and emotionally.

HSPs play a vital role in providing services to the IPV population, especially for the underserviced population of male IPV victims. Although the aforementioned research regarding HSPs' experiences illuminate important findings regarding their experiences of VT with female IPV victims, there is limited research on their experiences working specifically with male victims of IPV (Morrison et al., 2017). Given such, further research is warranted on HSPs' experiences of VT when working with male IPV victims to expand support for HSPs in dealing with the negative consequences of exposure to secondary trauma from the individuals they serve (Rauvola et al., 2019). To address this gap in the literature, I explored how HSPs described the impact and experiences of VT while working with male victims of IPV.

Purpose of Study

The purpose of this qualitative, generic study was to gain an understanding of what the HSPs' experiences with VT were after working with male victims of IPV. Ten

nonlicensed HSPs between the ages of 30 and 65 from Central Texas who had worked with male victims of IPV within the last 3 years were interviewed to gather information on their experiences with VT from working with male victims of IPV.

Research Question

The primary research question for this study was the following: What are HSPs' experiences with VT after working with male victims of IPV?

Conceptual Framework

The conceptual lens for the study was the constructivist self-development theory (CSDT). The CSDT, which was developed by McCann and Pearlman (1990b), addresses the concept that individuals develop their own realities and construct their own personal realities by creating intricate cognitive structures that determine how they perceive and understand events. CSDT focuses on the interaction between the individual and the circumstances surrounding the trauma, with special emphasis on self-development (Lee, 2017). This theory combines several theoretical and empirical influences on self-development and trauma, founded on a constructivist perspective (Foreman, 2018). The fundamental concept of any constructivist theory is that it stresses the role individuals play in creating and construing their perceived reality (Merriman & Joseph, 2018). The CSDT contends that the early development of individuals plays a major factor in how they interact with others and experience self later in life (Foreman, 2018). The CSDT supports the concept that helping professionals' experiences of VT can impact how they interact with people as well as alter their perspective of themselves and others.

CSDT was used to highlight how HSPs' experiences working with the male IPV population can expose them to VT, which may trigger a complex process unique to the individual that impacts personal values and creates images of the traumatic event and extends to the innermost segments of the individual's internal experience of self and world. CSDT, which is grounded in psychology, involves the ability of an individual to construct unique personal realities that are solely inherent to the individual as they interact with their environment (Perez, 2019). CSDT provides an assessment of the symptoms manifested by individuals as adaptive strategies that are cultivated to control opinions and emotions that jeopardize the integrity and safety of self (Lee, 2017). I used this theory to explore how exposure to graphic details of male IPV trauma experiences placed HSPs at higher risk for developing VT.

Nature of Study

The nature of this study was a generic, qualitative approach. The intent of a generic, qualitative study is to discard preconceived ideas, opinions, and biases to objectively develop a deeper understanding of the participants' personal recounts of their ideas, feelings, and beliefs regarding their experiences (Alase, 2017). The generic, qualitative approach was applicable for this study because I explored the impact of VT on HSPs who work with male victims of IVP. This method allowed the participants to recount their personal experiences of VT and was designed to collect rich data that provided a deeper understanding of VT that helping professionals experienced while working with male IPV victims.

A diverse group of 10 nonlicensed HSPs between the ages of 30 and 65 from Central Texas who provided services to male victims of IPV were selected to participate in this study. The selected participants were required to have a master's degree in human services or a similar field, be a nonlicensed HSP, have a minimum of 3 years as an HSP, and have directly worked with at least four male IPV victims. Semistructured interviews using open-ended questions were conducted virtually and telephonically with the participants.

Definitions

Emotional and verbal assault: Includes insults and attempts to scare, isolate, or control a nonconsenting individual in an attempt to control that person (Office on Women's Health, U.S. Department of Health and Human Services, 2018).

Physical assault: Involves overt aggressive, threatening behavior with the express intent to cause deliberate bodily harm to an individual (Victims of Crime, 2020).

Sexual assault: Involves any attempted or completed sexual act that is imposed upon an individual without their consent (U.S. National Library of Medicine, U.S. Department of Health and Human Services, National Institute of Health, 2018).

Stalking: Involves conduct toward an individual with the intent to incite fear for their safety (CDC, Injury Prevention and Control, 2020a).

Vicarious trauma (VT): The transformation that transpires within the helping professional because of emphatic emotions experienced from trauma clients' recounts of their traumatic experiences (ACA, 2014b).

Assumptions

The basic assumptions that influenced and guided this generic qualitative study were (a) the data collected from participants who were interviewed were reliable, (b) the participants had worked in some capacity with male victims of IPV, and (c) all participants had experienced VT after working with male victims of IPV. There are three vital assumptions to consider in qualitative methodology: ontology, epistemology, and axiology assumptions. Ontology assumes an individual's reality may be independent, socially constructed, or different from another person's reality (Bilau et al., 2018). Epistemology assumes that the researcher and the participant encourage each other through the conversation during the data collection (Baskarada & Koronios, 2018). This concept was important to the study, in that it highlighted aspects of the participants' recounted experiences that were influenced by personal feelings or opinions, as well as those recounts that were influenced by objective judgment and reflected clear facts (see Hothersall, 2019). Axiology assumptions relate to the values, beliefs, or worldview that a researcher has about the topic, which, according to Kelly et al. (2018), should be identified prior to initiating a study. This concept was important to the study in that it was an exploration of human values, which enabled me to identify the underlying beliefs and values that influenced the participants' perceptions and interpretation of their life experiences, decisions, and actions (Melville et al., 2019). During the data collection, both I and the participant drew rich data from the recounted unique experiences; I assumed that the experiences of the participants, though similar, would produce vivid accounts of their individually based reality of coping with VT and how the participants'

experiences with VT impacted their worldview, values, and beliefs with understanding and coping with VT.

Scope and Delimitations

The scope of this study was the HSPs' experiences with VT after working with male victims of IPV. Ten HSPs from various helping professions who worked with male victims of IPV were the target interview participants for the study. Semistructured interviews were used to gather data. HSPs' length, frequency, and severity of exposure to male IPV trauma clients were explored. HSPs' length of time and experience as an HSP and length of time working with male IPV victims were also explored. HSPs' experience with VT; how they experienced VT; and what self-care techniques, if any, they employed after experiencing VT were explored.

In consideration of incorporating a theory to address the transference of VT to HSPs, and to gain a greater understanding of contributing factors that predispose the HSP to experience VT, two additional theories were reviewed: wellness theory and emotional response theory. The wellness theory or wheel of wellness was first introduced by Sweeney and Witmer (1991, 1992). This is a multidisciplinary theory that is theoretically grounded and targeted at behavior and human development (Hattie et al., 2004; Myers et al., 2000). Wellness theory is one of the limited counseling-based theories. This is a wholeness theory that examines the impact of stressors on counselors who work with trauma clients and the supporting factors to recapturing their professional and personal wellness (Browning et al., 2019). This theory was not selected because its focus is

targeted toward behavior and human development, rather than experiences derived from a specific occurrence of an incident.

The concept of emotions that is used within emotion response theory was introduced in 1949 by Hebb, who proposed that emotions have no important function; they are only neural stimulation. According to emotion regulation theory, there are two primary constructs of emotion regulation strategies—one that is antecedent focused and focuses on the individual's emotions prior to affecting their behavior (Sewell, 2020), and the other that is a response-focused strategy, which focuses on emotional responses generated from the impact of emotions being expressed or demonstrated through action. This theory was not selected because it is more targeted to understanding how individuals control their emotions based on the behaviors of others, and how those emotions influence decision making and behavior, rather than how an individual experiences exposure to certain events that impact the ability to provide effective professional services.

Limitations

Worldviews, preconceived ideas, and biases play a role in behavior, interactions with others, and how people interpret and experience life. Saunders et al. (2018) stated that researchers typically study topics that reflect personal beliefs and values; bias and subjectivity are inevitable in research. Bracketing minimizes researcher bias, which, if not managed properly, can cause a threat to the credibility of a study (Dempsey et al., 2016). Although there are several bracketing measures that can be used to minimize researcher biases, I practiced self-reflection, maintained detailed documented field notes,

and journaled initial thoughts and feelings to discuss with research colleagues. These bracketing measures reinforced the transferability, conformability, credibility, dependability, and integrity of the study.

To mitigate the limitation of addressing potentially sensitive topics, I quickly built a rapport with the participants so that they felt comfortable sharing their experiences. Additionally, I reassured the participants that their participation was completely confidential and strictly voluntary. Throughout the interview, I demonstrated active listening and respect, and I maintained a nonjudgmental, warm, friendly conversational tone that encouraged a feeling of relaxation and camaraderie with the participant. This promoted unrestricted, free-flowing conversation with the participants as they shared their individual experiences with VT while working with male victims of VT.

Significance of Study

The intent of this study was to highlight VT and the impact it has on helping professionals who work with IPV clients, specifically male IPV victims. HSPs need support in establishing professional training and self-care programs that support HSP wellness (Neswald-Potter & Simmons, 2016). The results of the study could lead to improved VT self-care, setting realistic boundaries, and effective coping strategies for helping professionals who work with male victims of IPV. Established targeted trauma training identifying early warning signs and symptoms of VT countertransference could promote VT self-awareness and emotional stress management and developing individualized protective techniques to combat VT. Further, it could encourage verbalization and sharing of thoughts and feelings about VT with other helping

professionals to help reduce the effects of VT on the HSP. The results of this study could also lead to positive social change by providing information on increased trauma training and awareness of the wellness needs of HSPs and appropriate support services for male IPV victims.

Summary

Although the services that HSPs provide are uniquely challenging in nature, especially when working with IPV victims, it can be just as rewarding and fulfilling helping individuals heal from their trauma. VT includes intrusive thoughts, nightmares, and psychological responses after exposure to clients' personal accounts of traumatic experiences (Senreich et al., 2020). Helping professionals who enter the field of trauma work with the desire and dedication to assist victims in rebuilding their lives after trauma, without being aware of and prepared to address their own vulnerabilities (Cuartero & Campos-Vidal, 2019). The purpose of this study was to explore the experiences of HSPs who provide services to male IPV victims, specifically as they related to VT. The intent was to explore the HSPs through the conceptual lens of CSDT, as those experiences were shaped by the participants' values, beliefs, and worldview. In Chapter 1, I provided an overview of this study's background, problem statement, purpose, research question, conceptual framework, nature, definitions, assumptions, delimitations, limitations, and significance, concluding with a summary. I explained how HSPs experience VT resulting from working with male victims of IPV. I explained how, if left untreated, the impact of VT could result in adverse long-term effects on the HSP both personally and professionally. Due to minimal studies surrounding this concept, I sought to assist in

meeting the need for further exploration for the development of more effective strategies and models to determine risk factors for VT, the impact of VT on HSPs' ability to provide effective services, and ways to decrease the symptoms of VT while employing self-care measures.

Chapter 2 provided a review of associated literature regarding VT and how the helping professional could employ self-care techniques to minimize VT and become better equipped to work effectively with male victims of IPV.

Chapter 2: Literature Review

Introduction

The intent of the study was to gain an understanding of what the HSPs' experiences with VT were after working with male victims of IPV. HSPs can experience VT due to their exposure to listening to victims of trauma recount their experiences. Although scholars have addressed the VT experiences of HSPs who work with victims of IPV, most of these studies have not focused specifically on HSPs who experience VT after working with male IPV victims (Brend et al., 2020). Helping professionals who work with and listen to individuals who have experienced traumatic events experience empathy and may, over time, also experience the significant impact of VT (Newell et al., 2016). VT can have a long-term damaging impact on the HSP if not addressed (Hallinan et al., 2020). Helping professionals who do not successfully address their VT are at increased risk for burnout; mental health problems; and medical conditions such as PTSD, cardiovascular disease, and depression (Middleton & Potter, 2015). In this chapter, I review the literature on HSPs who experience VT from working with trauma clients and provide the literature search strategy; the conceptual framework of CSDT; and key concepts on the impact of VT on HSPs, coping strategies, and self-care measures.

Literature Search Strategy

The literature review included relevant peer-reviewed articles. The accessed databases included ProQuest, PsycInfo, Springer, Health & Medical Collection, MEDLINE, DOAJ, PubMed, Taylor & Francis, SocINDEX, Academic Search Complete, Criminal Justice Database, Nursing & Allied Health Premium, Research Library,

Psychology Database, Social Science Database, Sociology Database, Consumer Health Database, SAGE PsycArticles, Public Health Database, Wiley Online, CINAHL Plus, Science Database, Health & Medical Collection, and Google Scholar. The key search terms for the literature review included *VT*, *IPV*, *HSP*, *trauma counselors*, *mental health counselors*, *male and female victims of IPV*, *transference*, *counselor challenges*, *helping professionals*, *burnout*, *CF*, *STS*, *PTSD*, *vicarious traumatization*, *coping strategies*, *ethics*, *CSDT*, *generic qualitative research*, *qualitative studies on VT*, *counselor self-care*, and *HSPs with VT.* There were several variations of the key terms and phrases used to conduct the extensive searches to generate a more cumulative listing of relevant scholarly research material for the study. Additionally, searches of ACA, CDC, and Bureau of Labor and Statistics (BoLS) were used to gain data about counselor ethics, IPV prevalence, and the HSP population. Historical data on VT from the original authors (McCann & Pearlman, 1990a) were obtained. Lastly, because there was limited literature for reference on the study of the experiences of HSPs with VT after working with male victims of IPV, advance searches were conducted in the above databases as well as several others for articles relating to female victims of IPV and the HSPs who work with them and their experiences with VT.

Historical sources published between 1990 and 2004 included in the study provided primary data relating to VT, conceptual and behavioral theories, and the prevalence of IPV. Researchers such as McCann, Pearlman, and Saakvitne provided contextual information on the effects of VT on helping professionals. Researchers such as Sweeney and Witmer, Hattie, and Myers provided theoretically grounded theories

targeted at behavior and human development relating to the wellness of HSPs who work with trauma clients. All journal articles were peer reviewed. All additional primary references used in this study to provide comprehensive reviews of the concept of VT were within 5–6 years of publication.

Conceptual Framework

The conceptual framework for this study was CSDT. CSDT was originally introduced by Pearlman and McCann in the early 1990s, with the intent of helping define CSDT. CSDT is a theory that offers a basis for describing the impact to an individual who has experienced trauma. According to McCann and Pearlman (1990b), this theory is based on a theory-driven concept that changes in an individual's cognition occur gradually, which can cause shifts in their beliefs, ideas, and worldview. McCann and Pearlman (1992) asserted that CSDT involves an assumption that cognitive schemas or complex cognitive frameworks influence an individual's ability to create their realities. Primary or salient schemas determine the individuals' reaction to how the trauma was experienced (McCann & Pearlman, 1990). CSDT emphasizes five factors as a frame of reference: self-capacities, ego resources, perceptual and memory system, and central psychological needs, which also include five key aspects—safety, trust, control, esteem, and intimacy (McCann & Pearlman, 1992; Pearlman, 1998). The concepts of CSDT highlight the participants' personal realities and creation of intricate cognitive structures that demonstrate how they perceive and understand the circumstances surrounding their trauma.

CSDT combines psychoanalytic theory and social cognition and provides a theoretical framework for understanding the impact of trauma experienced by an individual. It is founded upon a constructivist view of trauma in which the individual's unique history shapes their experience of traumatic events and defines the adjustment to trauma (McCann & Pearlman, 1992). Pearlman (1998) asserted that by blending a variety of theoretical approaches, the CSDT framework implied that the impact of trauma was a result of aspects of the trauma that were psychologically significant to the individual, directly related to their psychological resources, defenses, and needs. Pearlman and McCann (1995) posited that CSDT described an individual's adjustments to trauma as exchanges between their own personalities such as their psychological needs, defensive styles, coping styles, and significant aspects of the traumatic events, completely related to social and cultural variables that shape the individuals' psychological responses to trauma experiences. CSDT illustrates how experiences of trauma shape an individual's responses to other factors in their life.

CSDT indicates that both socioeconomic and temporal contexts of violence exacerbate or minimize the downstream consequences of violence exposure. CSDT provides a framework for the systematic assessment and practical treatment of three aspects of the self that are affected by trauma (McCann & Pearlman, 1992). VT occurs as a change in a helping professional resulting from empathic exposure while working with trauma victims (Mottaghi et al., 2020). The areas impacted by VT can be improved by implementing self-care strategies (Pearlman, 1995). Self-care strategies, according to Pearlman (1997), can be applied to each area of the schema that experienced disruption

caused by VT. Early identification of the signs and symptoms of VT and the implementation of self-care techniques have been proven to minimize the impact of VT experienced by HSPs over time.

Since the introduction of CSDT, many other scholars have used CSDT to help in understanding VT and its impact on helping professionals. Lee (2017) used CSDT as a means for exploring whether probation practitioners experience VT and the impact of engagement with client trauma stories within probation supervision practices. Lee indicated that practitioners' encounters with trauma clients can result in VT and a distortion of their opinion of themselves. Further, these helping professionals can also experience negative changes in their worldview, confidence, trust, sense of personal safety, views of and disturbing thoughts of others, emotional fatigue, and detachment from all relationships (Lee, 2017). Lee showed that a combination of appropriate training linked with a theoretical understanding of trauma, VT, and active-coping strategies would help to lessen the risk of HSPs experiencing VT.

Helping professionals' understanding and interpretation of their worldview and of themselves may undergo challenges from their exposure to working with individuals who have experienced trauma. Van der Merwe and Hunt (2019) proposed that CSDT explained the effects of VT through its effects on an individual's schemas, and that individuals develop cognitive schemas that help them to adaptively interpret life experiences. These changes, which normally serve an adaptive function by protecting the listener from direct encounters with trauma, lead to irrational perceptions among people exposed to trauma (van der Merwe & Hunt, 2019). Professionals treating traumatized

clients illustrated how the experiences of helping professionals mirror the syndromes found among overwhelmed therapists, suggesting that it is the listening, and not so much the purpose for which one is listening, that can result in VT (van der Merwe & Hunt, 2019). Fieldworkers in the study were affected by participants' traumas and reported that they themselves felt traumatized, most often because of empathic response to the participants sharing their experiences of trauma (van der Merwe & Hunt, 2019). Both client and helping professional can be affected in detrimental ways by detailed trauma stories that are retold and heard.

CSDT was used to describe the cognitive and perceptual shifts that occur after exposure to trauma. Foreman et al. (2020) explored the initial experiences of counselor trainees as they engaged with clients who had experienced trauma, with the intent of gaining an understanding of how they defined trauma and developing an understanding of the development of VT and posttraumatic growth. VT occurs when a person is exposed to the traumatic experiences of others and impacts how individuals view themselves as competent, others as trustworthy, and the world as a safe place (Foreman et al., 2020). The counselor trainees shared a variety of experiences and views about the proximal process of counseling with clients who had experienced trauma (Foreman et al., 2020). Within their collective responses, they expressed that although the exposure to client trauma challenged them on many levels, they often initially did not recognize it was VT, and when they did, they responded with denial or avoidance (Foreman et al., 2020). The counselor trainees also conceptualized trauma as a subjective experience that left a long-lasting impact (Foreman et al., 2020). Further, Foreman et al. (2020) described trauma as

not the event itself but rather the effect left on the individual by the experience. The definitions of trauma varied based on the counselor trainee's personal experiences. Counselor trainees described site supervision as important to their personal and professional growth (Foreman et al., 2020). It is vital that individuals in helping professions are knowledgeable about trauma-informed care, VT, how CSDT provides the framework for understanding VT and its impact on the helping professional, and the importance of self-care, which helps prepare them to enter and remain in their profession.

CSDT was used as a lens in this study by providing a foundation for understanding how VT alters the schemas of HSPs because of their exposure to clients' stories of experienced trauma. CSDT was used to provide explanations of the underlying causes or influences of VT on HSPs. CSDT also helped provide insight regarding why HSPs sometimes fail to accurately identify the signs and symptoms of VT. CSDT assisted in developing a better understanding of how HSPs experience, cope with, and either resolve or lessen the impact of VT in their professional and personal lives. Finally, this theory helped in understanding how self-care can assist the HSP in creating a healthy work–life balance, improving their quality of work and their ability to function effectively in other areas of their lives.

Review of the Literature

Male Victims of Intimate Partner Violence

Experts have begun to target more studies about male IPV victims and examine the phenomenon as experienced from the male perspective. Previously, IPV-related research seemed to have fallen behind in examining the experiences of male IPV victims.

Turchik et al. (2016) reported that males were not officially recognized as victims of IPV until the 1970s. IPV traditionally focused on the experiences of female victims; however, studies have shown increasing interest in examining male victims of IPV (Lysova et al., 2019; McCarrick et al., 2016; Morgan & Wells, 2016). According to Walklate in Lysova et al. (2019), most of the previous literature on IPV was centered around female victims, which implied that men were not victims of IPV. This concept virtually left men in the shadows and unrecognized.

Much of the literature on IPV has focused on female victims, their help-seeking experiences, and HSPs' experiences in working with this population (Holmes et al., 1997; Young et al., 2018). Wright and Bertrand (2017) wrote that many IPV services continue to exclude men from the framework of services offered because they do not recognize men as victims of IPV. Williamson et al. (2020) also pointed out that not only do most programs not offer services for male IPV victims, but in those that do, the services are insufficient and do not adequately address the unique needs of the IPV male victim population. The lack of available services for male victims of IPV highlights the need for organizations to develop programs designed to address this population's unique needs.

IPV was stereotypically considered a male-perpetrated, woman-victimizing social issue. However, the 2015 National Intimate Partner and Sexual Violence Survey (NIPSVS) conducted by the CDC (2018) revealed that in the United States, both women and men reported experiencing at least one form of psychological aggression by a partner over their lifetime. Further, 21% of men will experience a form of IPV in their lifetime. Twenty people per minute or 10 million individuals annually are victims of physical

violence (Scarduzio et al., 2017). Annually, 6,000,000 Americans stalk their intimate partners (Office for National Statistics, 2015). In addition, 55.8% of male victims will experience IPV before the age of 25 (Smith et al., 2017). IPV has continued to plague communities and society as a public health issue that is grounded in community experiences and perceived social disempowerment and other underlying trauma (Kelly et al., 2017). IPV continues to be a major social issue for both female and male victims. Male IPV victims encounter additional challenges in being recognized as victims and finding support services that offer programs that adequately address their unique needs.

The portrayal of men as the predominant abusers in cases of IPV has caused male victims to be overlooked in society. This is reflected in the failure of communities to address the problem, the omission of the issue from research agendas, the neglect of the problem in social policy directives, and the absence of appropriate service provision. Men are often perceived as unacceptable victims of IPV (Simon & Wallace, 2018), and the issue is often treated as a "Great Taboo" due to Western patriarchal society (Tsang, 2015). Dewey and Heiss (2018) also asserted that current sociopolitical theories fail to explain the occurrence of male victimization of IPV and concluded that this issue has received only limited academic and research attention. Similarly, Simon and Wallace (2018) posited the existence of male victimization in IPV, suggesting that male dominance may explain the failure of male IPV victims as a subject of academic or social review. This may also explain why male victims of IPV have not previously been recognized.

There were different reasons cited in the literature to explain why male victims of IPV are being neglected in research and social services. First, the current typology in explaining IPV excluded the aspect of male victimization. Heath et al. (2017) classified IPV into two mutually exclusive types: common couple violence and terroristic violence, defined as violence against women. These concepts do not allow a place for male victims to fit into the existing typology, which is reflected in the limited available studies. Secondly, there is a presumption that women are often more seriously injured in IPV, which promotes the belief that women are victims rather than men (Heath et al., 2017). For this reason, physical violence against men and its consequences are underresearched (Anderson et al., 2020). There is an absence of research studies about the psychological impact of violence on male victims, especially with respect to externalizing and internalizing symptoms in response to the violence (Wahto & Swift, 2016). Although it appears that women are injured more seriously due to IPV, this does not mean that male victims do not suffer psychological symptoms from the violence (Wörmann et al., 2021). Psychological impacts of violence on female victims are often found to be more significant than those on male victims; thus, the impacts for the male victims are often overlooked and neglected (Heath et al., 2017). It is important to understand the uniqueness of the forms of violence experienced by male victims as well as the characteristics of the impact of different forms of violence on men.

The physical impact of IPV against male victims may not present as severely as for females; however, psychological abuse has significant impact. Gender-specific knowledge about male victims is needed as existing knowledge of battered spouses is

mostly based on the feminist perspective (Wörmann et al., 2021). Men who experienced psychological abuse were more likely to develop health problems and depressive symptoms (Cole & Ingram, 2020). Given that men are more likely to experience psychological abuse, the impacts on their physical and mental health aspects should not be overlooked.

Vicarious Trauma Among Human Services Professionals

Vicarious trauma was identified in the 1970s as a term used to describe the negative impact that clients' stories of trauma can have on the HSP. The development of VT was directly derived from the misplaced empathetic feelings the helping professional experiences while listening to the retelling of in-depth, explicit experiences of trauma by clients during counseling sessions (McCann & Pearlman, 1990). Pearlman and McCann (1990) noted that the VT distorts the perceptions, frame of reference, and other central psychological needs and related schemas. VT is often manifested by cognitive changes in the HSP, exhibited by avoidance, lack of interest in work, and indifference toward clients (Pirelli et al., 2020). HSPs, because of their profession, are at a higher risk of experiencing VT at some point in their careers.

VT can overtime surface and negatively impair the HSPs professional performance from their empathic exposure with trauma clients. DelTosta et al. (2019) asserted that clinical skills and competencies develop over time and with experience, which would suggest that less-developed empathy skills could help explain susceptibility to stressors like VT. Empathy is an essential part of the HSP understanding the client's circumstances and helps to establish a client-counselor rapport and working relationship

(Branson, 2019). Empathy, as noted by Lee et al. (2018), is a normal, expected, and unavoidable part of the helping profession. Emphatic exposure may leave the HSP in a vulnerable position of being affected by aspects of the client's trauma experience (DelTosta et al., 2019). Empathy is associated with another person's trauma through direct and indirect exposure with that individual.

VT was not widely used until after post 911 and the end of the Gulf War when military HSPs started exhibiting VT. VT left undetected or untreated can have long lasting effects on the individual (Andaházy, 2019). By virtue of their profession, HSP's are at a higher risk of being impacted by symptoms of VT (Molnar et al., 2017). Due to the stress and challenges of the HSPs' work, the rates of VT and similar conditions are higher than professions that are non-caring professionals. For example, HSPs experience a higher rate of PTSD at 15%, and those working in the fields of IPV, or sexual abuse, experience a higher rate of PTSD at 29% (Molnar et al., 2017). Caring, helping professions are exposed to trauma on a regular basis and may eventually experience some fallout from that repeated exposure.

Not only does VT have the potential to negatively impact an individual's professional environment, but it can also affect their personal lives. VT is difficult to screen, diagnose, and treat promptly because the of the gradual onset of symptoms and the gradual diminished emotional response after repeated exposure to client trauma (Branson, 2019). Ezell (2019) pointed out that symptoms such as headaches, problems sleeping, and fatigue are common conditions from working rather than signs and symptoms of VT. Similar conditions such as PTSD, STS, and BO much like VT can

exhibit many symptoms. Early, accurate identification of the signs and symptoms of VT is vital because, if not addressed, it can lead to the breakdown in the ability of the HSP to effectively preform their professional duties as well as successfully function on a personal level.

VT can impact and cause changes in HSPs' professional and/or personal life. Branson (2019) noted that these changes fall in four categories: intrusive imagery, arousal, avoidance behaviors, and negative changes to cognitions. According to Wagaman et al. (2015), VT is a cumulative response that can form over time as HSPs work with numerous trauma client cases, whereas countertransference refers to the feelings and responses counselors experience toward each client. The transference and the resulting response to that trauma may determine the severity and length of the effects on the individual.

VT does not remain restricted to the HSP's work environment; it has the potential to impact various aspects of their lives. Salloum et al. (2015) posited that an individual's worldview can be negatively impacted by VT. Various aspects of the HSP's life are affected, which overtime places them at greater risk of experiencing symptoms associated with VT such as empathy, anger, or sorrow regarding the violent trauma perpetuated against their clients, resulting in profound disruptions in the HSPs' basic sense of identity, and worldview.

Professional and Personal Prevalence of Vicarious Trauma Across Professions

Individuals who work in professions that require them to be in direct and indirect contact with persons and incidences that illicit episodes of trauma are more susceptible to

experience secondary VT. The negative effect of VT reaches across race, gender, and socioeconomic class (Branson, 2019; Sprang et al., 2019). For example, firefighters encounter multiple challenges in their everyday work, such as motor vehicle accidents, burned bodies, chemical hazards, life-threatening situations, suicides, failed rescue efforts, dangerous fire extinction scenarios, and having to witness the death of a colleague (Bastug et al., 2019). Further, Hallinan et al. (2020) purported that social workers, law enforcement officers, and firefighters impacted by VT all reported experiencing some form of depression, loss of morale, burnout, an increased risk for mental health conditions including PTSD, and an increased risk for medical conditions like cardiovascular disease. VT also affects employee organizational performance by decreased efficiency, loss of productivity, reduced morale and increased absenteeism, and increased employee turnover (Middleton & Potter, 2015; Pinto et al., 2015). Mental health care providers, including psychiatrists, psychologists, psychiatric nurse practitioners, counselors, and therapists, are all at risk of experiencing VT. Due to the constant emotional encounters with trauma clients, mental health professionals are at increased risk for experiencing the effects of VT (Borenstein, 2018; Isobel & Angus-Leppan, 2018). Over time, the stress and trauma experienced by these helping professions takes a toll on them, resulting in many leaving their jobs creating high employment turnover of HSPs.

Human Service Professional Turnover

Employee turnover in the helping professions impacts organizations, the service providers, the quality of services, and the clients. Employee turnover is the rate of which

employees depart and organization over a specific timeframe (Jayasekara & Pushpakumari, 2018). HSP turnover creates a significant deficit in HSP organizations, limiting some of its services to clients. Researchers (Brown Mahoney, 2020; Dwinijanti et al., 2020) noted that police department employee turnover significantly impacts crime control, and social worker employee turnover can lead to institutional knowledge loss and increased caseloads for the remaining workers, and in some cases substantial financial hardship. Institutional knowledge loss due to HSP turnover means that employees with expert skills and knowledge are departing jobs, leaving gaps in historical knowledge (Cho & Song, 2017). Loss of expertise because of an employees' departure may negatively impact the entire organization. Some of the reasons for this negative impact may include voids in available services due to limited service providers, and the increase in administrative and caseload responsibilities for remaining employees (Jayasekara & Pushpakumari, 2018). The increase in caseload for remaining employees means additional work and disruption in normal routines (Lee, 2018). Employees may have to work longer hours to keep up with the additional work, which can result in inefficiency in job performance resulting in overall instability of service (Lee, 2018). Some organizations may also experience financial hardships from turnovers and having to incur the expense of recruitment, hiring, training, and development of new cost of hiring new employees (Cho & Song, 2017). HSP turnovers create deficits, while increasing the demand for more HSPs to provide support services to those experiencing some form of trauma.

Overtime, the constant stressors from working with trauma clients, as well as administrative job requirements, can increase HSP job turnover. Turnover can be defined as leaving the profession and or leaving the organization (Cho & Song, 2017; Park & Pierce, 2020; Yamaguchi et al., 2016). According to Al-Hamdan (2016), the high turnover in the helping professions may be related to professional and personal demands as well as burnout. Boamah and Laschinger (2016) further noted that burnout accounted for reduced staff levels and diminishing work environments. These three factors not only contribute to reduced quality of care provided to clients, but also degrade mental health among HSPs (Prapanjaroensin et al., 2017; Yamaguchi et al., 2016). Increased turnover in the helping professions creates diminished and limited services availability for clients.

HSP turnover is a concern for health and human service organizations. Research indicates that HSP turnover has a detrimental impact on clients, theorizing that losing a positive relationship and transitioning to a new clinician represents a significant disruption in care (Fukui et al., 2021; Johnson-Kwochka et al., 2020). HSP turnover was associated with the most detrimental outcomes for clients doing well at the beginning of the observation period. Clients with relatively high baseline functioning were negatively impacted both physically and mentally because of HSP turnover (Johnson-Kwochka et al., 2020). Similarly, Fukui et al. (2021) posited that clients with high baseline activation and those with low or moderate baseline anxiety symptoms, HSP turnover negatively impacted their functioning. Additionally, Johnson-Kwochka et al. (2020) noted that older clients tended to be less resilient than younger clients when there was a disruption in their care, which caused negative effects on functioning. High HSP turnover in client service

care settings can lead to decreased quality of care for clients and can have a negative impact on the serviced clients.

There are some additional factors that lead to high turnover in helping professions. Turnover can be influenced by the work environment, management styles, trust, work engagement, and leader-employee exchange (Chang et al., 2018; Rodwell et al., 2017). Leader-employee exchange can impact turnover. Leader support could alleviate some turnover intention by decreasing emotional exhaustion as well as by increasing job satisfaction (Aarons et al., 2021; Fukui et al., 2020; Fukui et al., 2019). Further, increasing support from first-line supervisors focused on improving provider skills and needs could be a buffer for work stress and could facilitate job satisfaction, thereby reducing job turnover (Fukui et al., 2020). High rates of HSP turnover have become problematic for the health and human service system to service its clients. All of these factors contribute to HSPs experiencing stress and frustration, which leads to high turnover in the helping professions.

Human Service Professionals' Professional Impairment

VT has impacted various professionals working in the helping profession field. Many helping professionals impacted by VT also experience professional burnout as evidenced by missed work, loss of motivation, increased interpersonal distancing both professionally and personally, overall job dissatisfaction, and stress-induced medical conditions (Branson, 2019). In some instances, VT may result in increased scorn toward trauma clients as well as assuming of inappropriate roles with clients (Hazen et al., 2020). According to Branson (2019) and Chang (2018), eventually, many helping professionals

end up leaving the profession due to the stressors of the job and the impact of VT symptoms. Jimenez et al. (2021) posited that some mental health care workers who provide client services reported experiencing emotional, cognitive, and spiritual distress due to VT. Symptoms of VT are a natural hazard that comes with the job for those individuals who work in a helping profession and work with victims of trauma.

Due to the nature of their work, HSPs do not always readily recognize they are experiencing symptoms of VT. Some of these HSPs experience VT symptoms without even realizing what it is or the severity of it (Jimenez et al., 2021). HSP do not always recognize impairment because they are focused on their work helping their clients with their issues (Maguire & Byrne, 2017). HSPs sometimes inadvertently dismiss feelings and thoughts associated with impairment as normal hazards from their job rather than impaired professional performance (Makadia et al., 2017). Professional impairment breaks down the effectiveness of the HSP to provide quality service to their clients.

Professional impairment exists in almost all professions, although for the helping professions, the risk is greater. Stress related to employment, illness, or death of family members; marital or relationship problems; financial problems; midlife crises; personal physical or mental illness; legal problems; substance abuse; and professional education are just some of the factors that can lead to professional impairment (Brunetto, 2016; Yamaguchi, 2016). Depletion in interest in work and reduced work performance are signs of professional impairment.

Helping professional may start to question their work performance when experiencing decreased interest and motivation for their work. According to Louison

Vang et al. (2020), diminished emotions for work and reduced personal accomplishment create negative perceptions when HSPs evaluate their work performance, which create reduced confidence in an HSPs' professional capabilities. Professional impairment also decreases preparedness and overall quality of care and reduced work performance (Prapanjaroensin et al., 2017). Lack of confidence in the ability to work and provide quality services to their clients may trigger the HSP to leave their profession.

HSPs, as with other professions, encounter individuals within their ranks who experience impairment and are unable to function effectively in their jobs. Straussner et al. (2018) noted that impairment is compounded because some HSPs who experience the effects of mental illness or stress are often the last to recognize their behavior and poor job performance, which delays them from seeking help for their issues. Geoffrion et al. (2016) and Kundra et al. (2019) also posited that some of the HSPs who do recognize that they are experiencing impairment will sometimes attempt to avoid or hide their impairment rather than acknowledging their issues and seeking help. Impairment, coupled with other issues such as mental illness, have the potential to erode other areas of the helping professional's life and impact their overall quality of life.

Human Service Professionals' Personal Impairment

VT disrupts many facets of an individual's professional and personal life, sometimes causing irreversible damage. Hopwood et al. (2019) posited that trauma can seriously damage, if not, ruin friendships, intimate relationships, and marriages. VT can sometimes result in the individual experiencing feelings of abandonment and isolation (Klimley et al., 2018). Feelings of abandonment and isolation, according to Bundy

(2020), places an individual at a higher risk of experiencing more serious, longer lasting effects such as PTSD. The need for reducing the impact of VT on helping professionals is important for the professionals and the trauma clients with whom they work.

Functioning impairment can manifest in both professional and personal areas of an individual's life. Functional impairment describes the deterioration in the ability to carry out normal functions effectively (Rupert & Dorociak et al., 2019). These impairments, according to Dorociak et al. (2017), result not only in lower productivity; but in certain occupations, they can have serious consequences for HSPs because they can affect the health of the service provider as well as their clients. According to Cappiccie et al. (2020), impairment can occur in an individual's personal life first and then spill over to their professional life or the opposite. Rahman et al. (2020) suggested that interpersonal functioning is often compromised by depression, anxiety, irritability, and physical or bodily complaints. These complaints result from symptoms of BO, which can cause mental and physical ailments that compromise the effectiveness of the HSPs work.

HSPs who work with trauma clients can experience personal impairment. Impaired HSPs, often, distance themselves from family, friends, and coworkers because they no longer desire the closeness or comradery from those relationships (Molnar et al., 2017). Further, Cummings et al. (2018) noted that if helping professionals feel isolated, lost, and incapable of maintaining relationships, they may have lost their desire to function. Unidentified VT may create emotional, behavioral, physiological, cognitive, and spiritual impairment.

Emotional Impairment

VT creates emotional wellness vulnerability in the helping professionals who work with trauma clients. Symptoms of VT can include prolonged feelings of grief, anxiety, or sadness (Pirelli et al., 2020). Some may experience irritability or feelings of anger with others; some even become frequently distracted, feel unsafe or experience changes in their mood or their sense of humor (Molnar et al., 2017). HSPs who work with individuals who experienced trauma are more predisposed to stress from feeling and expressing empathy towards the pain and suffering of their clients. Neswald-Potter and Simmons (2016) observed that HSPs faced many challenges maintaining wellness due to their experiences in having to assist clients with their issues. HSPs resiliency and wellness requires deliberate healthy decision making.

Psychological Impairment

The psychological impact of VT on HSPs who work with trauma clients can cause significant issues that may have long lasting effects. Holt et al. (2017) asserted that helping professionals must be able to work within an emotionally charged relationship with their clients, while maintaining a sense of self. Burruss et al. (2017) claimed that maintaining balance allows HSPs to develop a healthy identity while creating reciprocal and satisfying interpersonal relationships. However, Burruss et al. (2017) further noted that any disruption to this balance has numerous psychological and physiological implications. Trauma alters its victims, as well trauma impacts the helping professionals who work with victims.

According to Bowen's (1998) family systems theory, differentiation of self (DoS) consists of intra and interpersonal dimensions, or the capacities for affect regulation and negotiating relational separateness and togetherness. There are two elements of self-differentiation: intrapersonal and interpersonal. Intrapersonal differentiation of self refers to the individual's ability to distinguish between thoughts and feelings and to choose whether to be guided by intellect or emotion (Sharps, 2019). Individuals who possess a high degree of differentiation of self-experience, a complete range of emotions, are able to apply rational thought processes when situations dictate (Halevi & Idisis, 2018). Additionally, they are flexible, adapt well to change, and cope effectively with stress, while maintaining an appropriate degree of autonomy in their relationships (Sharps, 2019). In an effort to provide the optimum services to clients, as well as to protect themselves against serious harmful effects of VT, HSPs can transform and integrate clients' traumatic material.

HSPs listen to their clients recount personal stories of trauma on a consistent basis and are eventually impacted by the interactions. Middleton et al. (2021) and Huggard et al. (2017) posited that these helping professionals may internalize the memories of their clients recounted events which may temporarily or permanently distort their own memory systems, causing psychological impairment. Moran and Asquith (2020) also found that distortions in memory may become intrusive or disruptive to the helping professionals psychologically. The likelihood of the HSPs experiencing VT symptoms becomes increased after working with victims who recount their trauma stories.

Spiritual Implications

Spirituality carries a personal and unique meaning for each individual. According to Clarke et al. (2016), it is this sense of spiritual purpose and meaning that an individual assigns to their connection and understanding of things, people, and events (Saban et al., 2019). Van Hook (2016) and Ho et al. (2016) defined spirituality as the values and morals an individual holds as scared, and the supreme which is personally attached to the supernatural, the mystical, and to organized religion. Coaston (2017) took a different stance, stating that spirituality is how individuals seek to obtain a closer connection with their higher power and their higher self, which does not necessarily refer to religion. Clarke et al. (2016) defined spirituality as it relates to counseling as the ability and need of all individuals to move toward personal growth responsibility and relationship with others by finding and constructing meaning about life and existence. The overall well-being of HSPs is grounded in the alignment of the mind, body, and spirit.

Spirituality plays an integral role in increasing the well-being of an individual and improving the overall health of the HSP. When the mind, body, and spirit of an individual are not integrated, it can hinder an individual from reaching optimal health and well-being (Meany-Walen et al., 2016). Harris et al. (2018) pointed out that when the aspects of an individual's spiritual world are disrupted, that individual may respond in a manner that violates their otherwise perceptions, practices, and beliefs of spirituality. Kim et al. (2021) posited that some identifiers of spiritual disconnectedness may include, losing sight of one's purpose and loss of hope; feeling unworthy, guilty, and feelings of lost love and an overall disconnection from others. When individuals feel alone and isolated, they

sometimes feel there is no hope or purpose in living. The prevention of burnout and the achievement of wellness through spirituality can provide a mental health professional with the ability to connect more fully with others and prevent the depletion of an individual's physical energy.

Distinction in Terminology

Several terms are used to describe the experience and concept of VT, and the negative impact it can have on the HSP. Contemporary studies have raised concern that this "vocabulary mismanagement" puzzles researchers on VT and the effects of secondary trauma (Branson, 2019; Knight, 2019; Pirelli et al., 2020; Sprang et al., 2019). Some researchers appear confused by the usage of different terms to explain the same topic, while others used those same terms to define distinct elements of this concept, if not an entirely different concept altogether (Branson, 2019; Sprang et al., 2019). While there still seems to be some overlap in terminology, each of the terms exhibit symptoms that are unique to the specific term.

Literalists maintain operational distinction between the terms. These scholars believe that the difficulty in distinction and separation of the terms is increased because some of these terms still have many overlapping features and descriptions (Branson, 2019; Sprang et al., 2019). Scholars have outlined four other primary terms used to describe similar but distinct phenomena related to VT: PTSD, compassion fatigue, secondary traumatic stress, and burnout (Branson, 2019; Figley & Ludick, 2017; Molnar et al., 2017; Sprang et al., 2019). Although the terms may present elements that overlap,

each has its distinct aspects that delineate cause and effect from direct and indirect exposure to trauma.

Some VT signs and symptoms of clearly intertwine with the signs and symptoms of the other conditions; however, those conditions impact individuals differently. VT, while it is different from PTSD, is associated with comparable symptoms, including reexperiencing the trauma and avoiding traumatic material and experiencing depressed mood (Taylor et al., 2016). Higher levels of exposure to traumatized patients are a significant predictor of VT (Cosden et al., 2016). The onset, appearance, and lasting effects of VT are unique from other psychological effects that HSPs may experience (Uziel et al., 2019). Knowledge and early identification of VT may lessen the impact and severity of VT symptoms.

VT may present with symptoms similar to other mental health issues, such as PTSD, CF, and STS, but the effects are different. VT differs from secondary trauma as it develops over a longer period due to gradual exposure to clients' traumatic events, while secondary trauma can result over a much shorter duration (Taylor et al., 2016). The changes associated with VT are more persistent and permanent, resulting in negative effects across areas of identity, self-perception, spirituality, and worldview (Uziel et al., 2019). As noted, higher levels of exposure along with length of exposure are key factors that determine the impact and lasting effects of VT.

Posttraumatic Stress Disorder

PTSD is a chronic condition associated with noticeable functional impairment after exposure to highly distressing, traumatic events. PTSD is a diagnosis involving

psychological anxiety resulting from exposure to threat via first-hand victimization, witness to threat, being overwhelmed by the knowledge of a loved one's trauma, or extreme repeated exposure to details of trauma (Price et al., 2018). PTSD symptoms must create daily impairment for more than a month and are divided among four clusters: reexperiencing the event, alterations in arousal, avoidance, and negative alterations in cognitions and mood (Branson, 2019). When looking at the symptoms of PTSD, there is overlap with VT; however, VT does not meet the requirements of the triggering events and PTSD can result from exposure of a single event causing lasting effects.

Exposure to a traumatic event is a high-risk factor for developing PTSD. Direct exposure, both current and past to trauma, has a greater impact on PTSD (Freedman & Mashiach, 2018). Exposure can also be indirect, such as helping professional who vicariously experience the traumatic events of their clients (May & Wisco, 2016). Indirect exposure can lead to STS: the symptoms of PTSD are present but are considered secondary because the exposure was indirect (Freedman & Mashiach, 2018). Direct and indirect exposure of a traumatic event have been combined to show that work-related indirect exposure can also be considered a potentially traumatic event (Freedman & Mashiach, 2018). Direct exposure to the high levels of distress seem to increase the risk of long-term consequences such as PTSD, with adverse outcomes for the whole organization (Orrù et al., 2021). PTSD accounts for the functioning impairment of individuals who are exposed to ongoing stressful environments.

Constant and extensive exposure to work-related trauma in the human service field may have an impact on the mental health of the helping professional. Research has

indicated that individuals with multiple types of exposures to trauma are more likely to experience symptomatology than those with fewer types of trauma exposure (Anderson et al., 2019; Briere et al., 2016). Hines and Douglas (2015) also noted that higher health risks are associated with PTSD such as low self-esteem, depression, and high blood pressure. PTSD can be caused by direct and indirect exposure to violence and other types of traumas, which determines the severity and lasting effects of PTSD symptoms.

Compassion Fatigue

CF can also present symptoms similar to that of VT in that helping professional shares in the individuals suffering with empathy and compassion. Figley (1995) claimed that CF is interchangeable with STS and is appropriate for loved ones, lay-persons, and professionals who are overwhelmed by their observations of trauma and desire to provide support. STS and CF often involve feelings of helplessness, as victims are often overwhelmed by the quantity of need and their lack of available comprehensive and/or meaningful resources.

CF is the loss of the ability to feel and show compassion concern for clients. CF's defining aspect is working in situations that involve repeated or long-term involvement with clients who have negative outcomes such as clients in hospice care, chronically homeless clients, or substance abuse clients who continually relapse, and trauma clients (Diaconescu, 2015). HSPs experiencing CF may feel hopeless, have difficulty experiencing pleasure, develop a negative attitude towards work and clients, experience difficulty focusing, and have sleep disturbances. In addition to the steps that are helpful in reducing VT, CF might be decreased by steps as simple as taking a vacation or

developing a hobby (Fox, 2019). Also helpful are establishing clear professional boundaries, including a clear understanding of the HSP's responsibilities and realistic definitions of successful outcomes for clients.

CF describes the overall experience of emotional and psychological fatigue. HSPs experience CF symptoms due to the chronic use of empathy when working with clients who are vulnerable or suffering in some way from a traumatic experience (Burnett, 2017). CF has been measured as a component of overall professional quality of life and as a combination of the symptoms of STS and professional burnout and is often compatible with other similar terms such as VT and STS (Kelly & Lefton, 2017; Yi et al., 2018). Although it has been suggested that indirect trauma reactions and the manifestation of CF has similar characteristics as other mental health conditions, they are distinct, independent occurring experiences.

The concept of CF suggests that HSPs may experience stress associated with their work. HSPs may or may not experience trauma resulting from their work, as implied by the terms STS and VT (Fox, 2019). Unlike the concepts of STS and VT, the potential triggers for CF are not solely contingent on the primary trauma of the client (Cetrano et al., 2017). CF is the combination of psychological stressors that exists in everyday HSP work and with the clients they work with who have experienced some type of trauma.

CF among HSPs has been studied in both the micro and the macro levels of HSP work. HSPs who work with individuals who have survived various types of traumas such as sexual assault and incest, veterans and military families, survivors of natural disasters, the mentally ill, IPV, and terminally ill clients have all been linked to CF due to their

work with these populations (Kiley et a., 2018). The literature has suggested that the single greatest risk factor for the experience of CF is simply human service work itself (Fox 2019). Any work conducted with individuals who are abused, suffering, or surviving a trauma experience places HSP at risk for CF or other mental health problems.

Human service work inherently requires them to be actively ready to use their own personal psychological resources of empathy and compassion to help their clients. Overtime, however, those resources may become tattered or exhausted, leaving HSPs vulnerable to effects of CF (Yi et al., 2018). Vulnerability factors for CF include history of personal trauma, caseload size, lack of professional work experience, and training (Burnett, 2017; Cetrano et al., 2017; Kelly & Lefton, 2017). In addition, the use of maladaptive coping skills in response to stressful work environments and poor professional boundaries have been identified as vulnerability factors for the effects of CF (Kiley et a., 2018). All helping professionals vicariously exposed to trauma through work will potentially experience some degree of negative symptoms of CF.

Secondary Traumatic Stress

STS results from HSPs being psychologically overwhelmed by their desire to help and comfort to their clients suffering from trauma. The term coined by Figley (1995), is most applicable to first responders, medical personnel, members of the legal/correctional community, and other professionals who encounter persons who suffer grave trauma and personal damage but do not develop an ongoing empathic relationship. Cummings et al. (2021) posited that STS presented like PTSD symptomology, such as avoidance, unwanted mental images, oversensitivity to trauma-related stimuli, and compromised

daily functioning. The key differences between STS and VT are the development of symptoms. STS is acute and can occur after a single episode of exposure, whereas VT results from a process of accumulation (Branson, 2019). The symptoms of STS overlap with BO and CF; however, it has a more acute onset in comparison to other work-related distress.

STS symptoms, like PTSD, include the characteristic of intrusion, avoidance, arousal and disturbance in mood and cognition. Rates of STS have been established for various at-risk HSP populations across studies; 6 to 26% of trauma therapists and up to 50% of child welfare professionals have been found to experience STS (Whitt-Woosley et al., 2020). Studies have shown increased incidence of STS associated with factors such as high caseloads of trauma clients, organizational isolation, inadequate training, limited experience and having a personal trauma history (Hensel et al., 2015; Whitt-Woosley & Sprang, 2018). Personal and professional support to include proven workplace practices have been found to decrease the symptoms and effects of STS (Hensel et al., 2015). Many helping professionals affected by STS are also at a higher risk for other similar negative psychological conditions.

STS has been shown to be natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other. Figley and Ludick (2017) posited that people who possess a strong desire to help individuals who have been subjected to incidents of trauma may experience high levels of stress as a result. The negative effects of secondary exposure to a traumatic event are nearly identical to those of primary exposure, with the difference being that exposure to a

traumatizing event experienced by one person becomes a traumatizing event for a second person (Orrù et al., 2021). Samson and Shvartzman (2018) noted that secondary traumatization of clinicians has been hypothesized to include symptoms parallel to those observed in individuals directly exposed to trauma, such as intrusive imagery related to the client's traumatic disclosures, avoidant responses, physiological arousal, distressing emotions, and functional impairment (Molnar et al., 2017). Thus, STS has a pattern of symptoms nearly identical to those of PTSD.

Burnout

Helping professionals rely heavily on their ability to care for others' emotional and mental trauma impacted experiences. BO is the product of a poor working environment, usually entailing deficient administrative support, insufficient compensation, persistent staffing problems, high turnover, poor morale, lack of opportunities for advancement, a lack of appreciation, and exasperating work with little hope of change (Sansbury et al., 2015). Indicators of BO are a feeling of depersonalization, a negative change in productivity, generalized apathy, and emotional exhaustion (Lee, 2019). BO and VT are similar in that they are both the result of a process and accumulation. However, the most significant difference is the prognosis of BO.

The symptoms of BO can be improved with some minor adjustments. These adjustments may include assigning the individual to a new or different position, increasing work responsibilities, assigning tasks that are more personal in nature, hiring additional staff to help with the excess workload, and allowing staff to have time off to

recharge physically and emotionally (Jie et al., 2021). The impact of VT is more prominent and prone to be permanent (Branson, 2019). BO negatively impacts the personal and professional quality of life of helping professionals.

BO is commonly understood as the result of work producing emotional exhaustion, depersonalization, and a decreased sense of personal accomplishment. BO is not necessarily related to client contact and may occur in any HSP worker (Wampole & Bressi, 2020). Emotional exhaustion may include feelings of being drained, overextended emotionally, and depletion of emotional resources. Depersonalization is distancing oneself from clients and co-workers and is frequently accompanied by a cynical attitude towards work (Dreison et al., 2018). BO may be exhibited as a decreased sense of personal accomplishment refers to feeling dissatisfied with work and having a sense of not achieving anything meaningful.

BO has many possible causes, some in no way related to working with clients. For example, limited resources, inadequate clinical supervision, conflicting demands and instructions from managers, organizational inefficiency, or emphasis on paperwork rather than client needs can result in BO (O'Connor et al., 2018). Other contributors to BO include conflicts between the HSP's values and those of the client or agency, requirements to report client behavior that may result in negative outcomes for the client, and incompatible HSP, client, and organizational priorities (Dreison et al., 2018). VT and CT can also contribute to BO.

Professional burnout or occupational burnout is the response to prolonged and chronic stress in the workplace. Orrù et al. (2021) further defined some of the

contributing factors of professional and occupational BO. These include emotional exhaustion, depersonalization, and reduction of personal abilities. Emotional exhaustion occurs when a helping professional's emotional resources become depleted by the overwhelming needs; demands; and expectations of their clients, supervisors, and organizations (Allday et al., 2020). Depersonalization refers to negative, cynical, or excessively detached responses to coworkers, job tasks, or to clients and their situations, and it reflects a change in interpersonal thoughts and feelings regarding work with clients that may occur in the process of professional burnout (Cummings et al., 2020). Reduction refers to an individual's sense of personal accomplishment that occurs when clients fail to respond to intervention despite HSP's diligent efforts (Allday et al., 2020). This may be an indication to the HSP that their methods are not effective, and the lack of positive client response indicates they are no longer able to reach the client, their professional ability has deteriorated in some way.

BO appears to be more predominant in the HSPs rather than in other professions that do not encounter trauma on a consistent basis. Colonnello et al. (2021) BO is characterized by gradual development of exhaustion, frustration, anger, and work environment depression over time accompanied by reduced professional satisfaction. BO according to Welp et al. (2015) can also lead to a poorer ability to judge, late or inadequate responses to changes in the clinical context and lacking the ability to show empathy with clients BO HSPs experience fatigue and often find themselves unable to face the demands of their job or engage with their clients.

Human Service Professional

The term human service professional (HSP) encompasses a wide range of fields of individuals who provide services to individuals who require assistance in coping with and persevering beyond the impact of some type of life altering traumatic experience. The Human Services field has evolved and emerged as a prominent discipline with a unique professional identity over the past few decades (Neukrug, 2017). HSPs are trained to work in a variety of settings with diverse client populations. The HSP is considered a generalist profession, making it imperative that HSPs work collaboratively with other professions to maximize the quality-of-service delivery to clients (Winfield et al., 2016). HSPs can and do work in a variety of different positions, including, but not limited to crisis intervention specialists, substance abuse counselors, domestic violence counselors, social service workers, case managers, probation officers, and mental health assistants (Neukrug, 2017). There are various service fields identified under the umbrella of HSP, each with its own unique skills, knowledge, and expertise; however, all provide valuable service to their clients.

HSPs play a critical role in responding to and meeting the needs of trauma survivors and, in doing so, they are exposed to trauma on a regular basis. Additionally, Johnson (2017) asserted that as a generalist profession, HSPs are a vital asset in building professional relationships; exhibiting empathy; and conveying genuineness, acceptance, cognitive complexity, wellness, competence, and cross-cultural sensitivity. Hence, HSPs are skilled to address the unique requirements of diverse client populations through an interdisciplinary knowledge base that focuses on identification, prevention, and

mitigation of issues (Council for Standards of Human Service Education [CSHSE], 2015). Although, HSPs are considered generalist by profession, they deliver a wide range of services in varying areas of the field of human services, while playing a vital role in the care, recovery, and reintegration of the clients.

Protective Factors

Protective factors are measures taken to combat the effects of stress, trauma, and other types of mental and emotional issues. Protective factor against VT may be attributed to possessing coping strategies which diminish VT symptoms (Halevi & Idisis, 2018). Lonn and Haiyasoso (2016) and Masson (2019) suggested that experiencing VT is necessary for professional growth, as through this experience, the individual learns coping strategies and builds self-efficacy. The experience of VT requires the individual to self-reflect (Masson, 2019). Salient themes of importance in support of implementing protective measures are age, years of work experience, training in working with traumatized individuals, and social and work support.

There are other factors that can be considered as protective against the impact of VT. Hensel et al. (2015) stated that older helping professionals with more experience in the trauma field are more likely to have experienced more stressful events during both their private and professional lives than their younger colleagues and are, therefore, better able to cope with such events. Also, Kunst et al. (2017) posited that helping professionals with years of experience have experienced more indirect exposure to trauma than their less experienced colleagues and have had more opportunities and time to develop successful coping skills. Trauma training may also act as a buffer against VT because it

can help HSPs better understand traumatized individuals and avoid VT by using coping strategies (Sage et al., 2018). Training and coping strategies, when implemented correctly and on a continual basis, may eliminate or decrease symptoms of VT.

Social and work support may minimize VT among helping professionals because it can affect the way they approach and handle stressors and promote healthy coping behavior. According to Hensel et al. (2015) and Hamama et al. (2019), supportive relationships may also be associated with lower VT, as well as a decrease in exhaustion and an increase in professional efficacy. The main themes identified in this study, professional support, social support, self-care, and propose in life, are important contributors in decreasing the symptoms and impact of VT.

Professional Support

Professional support refers to support received from colleagues, peers, and leaders in the work environment. MacRae and Strout (2015) recommended that leaders should create an avenue for HSPs to discuss issues relevant to client trauma stories. This type of leader-employee interaction may also provide an opportunity for the employee to share with leaders and colleagues their own past experiences, offering suggestions (Chipu & Downing, 2020). Training and strong professional support demonstrate positive protective measures.

Professional support is important for minimizing risk factors and maximizing protective factors for helping professionals. Giao et al. (2020) and Van Hook (2016) noted some factors that reduce work stress, which include self-advocating individual and group supervision empowered individuals to create personal boundaries; group

supervision provided a necessary and imperative means to gain support from coworkers, colleagues, and supervisors alike, and peer supervision allowed colleagues and coworkers an opportunity to discuss cases or other work activities. Ogbonnaya et al. (2018) observed that peer supervision also provides colleagues with the opportunity to debrief, examine their perspective, and verbalize reactions to clients' trauma stories. Coworker support and engagement is a meaningful way to prevent burnout by increasing a sense of solidarity, providing honest feedback, and allowing the HSP to be heard.

Different constructs have been used to describe the psychological effects that can be experienced by HSPs who work with victims of trauma. Hensel et al. (2015) noted some professional support factors impacting VT included training, job experience, and organizational satisfaction. Education on coping strategies in the workplace have been found to be effective in managing stress, influencing better coping skills, and reduced employee psychological distress (Gil & Weinberg, 2015). Therefore, Brooks et al. (2015) and Brooks et al. (2017) posited that it may be beneficial for employers to include education about successful coping into their workplace, including encouraging HSPs to engage in off-duty hobbies, take time to relax, and seek social support. Lewis and King (2019) pointed out that HSPs constant exposure to trauma recounts from their clients, should ensure that self-care techniques and strategies are implemented into their daily routine as factors for helping mitigate the risks of developing VT. The chances of HSPs experiencing VT are influenced by aspects of the work environment, such as workload, work pace, pressure to secure grants, and long hours (Devenish Meares, 2015; Dugan & Barnes-Farrell, 2017; Wilson, 2016). When the symptoms of VT go unmanaged, stress

accumulates, and it can negatively impact the HSPs' personal and professional relationships (Wagaman et al., 2015). Workplace education, training, and support foster a healthier workforce by integrating these techniques into their practice and curriculum (Reis et al., 2015). Given the greater risk associated with HSP work, implementing measures such as increased communication, including reflective assignments, debriefing, and engaging in intentional conversations on wellness practices promotes shared learning and greater awareness for the potential of job related phycological distress (Martin et al., 2020). Workplace administrators are in a unique position to equip HSPs with the strategies and training needed to maintain professional wellness.

Workplace training sessions could also provide information regarding the effects that VT exposure can have on employees' lives. Brooks et al. (2019) noted training sessions that increase awareness about the potential risks could allow for employees to psychologically prepare for and possibly prevent the impact of VT (Quevillon et al., 2016). Additionally, positive coping strategies used by HSPs may protect them from developing VT, while minimizing distress and maximizing well-being (Dugan & Barnes-Farrell, 2017). These sessions could bring awareness of available resources in the event HSPs are impacted by VT.

Social Support

Social support systems are a needed and vital factor in the mental and emotional well-being of helping professionals. There are different models of wellness, usually consisting of between six and eight domains; however, most include a social or interpersonal component (Stehman et al., 2020). Duff (2016) described the subjective

indicators of well-being as individuals experiencing feelings of being heard, valued, appreciated, treated with respect and dignity. According to Duff (2016), supportive interpersonal relationships is one of the strongest predictors of well-being. Interpersonal relationships are important for overall physical and emotional wellness because those relationships foster a sense of connectedness and purpose in life (PIL).

Social support plays an important role in physical and emotional well-being. A strong support network is shown to improve the mental, emotional, and overall well-being of helping professionals (Salloum et al., 2015). Having strong social support outside of work and use of positive coping strategies such as getting adequate sleep, taking breaks at work, and eating meals away from work area, have all been associated with higher compassion satisfaction and lower secondary traumatic stress and burnout (Brady, 2017). Occupations like that of HSPs are highly stressful by virtue of the diverse client population they serve; therefore, social support is vital in the overall well-being of the HSP.

HSPs engage in varied self-care practices that address different aspects of their well-being. Some of these self-care practices include physical health activities, spiritual activities, leisure activities, debriefing, and seeking emotional and helpful social support (Blount et al., 2020). Research emphasizes the importance of establishing and utilizing social supports early on because VT affects one's ability to trust others and experience intimacy in relationships (Miller et al., 2018), which can increase isolation and negatively affect well-being. Social support is a protective factor for emotional and mental health that may result from VT. Awareness of the potential for experiencing VT and building

professional and personal support networks as well as habits of self-appraisal and self-care can decrease the likelihood of VT occurring.

Self-Care

Not only is it vital for the HSP to understand the damaging effects of VT, but it is also equally important for them to understand and implement self-care measures that protect them in their work with trauma populations. Lawler (2020) stated that self-care is the practice of implementing protective measures that safeguard a person's well-being by shielding them from extreme stress-related situations. Self-care practices may buffer against burnout and STS (Steinlin et al., 2017). When implemented, self-care practices may buffer against STS and contribute to vicarious posttraumatic growth (Manning-Jones et al., 2016). Vicarious posttraumatic growth is defined as positive changes in self, relationships, and view of life due to working with people who have experienced trauma (Salloum et al., 2015). Self-care plays a vital role in establishing and maintaining a healthy work-life balance.

Self-care generally refers to activities or processes that an individual implements for the purpose of relieving symptoms of stress. Jie et al. (2021) asserted that when helping professionals make self-care a priority, they are not only supporting their health and well-being, but they are also implementing stress relief measures. Lewis et al. (2019) also stated that the implementation of self-care practices plays a role in the HSPs' professional posture, and it is linked to the HSPs' ability to be fully present for their clients in order to deliver quality services. It is necessary for HSPs to practice self-care measures because it is most beneficial to their holistic wellness and helps maintain a

highly functioning work/life balance that allows them to provide quality services to clients as well as avoid possible harm to clients (Jie et al., 2021). Protective factors that extend to HSPs' personal life and overall well-being may also influence a healthy work/life balance, which may decrease the effects of VT.

There are many forms of self-care that can be implemented to help mitigate VT; however, as everyone is different, self-care measures work better for some than others. While self-care measures might involve seeking help from others such as family, friends, or a professional therapist, it is still considered a form of care for self (Bressi & Vaden, 2017). Self-care can help to mitigate the negative effects of VT on helping professional's well-being; research suggested that social support is an essential aspect of the helping professionals' self-care (Houston-Kolnik et al., 2021). Individuals who engage in self-care practices experience less professional burnout, higher levels of professional efficacy, higher professionalism, and lower workplace turnover (Acker, 2018; Miller et al., 2019; Rahman et al., 2020). Self-care refers to any care that is performed by the individual that helps them feel good about themselves and reduces the causes of stress and tension.

Administrators and supervisors should monitor self-care practices in the workplace. Setting boundaries between an individual's professional and personal commitments, as well as fostering a healthy work-life balance, is important in establishing and maintaining overall well-being (Cleary et al., 2020). HSPs should be mindful of the potential factors that contribute to negative impact of job-related stressors, such as VT. According to Wilson (2016), neglecting to implement self-care measures increase an individual's vulnerability to VT, which may also impact client care and

professional relationships. Moloney et al. (2018) noted that self-care should viewed as a necessary element in work-life balance, not as an indulgence. Lewis and King (2019) further noted that self-care is a process of reflection and awareness, which promotes resilience and develops professional boundaries, especially for those who work in traumatic environments. It is natural for those who work in traumatic environments to experience some type of emotional distress as a result of their trauma work.

It is not easy for some HSPs to leave work-related issues and stress in the workplace. HSPs experience a high degree of stress in the workplace; however, self-care can minimize the stress and empower them to place their own health and wellness needs as a priority (Wilson, 2016). Cleary et al. (2020) noted that promoting an environment of awareness about the negative impact of trauma can assist individuals with identifying contributing factors of VT and promote healthier responses and trauma informed care for themselves and their clients. Successful implementation of self-care techniques has the potential to improve delivery of care for the clients and improve overall mental well-being of the HSP.

Purpose in Life (PIL)

There are several protective measures that individuals can take to help them avoid or limit the impact of trauma exposure. PIL is one of the key strategies. PIL refers to the feeling that life has meaning and direction, and that an individual's goals and potential are being realized or are attainable (Singer, 2020). Individuals with high PIL create life goals, purpose, and objectives, whereas those individuals who exhibit lower levels of PIL display no interest in setting goals, and seemingly attach no meaning in life, with little or

no direction for future accomplishments (Goodman et al., 2018). PIL helps individuals to find and assign purpose and meaning to life, which aids in minimizing psychological impairments after experiencing VT.

PIL has been found to be a protective factor for both psychological and medical conditions. Psychologically, PIL has been highly correlated with happiness and negatively correlated with depression (Itzick et al., 2018). Higher PIL is associated with increased longevity (Cohen et al., 2016), decreased risk of undergoing injury or disability (Akhtar et al., 2017; Steger, 2017; Steptoe et al., 2015), and a reduction in the risk of acquiring Alzheimer's disease and other cognitive impairments (Steptoe et al., 2015). PIL is linked to greater psychological wellness and well-being (Akhtar et al., 2017). Furthermore, individuals who are more resilient after experiencing a trauma have higher rates of PIL and meaning in life than individuals who have negative side effects after experiencing a trauma (Goodman et al., 2018). PIL could help guard against psychological stress, BO, and other forms of indirect trauma sustained through HSPs' routine occupational duties, while reducing burnout and employee turnover and improving client care.

Well-Being—Wellness

The demands placed on HSPs because of the work that they do in helping others overcome or manage their traumatic circumstances can create stressor in their personal and professional environment. Wellness, according to Tedrick et al. (2018), is establishing a sense of well-being, which is often achieved through implementing self-care measures. Gleason et al. (2019) further noted that using self-care methods to cope

with the stress of work helps bring alignment in their personal, professional, mental, spiritual, emotional, and physical aspects of an individual. When an individual is able to place their wellness as a priority, they are able to also manage the stress of work and the demands of their personal obligations effectively. Maintaining wellness in the workplace is the responsibility of the entire workforce. Callahan et al. (2018) posited that one of the key factors of well-being in the work environment is managing stress. Additionally, Meany-Walen et al. (2016) added that providing clients services, facilitation of professional accountability, and ethical behavior can only be achieved through wellness. Achieving a state of well-being is important for HSP's to be able to function effectively in the jobs.

The work of HSPs does not promote an atmosphere for wellness; therefore, they have to make a deliberate effort to work toward wellness. Brasfield et al. (2019) posited that achieving wellness for individuals who work in the human service professions can be challenging when trying to balance their work and homelife. Gleason et al. (2019) also added that, due to the demands of their work, HSPs most often practice self-wellness techniques outside of work hours when there is less distraction, and they are better able to focus. Callahan et al. (2018) posited that the impact HSPs have on their clients is dependent on their awareness of the stress and challenges and being able to manage that stress with self-care and wellness. Although wellness is key to HSP success, the overarching goal of the HSP is to provide optimum professional care and service to their clients; without wellness, that becomes a difficult impossible task.

Summary and Conclusions

Five major themes were developed from the literature review of VT: the development and prevalence of VT, the prevalence of VT across professions, HSP turnover, HSP professional and personal impairment to include the impact of VT on the HSPs emotional, behavioral, physiological, cognitive, and spiritual environments. The distinction in terms of other mental health issues, PTSD, CF, STS, and BO are identified to show the similarities and differences impacting HSPs who work with trauma clients. Social support and self-care are coping strategies identified as a means for HSPs to help reduce the impact, effects, and manage symptoms of VT.

Although extensive research on the topic of HSPs experiencing VT have been studied, minimal research exists on the narratives of HSPs who work with the male IPV victim populations and the impact of VT within aspects of both their professional and personal life.

Chapter 3 provides an overview of the research design and rationale for the selected study approach. I discussed sections of the research which included the role of the researcher, methodology, and the issues of trustworthiness in qualitative research, then provided a summary of the information presented in the chapter.

Chapter 3: Research Method

Introduction

Individuals who experience IPV may have lasting effects that impact them mentally, physically, and emotionally. Targeted services for IPV victims are vital for their recovery, especially for male victims, who tend to be reluctant to seek out professional services. HSPs who work with the male IPV population may experience VT after working with them. The purpose of this generic qualitative research study was to investigate HSPs' experiences with VT after working with male IPV victims.

In this chapter, I provide information on the research design and rationale, my role as the researcher, and information on the methodology selected for the study. I also discuss the inclusion and exclusion criteria for selecting the research participants and the interview protocol for data collection and analysis. Lastly, I discuss the importance of trustworthiness in qualitative research.

Research Design and Rationale

The research question for this study was the following: What are HSPs' experiences with VT after working with male victims of IPV?

Qualitative research is a multifaceted approach to gaining insight into a phenomenon. The qualitative design is historically grounded in sociology and anthropology (Maxwell, 2021). According to Aspers and Corte (2019), qualitative research includes both an interpretative and naturalistic approach, which allows the participant an opportunity to share personal experiences about the phenomenon being explored. Additionally, Busetto et al. (2020) noted that from a researcher's perspective,

qualitative research offers a glimpse inside participants' lives as they tell their stories about the phenomena being studied in an effort to interpret the meanings in the stories. Hussain et al. (2021) posited that qualitative research is comprised of a variety of empirical materials such as personal experience; life stories; case studies; introspection; interviews; and observational, historical, interactional, and visual texts, which all depict aspects of varied occurrences in a person's life. Mohajan (2018) also noted that qualitative research includes observing the world in its natural setting while attempting to interpret the objective and subjective nature of the meaning individuals assign to their life experiences. Collins and Stockton (2018) noted that researchers who choose a qualitative approach seek to investigate the meanings people assign to their experiences and identify and explain the social structures and processes that shape those meanings. Qualitative research was the most suitable research design for this study because it allowed me the opportunity to examine the personal experiences of HSPs who work with male IPV victims and explore their personal stories. Qualitative research allowed me the ability to explore the concept of VT among HSPs who work with male victims of IPV and collect data through extensive interaction using a semistructured interview technique in an unstructured environment with the participants to answer the research question.

The generic design combines elements of the qualitative design and includes multiple approaches, and the study does not adopt a specific methodological viewpoint. Belotto (2018) posited that generic qualitative inquiry is appropriate when the researcher intends to gain a deeper understanding of the participants' emotions, ideas, and views as they are retelling the story of their experience. Goodell et al. (2016) postulated that

generic qualitative inquiry focuses on the meaning assigned to an experience of a single individual as it occurs. The generic inquiry is an exploratory method. Jamali (2018) suggested that the use of generic qualitative inquiry is most appropriate when the researcher is interested in exploring and gathering information describing the experiences of the research participants' perception of the experience. Individuals' experiences are merged and cannot be diminished or separated. A generic qualitative inquiry is appropriate for examining issues when there is insufficient information on the subject. Willis et al. (2016) pointed out that generic studies are used to develop a theme while gaining innovative insight into the phenomena, thus resulting in a greater understanding of the phenomena. I choose this generic design approach because it provided an opportunity to delve deep into the stories from the experiences of HSPs as they recounted their interpretations and beliefs regarding VT. A generic qualitative approach was optimal for gaining knowledge and understanding of VT from an active research participant perspective.

Ethnography, case study, grounded theory, and phenomenology were considered for conducting this study. Ethnography focuses on investigating the network of social groupings, social customs, beliefs, behaviors, collections, and practices (Jamali, 2018). I did not select this approach because the researcher spends a great deal of time immersed in the research population's culture studying and understanding the network of social groupings, social customs, beliefs, behaviors, groupings, and practices of the culture. Case studies are in-depth investigations of a case using multiple methods and multiple data sources (Hoorani et al., 2019). Case studies can be exploratory, explanatory, or

descriptive and most often involve multiple sources of evidence such as observation, interviews, and documents (Houghton et al., 2017). I did not select this approach because the intent was to collect data from one specific source, through semistructured interviews with participants. Grounded theory involves using data from people to develop a theory or explanation or storyline that describes the idea for the process in question developed over time (Charmaz & Belgrave, 2019). A person's reality is passed along between people, always changing, and constantly evolving (Hoddy, 2017). A person's reality is ever changing, not necessarily based on their personal experience, but rather passed along from someone else's experience (Timonen et al., 2018). I did not choose this approach because the intent of the study was to explore the phenomena through the lens of the participant's own personal experiences, rather than developing a theory of the phenomena. Phenomenology is used to investigate the lived experience of various psychological phenomena (Neubauer et al., 2019), and it includes the inner essence of those cognitive processes, not the external content or referents that may trigger the mental processes (Tuffour, 2017). I did not select this approach because the intent of this study was to gain an understanding of the participants' interpretation of their own experiences of the phenomena. I selected the generic qualitative research approach for this study because it is designed to identify and describe perceptions of the participant's experiences while focusing on the outer feelings instead of the inner feelings (see Percy et al., 2015). Using the generic qualitative approach increases understanding from the viewpoint of the study participants (Kahlke, 2018). The themes developed from the data collected will be representative of the recounted stories from the experiences of the participants.

Role of the Researcher

The researcher is the instrument in the qualitative research approach. Qualitative researchers are involved in all stages of the study from defining a concept to design, conducting interviews, transcription, analysis, verification, and reporting the concepts and themes. Rahi (2017) noted that when instruments are used in qualitative research often means the researcher plays an integral part of the process. According to Rogers (2018), naturalistic research as with qualitative research involves the researcher as the primary instrument because they possess characteristics that are highly responsive to environmental stimuli, have the ability to interact with the situation, pull together different pieces of information at multiple levels simultaneously, and perceive situations holistically; they are able to process findings the instant they become available and present feedback immediately when received. These characteristics, along with good interpersonal skills, make them appropriate instruments in natural settings and study processes.

For a researcher, it is important to be engaged in all aspects of a study to increase creditability in the study and to mitigate bias. Self-reflection is a method used to gain awareness and identify any potential biases and assumptions that could impact the study (FitzPatrick, 2019). It is important to self-reflect and set aside any personal connections to the topic that may exist while conducting the research without bringing harm to the participants (Kristanto & Padmi, 2020; Peterson, 2019). The study participants were nonlicensed HSPs who experienced VT after working with male IPV victims. Although I am not an HSP and have not experienced VT, I have experienced IPV, I have been

diagnosed with PTSD, and I meet with a counselor on a weekly basis. Therefore, the potential for bias did exist, which is why it was important for me to identify and develop strategies for decreasing the potential of those biases during the study. I maintained a personal journal to record my thoughts and feelings that could have caused personal bias to surface throughout the study.

In research, bias management is vital to the study's success, specifically as it relates to data collection and analysis. The researcher's preconceptions and biases can influence decisions and actions throughout the study (FitzPatrick, 2019). As noted by Kristanto and Padmi (2020), bias can be minimized by incorporating a computer-generated database application. This provides an additional layer of dependability and trustworthiness to the study. Fusch and Ness (2015) noted that researchers typically study topics that reflect personal beliefs and values; therefore, as Dodgson (2019) noted, it is unrealistic for a researcher to think that total detachment from the research is possible. For that reason, Reid et al. (2018) posited that reflexivity keeps the researcher present by helping them recognize bias while conducting analysis of personal involvement in the study.

Reflexivity is a researcher's insight into their own biases and rationale for decision making throughout the study to demonstrate rigor (Johnson et al., 2020). Reflexivity, according to Reid et al. (2018), is used to increase the creditability of the findings. Reflexivity also enables the researcher to conduct ongoing analysis of personal involvement, which helps make the analysis process open and transparent (Florczak, 2021). Levitt et al. (2018) noted that it is important for researchers to be as transparent as

possible by focusing on the importance of their role in the development of the study. When qualitative researchers highlight the overlapping relationships between the participants and researcher, it strengthens the creditability of the findings and increases understanding about the study (Reid et al., 2018).

For this study, I monitored personal biases, beliefs, and personal experiences and how they intersected with the study, as well as maintained a balance between personal views and overall knowledge gained from the research through bracketing. Bracketing methods are intended to mitigate the preconceptions and presumptions of the researcher that could potentially cause harm during the study (Butler, 2016). Bracketing requires the researcher to set aside past knowledge and understanding of the study topic by maintaining self-awareness and remaining present and grounded in the study throughout the study process (Shufutinsky & Long, 2017). Journaling is a way of demonstrating transparency and for conducting continued self-reflection and analysis (Kahlke, 2018). It also helps the researcher stay mindful of personal opinions.

Ethical issues can arise at any time throughout the study; one of the times is when the researcher offers an incentive to study participants. Brown et al. (2016) noted that research incentives encourage participation, can help to equally compensate participants for their time, and can keep more study participants but should not cause unnecessary enticement to participate in the study. As a recruitment incentive, I gave each of the participants a $15 Visa gift card, which was addressed in detail on the informed consent. Incentives were not used as a coercive tool, but rather as a small expression of gratitude to the participants for volunteering to participate in the study.

Methodology

Participant Selection Method

The intended population for this study consisted of nonlicensed HSPs between the ages of 30 and 65 from Central Texas who currently or previously provided services to male victims of IPV. In this study, my goal was a sample of 10 participants from this population (see further discussion in Sample Size). The HSP was required to have a master's degree in a related human services field, have a minimum of 5 years as an HSP, and have directly worked with at least four male IPV victims. The exclusion criteria applied to HSPs (a) who did not fall within the suggested age range, (b) who did not live in Central Texas, (c) who did not hold a master's degree, (d) who had not worked in the field for a minimum of 5 years, and (e) who had not worked directly with male victims of IPV between the ages of 30 and 65 within 3 years. It was important to select HSPs from a wide age range, with 5 or more years working in the field of human services, but most importantly a minimum of 3 years working with male IPV victims. The members of this select diverse group of participants provided rich information, were knowledgeable on the study topic, and were able to reflect at length and in depth on the topic of interest.

The intended sampling strategy for this study included purposive sampling and snowball sampling. The purposive sampling approach is commonly referred to as *judgmental*, *selective*, or *subjective sampling* because the researcher makes the selection of the study participants based solely on the qualities they possess (Sharma, 2017). Rivera (2019) further noted that in purposive sampling, the researcher determines the information that needs to be known and purposely seeks participants who meet the

criteria and are willing to provide information on the research topic. I selected the nonprobability, purposive sampling approach because the desired population required specific qualifications due to the type, nature, and purpose of the study. The type, nature, and purpose of the study required a unique skill set that directly informed the data collection for the study. This sampling technique was selected because it was cost effective, less time intensive, and could be implemented more quickly than with other sampling techniques.

In addition, snowball sampling was used as an alternative method for obtaining participants if not enough participation was acquired with the purposeful sampling alone. Snowball sampling, or chain referral sampling, is an approach in which the researcher starts with an initial convenience sample of a concealed population whose members recruit other participants, and in turn, the recruited group recruits others to participate in the study, expanding the participant pool (Etikan & Bala, 2017). I recruited potential participants by asking confirmed participants if they knew of other professional colleagues who met the participant inclusion criteria who may have been interested in participating in the study.

The intent was to recruit a total of 10 nonlicensed HSPs who specialized in providing services to male IPV clients throughout Central Texas. Moser and Korstjens (2018) noted that qualitative research does not typically set guidelines as to how large or small the sample size should be. Boddy (2016) suggested that although sample size in qualitative research depends largely on the type and extent of the study, the suggested sample size ranges from 10–12 among homogenous participants. However, Malterud et

al. (2016) pointed out that an adequate sample size for qualitative research is determined by the amount of information the sample holds that is pertinent for the actual study. Although the goal was to interview 10–12 participants, the sample size may be a smaller or larger number depending on extensiveness of the data collected and data saturation or redundancy.

There are no standardized guidelines for reaching data saturation. Data saturation is defined as information repetition, when there is no new information, codes, or themes generated from the data collection (Fusch & Ness, 2015). According to Nelson (2017), a guiding principle in qualitative research is to conduct interviews only until data saturation has been achieved. Data saturation includes the collection of qualitative data to the point where additional data do not yield new information (Lowe et al., 2018). Qualitative research sample size largely depends on the richness of the data, the variety of participants, the broadness of the research question and the phenomenon, the data collection method, and the type of sampling strategy (Moser & Korstjens, 2018). The most important aspect of data saturation, as noted by Braun and Clarke (2021), is the availability of enough in-depth data that clearly distinguish the patterns, categories, and variety of information about the phenomenon being studied. I conducted interviews with participants and collected data until no new themes emerged, which indicated that data saturation had been reached and the data collected would provide all the essential information to answer the research question.

Instrumentation

For this study, I created an interview protocol. An interview protocol is a tool for guiding and preparing the script that was used to assist with the interview process. The interview protocol consisted of a script that outlines elements of the interview that need to be covered before starting the data collection, prompts during the interview, and reminders at the conclusion of the interview to ensure that all the elements on the script are covered (McGrath et al., 2019). There are details that the interviewer needs to cover with the participant prior to beginning the interview, during the interview, and at the end of the interview, that without a script, may be forgotten (Hoover et al., 2018). The interview protocol script should be written in clear, understandable language and highlight each of the elements of the protocol details throughout the process, such as information about the study, revisiting the informed consent, and confidentiality (Castillo-Montoya, 2016). An interview protocol enhances validity and reliability in the study as well as increases the effectiveness of the interview process by ensuring comprehensive information is generated during the interview (Yeong et al., 2018). Establishing a well-developed interview protocol was vital to the success of the interview phase of a study.

The interview protocol should be developed once the research question has been developed. The interview protocol guiding this study was adapted from Jacob and Furgerson's (2012) tips for the development of a successful interview protocol. These tips included 14 factors from the development of the research topic, research questions, using a script, prompts, structuring open-ended questions, starting the interview with

basic questions, Institutional Review Board (IRB) approval, the length of the interview, and then ending the interview. The elements of the interview protocol as it related to instrumentation covered the research question. I developed interview questions that elicited conversation. Although the interview questions aligned with the research questions, they were structured differently in that they were questions asked of the participant to gain an understanding of their experience rather than formulating a question to gain understanding of a phenomenon. The interview questions were written in clear, simplistic language, and they were free of jargon so that the participant clearly understood what was being asked and they were comfortable providing a response. The questions were phrased in a way that promoted a casual, friendly atmosphere that made the participant comfortable and established a good rapport. Once the participant appeared to be more comfortable, I used my interview guide to begin the formal interview by asking the participant a series of main, probing, and follow-up questions related to the topic of study, until all questions were asked.

Procedures for Pilot Study

Conducting a pilot study of the interview protocol and interview questions may highlight information the researcher may have overlooked. Dikko (2016) posited that pilot testing should closely emulate the actual interview process and suggested that the researcher should pilot test the interview protocol and questions with people they know to validate that the protocol and questions are clear and understandable. According to Jacob and Furgerson (2012), a pilot test can uncover details that strengthens the interview protocol before conducting the actual interviews. The researcher should also seek the

advice/guidance of a mentor, IRB, and an experienced qualitative researcher (Hammarberg et al., 2016). Jacob and Furgerson further noted that novice researchers may find it necessary to bring others in to collaborate with during the development phase of the first iteration of questions. Dikko (2016) noted that doctoral students most often work with their assigned mentor and or dissertation committee regarding decisions about initial interview questions. Interview protocol feedback (Castillo-Montoya, 2016) enhances its reliability and trustworthiness as a research instrument by providing information about how understandable or unclear the interview questions were and if they align with intended expectations of the researcher.

I contacted 10 individuals through email to participate in a pilot study. Five of the 10 individuals responded. The five individuals who agreed to participate included three fellow human service PhD cohorts, one third year law school student, and one computer engineer. I then emailed each of them the list of interview questions, and I asked them to review and answer the questions and provide feedback regarding the relevance of the questions in relation to the research question. I also asked that they evaluate the quality of the interview questions and to highlight any questions they felt needed to be revised or removed from the list then explain their reasoning why. Lastly, I asked them to return the questions with their feedback to me via email within 2 days. Once I received the completed questions, I emailed a thank you note to each participant along with information about the confidentiality and safeguarding of their information. Some responses included recommendations to revise some questions because they were more closely aligned with closed-ended questions rather than open-ended question. There were

also suggestions related to removing a few questions because they did not align with the research question. The pilot study helped me to better prepare for the actual study interviews by organizing and filtering the interview questions to align more closely with the research question.

Participant Recruitment and Selection Strategy

The intent was to use social media outlets, such as messenger, META (formerly Facebook), snapchat, twitter, Nextdoor and LinkedIn to recruit participants. Social media outlets and health and human services agencies are good outlets for posting information about the study because more people are using social media outlets to network and form social connections. According to (Mendez, 2020) the snowball or referral chain methods in sensitive issues research are best used for attracting individuals who meet the study criteria. Using multiple outlets to advertise the study increased visibility about the study and promoted interest in participating in the study.

Any individuals who expressed interest in participating in the study were instructed to contact me at which time I sent them an email with the inclusionary criteria questionnaire. All the individuals who met the inclusion criteria were emailed the informed consent. I followed up with a phone call to the participant to go over the consent form with them and asked that they sign and return it to me via email at least 24 hours prior to conducting the interview.

Following the interview protocol, I answered any questions or concerns they had, as well as provided an overview of what to expect during in the interview (1 hour, voice recorded, semistructured, open-ended question interview). I explained that participation

was strictly voluntary and that there were no rewards for participation. I explained that participation in the interview posed no foreseeable harm to them for participating. I also informed each participant that the interview, as well as the data collected, was confidential, and I explained how the data would be safeguarded during and after the study. I asked them again if they had any questions or concerns and addressed any they had. Once the signed informed consent was returned, I contacted the participant by phone to schedule the interview for a day/time and media platform that worked best for the participants.

Data Collection

Data was collected via semistructured, voice recorded interviews using either Skype, WhatsApp, Zoom, or MS Teams virtual platform. The interviews consisted of preset, open-ended questions. This method afforded the participants an opportunity to provide answers that offer a broad range of opinions, ideas, and reflections of their experiences in their own words. Johnstone (2017) asserted that when a researcher wishes to gain an in-depth understanding of participants′ experiences, perceptions, opinions, feelings, and knowledge, conducting in-depth interviews can provide an avenue for gaining richer knowledge about the target of study. Goodell et al. (2016) found that semistructured interviews using open ended questions stimulated depth and vitality, which generated new concepts and increased the validity of the study. This method of data collection provided valuable data for analysis.

Before concluding the interview, I asked the participants if they had any additional information they wanted to share before concluding the interview. If the

participant did not have any additional information they wanted to add or had questions, I proceeded with providing a detailed description of what happened with the collected data and the next steps in the research process. I informed them that the collected data along with their interview materials would remain confidential and stored in a limited access secure storage area throughout the study. Finally, before ending the interview, the participants were asked if they had any questions or concerns regarding any part of the interview. I mailed each participant a $15 Visa gift card via postal mail.

After completing each interview, I continued to use my personal computer to transcribe the audio taped interviews. Microsoft 365 was used as the primary tool to record and transcribe the interviews. MS Teams and Zoom were used as secondary tools for recording and transcribing the interviews when necessary. The Microsoft 365 transcribe feature converts spoken word into text transcripts and separates each speaker's voice individually. The audio record feature allowed me the ability to playback any part or section of the recording, timestamp, and edit the transcription to save some or all the transcript as a word document or insert sections into an existing document. According to Alase (2017), transcription allows the textural and structural descriptions of the participants exact words to be used. After the data were transcribed, I reviewed the document as I listen to the audio recording to ensure accuracy. I made any necessary revisions to the transcripts and completed the data collection phase of the research.

Data Analysis

Data was analyzed at the conclusion of each interview. Data analysis for the study was adapted from Miles and Huberman (1994), who defined data analysis as consisting

of three components: data reduction, data display, and conclusion drawing and verification of the data. These three elements made up the data analysis. Similarly, Walliman (2017 noted that this method of data analysis should be a sequential process that builds throughout the data collection. Data analysis employs detailed techniques that elucidate the premise of the qualitative research.

The first component is data reduction. Data reduction involves a process of compiling all the raw data collected (audio tapes, transcripts, and field notes), and organizing them in a format manageable for the analysis. Qualitative data analysis relies on the data to be maintained in an organized manner so that it is readily accessible (Miles & Huberman, 1994). According to Huberman and Miles (1994), categories can be formed from codes and themes, which summarize the data while retaining the original data framework, richness, and complexity. Elliott (2018) asserted that codes are broken apart data to identify relevant information that aligns with the research. Open coding helps in identifying themes and subthemes (Elliott, 2018). According to Rogers (2018), coding is a process of organizing the data and separating it into themes that point out similarities and unique anomalies. The themes are the relevant information that emerges from the codes (Wutich & Bernard, 2016). Coding began once all the data had been collected and transcribed.

The conventional coding strategy I used for this study aligned with the open-ended research question, in that the intent was to explore the participants' experiences of VT. I thoroughly reviewed the transcripts from the collected data and highlighted all phrases and sentences that appeared to signify an important recount of VT experiences.

Once completed, I coded all highlighted passages using predetermined category of codes. I labeled and assigned a new code to any of the highlighted phrases or sentences that did not align with the predetermined codes. Once the coding was completed, I examined the data in each category to determine what themes and unique incidents surfaced, as well as determined if there was a need to create subcategories. Coding categories were created directly from collected data, which helped in gaining both enhanced knowledge and understanding about the research.

The second component is data display. Data display involves separating and organizing data in a compact format so that it is easily readable and understandable. Miles and Huberman (1994) noted that the data display should be assembled so that the information is immediately accessible, and the researcher can examine the information for themes and possible conclusions. I created a matrix with rows and columns to separate the data into a compact format so that I could better see and understand the breakout of the data to decipher emerging themes.

The third component is conclusion drawing and verification. Conclusion drawing and verification is a process of identifying similarities and patterns in data points. Miles and Huberman (1994) posited that the final conclusion may not emerge until after all of the data are collected and that the conclusion is dependent on the volume of data and other tools used during the data collection. I reviewed the data as they were collected and notated any similarities in the participants' stories. Notating the similarities began the development of the initial conclusions. As the data analysis process progressed, these initial observations evolved into more developed final conclusions. Walliman (217) also

pointed out that the beginning of data analysis is a dense cumulation of unorganized information, that must be pulled together and organized into categories and like classifications. Verification, according to Huberman and Miles, involves the researcher conducting an in-depth review of all the data collected to ensure that there were no discrepancies in the translation of audiotape and written notes through the transcription process. It can also involve having colleagues review the data to determine if the findings can be replicated in other studies (Huberman & Miles, 1994). For this study, I conducted an extensive review of the data to test the confirmability of the material.

Issues of Trustworthiness

Trustworthiness is a key component in qualitative research. Daniel (2019) posited that trustworthiness reinforces both accuracy in the research process and the significance of the study. Establishing trustworthiness is necessary for heightening understanding and clarification of the findings (Daniel, 2019). According to Kyngäs et al. (2020), achieving trustworthiness requires the researcher to employ a systematic process of organizing and analyzing the research data so that it demonstrates a degree of integrity in the process and results of the study.

Confirmability

Confirmability means providing a comprehensive picture that details the methods and procedures used in the study. Stewart et al. (2017) and Tracy and Hinrichs (2017) posited that for the researcher to gain trustworthiness, they must ensure objectivity or confirmability of the research by maintaining neutrality, which also decreases the probability of researcher bias. I demonstrated confirmability by detailing the methods and

procedures of the study; the sequence of data collection, analysis, and presentation methods; maintaining all the data so that it was available to collaborators for evaluation; and by staying abreast of and reporting personal assumptions and potential bias. All the steps reinforced confirmability and created an audit trail of the study.

Dependability

Dependability aims to demonstrate the stability of the data. Dependability refers to the stability of the data collected and is demonstrated by using a strategy of conducting audits and maintaining audit trails (Baillie, 2015). Colorafi and Evans (2016) noted that an audit trail can be established by outlining the purpose of the study and detailing how and why individuals were selected to participate in the study. The audit served several purposes; it described how the data were collected, how long it took to obtain data, and how data were condensed or converted for analysis. Discussing the interpretation and presentation of research findings, and communicating the specific techniques used to determine data credibility, is also a benefit for maintaining an audit trail (Morse, 2015). For this study, I demonstrated dependability by enlisting two colleagues and one veteran researcher to replicate the study for similarities in the research. These individuals although familiar with the subject matter were not involved in the actual study. According to Birt et al. (2016), these individuals can conduct a step-by-step replication of the study, provide comprehensive explanations about the research method, and check for any similarities in the research findings. The individuals were asked to review the study for consistency throughout the entire study and provide feedback. I used the review to

help determine if others viewed the research process as clear, understandable, and consistent, which then established dependability.

Transferability

Transferability means ensuring that the content of the data collection method used aligns with the lives of the participants. Transferability refers to whether or not particular results can be transferred to similar situations, and still preserve the integrity from the completed study (Hennink et al., 2017). Transferability requires the researcher to have professional knowledge about the demographics of the participant population, their experiences, and the recruitment and sample selection. Transferability implies that the participants have expert knowledge about the phenomenon being studied (Forero et al., 2018). In qualitative research, transferability is achieved when the researcher can present rich evidence depicted from the participants' actual traumatic experiences (Ospina et al., 2018). I increased transferability by doing a comprehensive job of detailing the research framework, along with the assumptions that were key to the study to provide evidence that the findings could be applied in other situations and studies. For this study, participants were able to review and analyze the research results to ensure that it was easily interpreted and could be utilized to offer lessons in other research settings without losing its intended purpose which was to highlight the experiences of HSPs who experienced VT after working with male IPV victims.

Ethical Considerations

I ensured provisions were made to address any protentional ethical issues during and at the end of the study. I obtained IRB approval prior to initiating recruitment, data

collection, and analysis. As noted by Reid et al. (2018), ethical procedures are procedures that require an agreement by the researcher to adhere to all outlined ethical guidelines and formal approvals to conduct a study. Once I received IRB approval, I started the recruitment process for potential participants by posting the study information along with my contact information to various social media outlets. I emailed an inclusionary criteria questionnaire to all the individuals who contacted me about the study. Those who met the inclusion criteria and were selected to participate were emailed the informed consent. Once I received the signed consent forms, I contacted the participants to give them a comprehensive overview of the study including any potential benefits and harm associated with participating in the study. I informed them that their participation in the study was totally voluntary and that they had the option to withdraw from the study at any time without retribution. I discussed the safeguarding of all research data and confidentiality guidelines. I also addressed any questions regarding the informed consent form. Manti and Licari (2018) also noted that informed consent forms must be written in a way that ensures all participants easily understand the possible risks associated with participating in the research and that it is their decision to participate. I continuously monitored the participant's well-being throughout the study to ensure that any perceived ethical issues were addressed expeditiously, while adhering to informed consent code of ethics. It was reiterated that study participation was totally voluntary, and there was no coercion or excessive influence for them to participate in the study.

In addition, all research materials to include recruitment and screening documents, informed consent forms, interview notes, journals, digitally recorded audio

tapes, and data analysis material was labeled using alpha numeric codes to protect the participants' identity. According to Arifin (2018), the researcher should be the only person able to match the identity of the participants to any of their data collection documents. All the research materials will be stored appropriately. Digital records will be stored on a personal password protected computer for 5 years after which time they will be permanently deleted from the hard drive. All handwritten material will be stored in a numeric password protected fireproof safe located in my home office for 5 years as required after completion of the study. The document will then be taken to a professional shredding company to be shredded once the 5 years expire. Accessibility to the research materials was only afforded to me as the researcher and my doctorial committee.

Lastly, all participants were provided with my personal email and cell number for any questions or concerns they may have had throughout the duration of the study. Although, I did not anticipate any harm to the participants because of their participation in the study, I provided them with the names of local HSPs in the event they may have needed to seek professional assistance.

Summary

This chapter provided detailed information about the intended research design and rationale, my role as the researcher, and the proposed methodology selected for the study. I also presented the inclusion and exclusion criteria for selecting the research participants, and the interview protocol for data collection and analysis. Lastly, I discussed the importance of trustworthiness in qualitative research.

Chapter 4 provides a presentation of the data collection, data analysis, evidence of trustworthiness, and research results, concluding with a summary of the information presented in the chapter.

Chapter 4: Results

Introduction

The purpose of this generic qualitative research study was to investigate HSPs' experiences with VT after working with male IPV victims. The goal was to identify the collective themes related to HSPs' experiences of VT as a result of working with male IPV clients. Additionally, the goal was to contribute to the literature regarding how HSPs cope with VT both professionally and personally. I completed this study to answer the research question: What are HSPs' experiences with VT after working with male victims of IPV?

In this chapter, I provide sections that outline the setting, demographics, data collection, and data analysis. The issue of trustworthiness is evidenced by highlighting three key elements, confirmability, dependability, and transferability, as mentioned in Chapter 3, and the development of themes. Additionally, I present the results of the study along with a comprehensive overview of the interview responses from the participants sharing their experiences with VT. I conclude with a culminating summary of the information presented in the chapter.

Setting

The COVID-19 global pandemic forced a complete change in traditional methods of conducting research and collecting data. Technology became vital for maintaining professional and social connections. Businesses, the military, educational institutions, and the whole world economy had to learn and adapt to doing things differently in order to survive in the "new normal" way of functioning and way of life. With that, face-to-face

interviews were no longer realistic or doable. Therefore, due to the high probability of contracting the COVID-19 virus, all interviews were conducted remotely via FaceTime calls using the Microsoft Word dictate function to record and transcribe the interviews. To ensure the participants' safety as well as my own, all pre- and post-interview communication was conducted through email, text, and in some cases, telephone.

On June 14, 2022, I received the notification of approval to proceed to the final study stage from the IRB, which meant that I could post my research flyers and begin participant recruitment. On June 16, 2022, the research flyer was posted to Facebook and LinkedIn social media outlets, which were used as the instruments to recruit prospective participants. In order to gain access to view the social media posts, prospective participants needed to have internet capability. The flyer included information about the study, inclusion criteria, and my Walden University email. After a prospective participant contacted me and it was determined that they met the inclusion criteria, I forwarded the consent form via email for them to review, complete, and return to me. Once I received the consent form back, I contacted the participant either by text or by email, depending on which method of communication the participant stated worked best for them, to schedule the interview for the date and time that worked best for the participant.

I conducted the first interview on July 18, 2022, and the final interview was conducted on November 5, 2022. All the interviews were conducted virtually and individually using the FaceTime application on my Apple iPhone. Although 60 minutes was allocated for each interview, the interviews lasted an average of 45 minutes, with the longest lasting almost 75 minutes. No special equipment was required for the participant

to have or obtain to participate in the study. There were no technical issues or concerns regarding the use of the FaceTime application or Microsoft Word dictate function to record the interviews.

Demographics

Demographic data were not collected for this study. The selected population for this study was human service professionals who experienced VT as a result of working with male IPV clients. The 11 individuals who met the inclusion criteria for the study (a) were nonlicensed HSPs, (b) were between the ages of 30 and 65, (c) were from Central Texas, (d) had worked with male victims of IPV within the last 3 years, (e) provided services to male victims of IPV, (f) held a master's degree in a related human services field, and (g) had a minimum of 5 years as an HSP. All 11 selected participants met the seven required inclusion criteria for the study.

Data Collection

LinkedIn and Facebook social media outlets were used to recruit participants for the research study. Due to the low response, I also used the snowball sampling method, which is an alternative method used to solicit additional participants when interest and participation are low and/or slow. Etikan and Bala (2017) stated that snowball sampling expands the participant pool by using the already confirmed study participants to recruit individuals whom they know who may meet the inclusion criteria and be interested in participating in the study.

The social media flyers included information about the study, inclusion criteria, and my contact information. Thirteen individuals responded to the study participant

invitation, but only 11 met the inclusion criteria. One individual did not meet the age range criteria; the other expressed interest but never responded to provide consent to take part in the study. Once I received the email consent responses, I scheduled the virtual interview for a day and time that was convenient for the participants' schedule. Each interview was conducted using Microsoft Word dictate recording and written transcription application. The Facetime application on my iPhone was used in conjunction with the Microsoft Word application to conduct the virtual face-to-face portion of the 60-minute semistructured open-ended-question interviews.

The interview protocol was used to guide each of the interviews. Each interview began with a scripted introduction, which included a review of the consent form, voluntary participation, data collection and storage, and participant confidentiality. Each participant was asked the same seven open-ended interview questions to include additional probing questions in order to gain further explanation and member checking on specific questions. After completing each interview, I compared the recording and dictated transcripts for accuracy. Corrections were made as necessary. Once the revisions were completed, the audio recording, original unedited transcripts, and edited transcripts were saved and uploaded to a uniquely labeled locked file on my personally owned Apple MacBook Pro computer. The data collection methods used did not deviate from the proposed data collection outlined in Chapter 3, and there were no unusual circumstances that arose during this process.

Data Analysis

The research question that is used to influence a study informs the thematic analysis approach adopted by the researcher. The thematic analysis approach that was used in this study was adopted from the seminal work of Huberman and Miles (1994), who distinguished between three main elements in conventional coding: data reduction, data display, and conclusion drawing and verification of the data. Analysis of the collected data began once all the interviews had been completed.

Data reduction, which is the first step in the three-element process, began with comparing the audio recordings and raw transcripts for accuracy. This was done by replaying each recording, listening to it as I read the raw transcript along with the recording. I was able to stop the recording and replay it at will to evaluate the content and make necessary corrections to the raw transcripts. This enabled me to properly document the participants' stories as they told them without the jargon, which presented the material in a more understandable format for readers. Miles and Huberman (1994) pointed out that data reduction is a way for the researcher to sort, keep, discard, and organize data in a way that conclusion drawing, and verification was evident. Although data reduction has been a continuing process throughout this research project, as it specifically relates to data collection and analysis, it allowed me to select and transform the raw data into a simplified, usable product.

During the initial coding, I also reviewed the transcripts numerous times, highlighting specific sentences and portions of the transcripts to include writing notes in the margin and on posted notes; I then compared the notes written during the interview

with post interview notes to ensure that I identified the essence in the meaning of the patterns in the emerging themes. I coded all highlighted passages and placed them in coded categories. Once the categories were identified and separated, I sorted out similar participant responses, and I then placed them under the categories. An example of participant statement similarities included, "I believed I would be judged, that my coworkers would think that I was not able to do my job." After completing the category grouping, I started labeling and assigning new codes to the highlighted phrases and sentences that did not align with the already-identified codes. The coding process produced codes; some examples of codes included short phases such as sadness, anger, helplessness, interaction, challenges, and experience. Once the coding was completed, I examined the data in each category to determine what themes and unique incidents emerged, and if any subcategories needed to be created.

The second element, data display, began with separating and organizing the data in a compact format so that the data were easily readable and understandable. Huberman and Miles (1994) noted that the researcher develops an enhanced understanding of the data once they are systematically condensed. I created a five-row, five-column matrix to separate the data into a compact format so that I could better see and understand the breakout of the data in order to decipher emerging themes. The first column of the matrix contained the labels assigned to each participant for distinction, such as IP1 and IP2; the second column contained the interview questions; the third column contained short descriptive participant responses (raw data) to each of the questions; the fourth column contained the themes, and the fifth column contained the codes. The matrix produced five

codes, which consisted of VT exposure, impacts of VT, tackling VT, risks of VT, and support systems; eight categories, which consisted of VT risk factors, symptoms of VT, VT negative and positive impact, preventive and coping strategies, strategy challenges, VT awareness, work environment, and support system availability; and 13 themes, which consisted of emotions enable vicarious trauma vulnerability, lack of awareness leads to poor diagnosis, work experiences play a role in associated risks, stigma prevents the professional from seeking help, vicarious trauma impacts mental and physical health, vicarious trauma affects the professional's productivity, vicarious trauma improves self-care and services offered, preventive strategies minimize risks associated with vicarious trauma, coping strategies limit the symptoms related to vicarious trauma, ineffective coping strategies caused challenges among professionals, availability of employer sponsors' professional support systems, challenges the professional faces with employer-funded support systems, and rewards related to utilizing professional support systems. According to Huberman and Miles, data display methods can be modified to meet the needs of any study; however, what is most important is that the display helps the researcher in furthering their understanding of the data. The intent of this display was to preserve the richness of the data by pulling out what was essential to my research.

In the conclusion drawing and verification, which is the final element of the process, I identified similarities and patterns in data elements. Miles and Huberman (1994) posited that, at the start of data collection, the researcher begins to notice similarities, patterns, and the meaning of things. The matrix used for this study displayed the data with clarity and dense detail, which revealed intent, meaning, and how things

developed overtime with each data collection. This made identifying similarities and patterns during conclusion drawing and verification much easier. The data analysis did not reveal any discrepancies or outliers. The data analysis process allowed me to transform the raw collected data into clear, understandable language that generated categories, which I combined similar participant responses. From this, codes and categories emerged, and were translated into unique themes that ultimately answered the research question.

Evidence of Trustworthiness

Trustworthiness is an important factor in all types of research. Demonstrating trustworthiness is especially important in qualitative research because the researcher is the primary research instrument (Dodgson, 2019). The entire research is compromised if readers question or do not believe that the researcher trustworthy. Rather than evaluating qualitative research with scientific measures, Lincoln and Guba (1985) posited that qualitative research should be based on trustworthiness, which should be established by considering elements such as credibility, transferability, dependability, and confirmability. These four elements help establish transparency and strengthen the qualitative research.

Credibility

Establishing credibility in qualitative research is just one element when demonstrating trustworthiness of the study. Rose and Johnson (2020) posited that one way the researcher can show soundness of the research is by establishing credibility, which requires validating the collected data using a process known as member checking.

Member checking is a process that allows the researcher to share the transcribed documents from the interviews with the respective participant to review for accuracy (Nassaji, 2020). Member checking was used during data collection by asking open-ended questions along with probing questions to further explore participants' responses. To ensure that their recount of an experience was captured correctly, I used a technique known as mirroring, which consists of clarifying a participant response by saying "What I heard you say was that you." Member checking continued after data collection. After each transcript was completed and reviewed, I provided a copy to the respective participant to review. Sharing the transcripts with the participant not only gave them an opportunity to verify that the transcript accurately reflected the information that was shared in their interview, but it also demonstrated inclusiveness.

Transferability

Transferability can be challenging in qualitative research as it relies on the researchers' ability to demonstrate richness in the study content. Stahl and King (2020) posited that transferability can only be established when the research reflects thorough descriptions and rich content of the study and that it can align with and used to inform similar research relating to the topic of interest. In this study, transferability was established throughout the study as I documented field notes, which included detailed descriptions and vivid interpretations of the participants' experiences with VT. I also recorded lessons learned during the duration of the study, which could be used in similar studies to enhance understanding of the impact of VT on HSPs and promote advancement in current practices and policies to combat VT in the human service profession.

Dependability

The research can establish dependability by maintaining detailed written procedures or an audit trail. According to Singh et al. (2021), the researcher can increase dependability during the data collection and analysis phases of the study by demonstrating consistency in the methods used during this process. I used all of Walden's research standards to show dependability in the study. These research standards included Form C, Ethic Self Check Application for IRB Approval, Qualitative Dissertation Checklist, Dissertation process worksheet, Informed Consent Form, and Interview Protocol, which kept me on track with the various steps to completing the dissertation to this point. All of these standards provided guidance for ensuring that there was no deviation from Chapter 3 sections for data collection and analysis. With regard to the data collection, all participants were vetted to ensure that they met the inclusion criteria in order to eligible to participate in the study; all participants were asked the same set of seven semistructured questions, with the only variance being the probing questions that were dependent on participants' responses to questions that required additional clarification. Regarding data analysis, all interviews were recorded and transcribed simultaneously using the MS Word dictate option on my personally own computer. All the data collection transcripts were provided to my department chair for review and feedback to ensure thoroughness, and that protocol was followed. This phase allowed me to refine the audit trail of all the materials created and used in the study up to this point, while strengthening dependability of the study.

Confirmability

Confirmability can present with challenges because it requires the researcher to remain neutral throughout the research process. This can be difficult in qualitative research because as Singh et al. (2021) noted, qualitative research is a more hands-on approach, which requires the researcher to have direct interaction with study participants. I demonstrated confirmability in the study by journaling throughout the study. Journaling allowed me to self-reflect by recording my thoughts and assumptions about the study to address and control any biases, which is known as bracketing. Bracketing, according to Gregory (2019), gives the researcher the ability to set boundaries, making it easier to focus on the research rather than to their own underlying relationship to the topic. As an added measure, my department chair reviewed all the transcripts to ensure there were no researcher biases present in the documents. Transparency through establishing trustworthiness aided in not only helping me as a researcher to gain a better understanding about conducting a qualitative study, but it also provided an inside view of individual experiences with VT and the depth of affect it can have on both a person's personal and professional environments.

Results

To address the research question, participants were asked seven interview questions to include probing questions for those questions requiring additional exploration. During the data analysis process, 13 major themes were discovered.

Emotions Enable Vicarious Trauma Vulnerability

Emotional impairment of the HSP places them at a higher risk for experiencing VT. Emotional impairment happens when over time the HSPs' thoughts, behaviors, and actions become skewed because of direct contact with clients who have experienced trauma, and the stories of those traumatic events are retold to the HSP. Participant 1 shared their experience of emotional vulnerability by saying, Participant 2 stated,

> As I see and listen to my clients tell their stories of physical, mental, and or emotional abuse from someone they know or someone who they thought loved them it sometimes becomes hard to remain detached and not internalize. Sometimes as they share their stories, I start to visualize what they have gone through, and I feel as though I am going through the trauma along with them. At one point, in the beginning of my career I was so overwhelmed, I would leave work, go home, close the blinds, and sit on the couch in the dark and just cry.

Participant 3 also added to this emotional experience by sharing that,

> negative consequences from the trauma on the client's overall mental, physical, and emotional well-being is significantly impacted, at times became more and more difficult to distinguish empathy from my inner/personal emotions. I would internalize their trauma and become so distracted, that I would forget to annotate the notes from client meetings. I also experienced frustration when the client would share their stories and afterward say they were still with their abuser. I found myself getting angry and impatient with them, and also judgmental. When a human service professional works with individuals on a consistent basis who've

> experienced trauma sometimes listening to that trauma can impact in a way that causes them distress; that was me destressed and stressed.

Participant 10 said,

> Hearing my client's stories and hearing like the hard things that they have to go through it can be difficult because you feel a lot of empathy for them, and you want to solve their problem. You can help but you can't solve it. It's been difficult; it can be immediately like all consuming like that's like when I was in clinic I had a lot of clients that had a lot of like really hard issues a lot of things that were going on with their life so I made my clinic class my entire life, so I was always doing work, always trying to figure out what was going on and how I could better assist them. I did not necessarily establish boundaries. I made myself constantly available to them; on the phone always like stopping what I was doing in class to answer phone calls or like just doing work around the clock all day every day, so it more so just consumed my entire life. I experienced a lot of anxiety, anger, and a lot of empathy. I was annoyed a lot. I was very irritable. I didn't understand, I was just really annoyed with how my clients were being treated by like their partners so I felt like a lot of anger because most of my clients are poor so those are some of the emotions that I went through.

Participant 8 also shared,

> I would have to say seeing their responses of not only just the people that I work with and for me I would have to say that mentally I'm just listening to some of the things that those that I work with have experienced around me it can cause you to

> just feel like sometimes emotional instability where like there's this open door of fluctuating emotions.

By the very nature of their profession, HSPs often eventually experience some type of psychological impact during their care. The severity of the emotional impact determines coping and recovery.

Lack of Awareness Leads to Poor Diagnosis

HSPs are often so focused on helping their clients that they either lack awareness or forget that they also need to establish supportive outlet for self-care. The lack of awareness can lead poor or misdiagnosis of the issues such as VT that the HSPs are experiencing. Participant 9 shared their experience,

> It's been difficult; it can be immediately like all consuming like that's like when I was in clinic I had a lot of clients that had a lot of like really hard issues a lot of things that were going on with their life so I made my clinic class my entire life, so I was always doing work, always trying to figure out what was going on and how I could better assist them. I did not necessarily establish boundaries. I made myself constantly available to them; on the phone always like stopping what I was doing in class to answer phone calls or like just doing work around the clock all day every day, so it more so just consumed my entire life.

Participant 7 shared,

> So personally, I would say that through my experiences it has kept me from being able to sometimes flourish in some of the things that I felt well that were important to me. Also, I didn't realize that the trauma had impacted me until later

> on and it kept me from exploring some of the things that yeah others were able to enjoy and that I did not realize was of bulleted fear for me.

Participant 6 also stated that,

> I don't even realize that I've taken on the guilt, and I've visualized me going through the experience and I don't even realize that my behavior has changed, it's modified my behavior unless somebody calls me out on it.

Participant 5 said,

> Most often when you think about trauma you automatically think about clients, but as helping professionals we have trauma too, but we have to still come to work with a smile on our face, put that mask on and go to work helping others when we too need help.

VT symptoms can imitate symptoms of other psychological impairments, and it can sometimes be mistaken as fatigue from long work hours and heavy caseloads, when in fact it is possibly an impairment like VT. Failure to properly identify and address the impairment symptoms can sometime result in increased severity and length of lingering symptoms.

Work Experiences Play a Role in Associated Risks

Work experiences play a role in the vulnerability of some HSPs and how they establish coping techniques and deal with experiences of VT. HSPs new to the profession are more at risk than HSPs who have been in the profession over several years. This is because the more seasoned HSPs have had time to adjust to the nuances and demands of the work, have successful work-life balance, understand the stressors of the work, and

have established effective copying techniques. Participant 3 stated, “When a human service professional works with individuals on a consistent basis who've experienced trauma sometimes listening to that trauma can impact in a way that causes them distress; that was me destressed and stressed. Participant 4 said,

> just because I did not have that struggle did not mean that I did not struggle with other things, that I don't understand. I had to explain to him that everyone at some point struggles with something. Some people have harder struggles than others, but it is still their trauma they have to overcome in their own way, in their own time. Every day you're dealing with it.

Participant 2 shared,

> I believe it was hard because I was recently retired and new to the profession and also because some of their stories closely mirrored my own or one of my buddies from the military. I actually ended up taking a few days off to get myself together, which I thought would help, but unfortunately it was like putting a band aid on a gashing wound.

The work that HSPs do can be demanding and stressful; because of the type of work that they do, they are placed in a position of vulnerability daily. HSPs are constantly at risk for experiencing some type of mental or emotional impairment such as VT, which cannot only impact them professionally as well spill over into their personal lives.

Stigma Prevents the Professional From Seeking Help

Societal and work-related stigma discourages many people from seeking needed support services to address their psychological issues. Stigma perceived or real causes

worry, stress, and other emotional issues that can have an impact on an individual's ability to function effectively. Participant 2 shared,

> I definitely did not want anybody from work to know I was seeing someone for my own issues. And before you ask why, I will just tell you that it was because I didn't want my coworkers or supervisor thinking I couldn't handle my job.

Participant 8 noted that,

> It's good that they have it available, but you know, young people don't feel comfortable using it and I really understand that because of the stigma that might be attached to it too. Some people have talked about going but backed out because they felt others would think that they are not able to do their job. It is especially prominent amongst African Americans and that is the men and the women. Sure, just comments that I hear regarding those that are African Americans that if they go in, how is that going to look to everyone else that works. They are caught up on their coworker's the perception of what it looks like; that they can't do their job and the work is finally getting to them or breaking them; unfortunately, a lot of them are looking at it like that.

Participant 7 provided,

> I would feel more comfortable with because in a group of my peers I would honestly probably still feel judged. I definitely would because just because you have the title does not necessarily mean all therapists are regulating themselves accordingly.

Participant 3 said,

> It is not that I did not believe the programs available at work weren't effective, I simply overanalyzed it, thinking that the people in the programs were the same people I worked with and saw on a consistent basis; and being fairly new to the organization and profession, I did not want them to judge me and think I was not equipped to handle the demands of the job. Honestly, I just did not want them to think less of me professionally.

Some of the participants shared their reluctance for fear of being judged as not being capable to their job. Work-related stigma in the human service profession, as noted by some of the participants, kept them from participating in workplace support groups and counseling that was offered to the HSPs.

Vicarious Trauma Impacts Mental and Physical Health

The impact of VT has the potential to have far reaching results depending on identification of symptoms, when and how the issues are addressed, and establishment of effective coping strategies. Participant 1 said their experience with VT,

> Some of the depression that I've had to work through, I actually used some of the same coping skills that I teach my clients. Sometimes there has been anxiety and anger because of some of the experiences that I've heard or witnessed personally. Some sadness definitely but for the most part it's been a lot of anxiety and some sadness dealing with some of the clients that I've worked with that have experienced trauma.

Participant 7 also shared,

> Sure, it was fear that kind of stops you in your tracks, it debilitates you. I would just shut down. I didn't want to go anywhere, do anything. I just sort of shut myself off from the outside world both personally and professionally. I had no coping skills to combat the VT.

Participant 3 stated,

> The helplessness was because I would be doubtful that due to all of the trauma my client experience, I would not be able to help them because I wouldn't know how to connect with them to even begin to build trust. I think the helplessness was the scariest because it made me feel incompetent and useless.

In order for the HSP to provide effective supportive service to their clients, it is important that they themselves are aware of the signs and symptoms of VT so they can address them quickly to minimize disruption of services to clients and their other professional obligations.

Vicarious Trauma Affects the Professional's Productivity

VT can impact the HSPs ability to effectively establish the helping professional client alliance. This alliance is pivotal in the HSP being able to connect and help their clients professionally. Participant 7 stated,

> I would sometimes find myself not being able to focus on my client and reliving aspects of my own personal trauma and I realized that because of that I would experience anxiety and find my hands sometimes being sweaty and also just like having flight flashbacks when they talked about things that they had experienced.

Participant 11 shared,

> This impacted me because the client was around the same age as my own son, so I felt compassion, helplessness, sadness, anxiety, and a little anger. At some point, I realized that I needed to unpack all these feelings before I could be effective for my clients. I think that my counselor, helping me set clear boundaries by learning how to detach the client's trauma from distracting me from the mission of helping them overcome their circumstances.

Participant 5 noted,

> Helplessness makes me feel ineffective, incompetent, like I am unable to perform my job in a way that will truly help my client overcome all or even some of their obstacles. It is the one thing that causes me to question my ability as a helping professional.

Maintaining a professional posture is just as important as establishing a collaborative union with clients. Impairment in either one of these elements impacts the other, which ultimately adversely affects the services to clients.

Vicarious Trauma Improves Self-Care and Services Offered

VT is often linked to negative implications; however, sometimes VT triggers positive results. When VT is identified and appropriately addressed, the outcome can be both a learning and growing experience professionally and personally. Participant 1 shared,

> One thing about the helping profession as there are so many groups and so many seminars and so many different work groups that are available to attend that address with self-care which too often people don't realize how important that is

> to help with minimize vicarious trauma. Self-care is like the one of the biggest coping mechanisms that I use to kind of help me not experience symptoms of vicarious trauma. Learning how to externalize, learning how not of absorb those emotions as I did early in my career. I work hard to keep the focus on the client and not make it about me. More than anything I just listen, I observe, and I focus on their needs and not make it so much about me. All of those support groups, coping skills, and coping mechanisms definitely have helped.

Participant 3 stated,

> It has helped me how to not internalize the stories my clients tell as if they are my own. I had to learn how to stop "hitting," that rewind button in my head, replaying those stories of trauma over and over. I have "toolbox" a lot of valuable coping/management skills, as well as early detection skills to combat the impact of VT. Those skills along with my now years of experience, and personal "me time" outlets really have made a tremendous difference professionally and personally.

For the HSP to reduce the impact of VT, they must find effective coping and self-care techniques that work best for them. There are many self-care methods; however, not one method works for everyone. Once the HSP discovers what works for them in relieving the impact of VT along with other work-related stressors, they are better able to effectively make their work and personal life obligations.

Preventive Strategies Minimize Risks Associated With Vicarious Trauma

Incorporating preventive strategies to minimize the risk factors of developing VT enhances the HSP's resilience. Preventive strategies include training and supervision and instituting organizational policies that support the health and wellness of its employees. Participant 1 shared,

> One thing about the helping profession as there are so many groups and so many seminars and so many different work groups that are available to attend that address with self-care which too often people don't realize how important that is to help with minimize vicarious trauma.

Participant 7 stated,

> I can reach out to my supervisor to discuss things and still feel safe, not judged. It's still a check and balance system that you need to have.

Participant 8 also added,

> Yes, it does, it definitely helps to be able to finally communicate those feelings and those emotions that we are having. It is also helping us with turning off the client's words (stories) and separating it apart from our personal lives.

Participant 2 shared,

> I would have to say that because of counseling I am a better helping professional. I have a great supervisor, who promotes holistic wellness in work and personal life. They encourage continuing learning and growth. Overall, the work environment is positive which does help a great deal with the stressors that come with the profession.

Preventative strategies can be personal or professional or a combination of both. Strategies are determined effective by the individual who uses them; they decide what works best for them and gives them the best results. Preventative strategies are those measures that are put in place to assist with education, identification, and minimizing VT risk factors. There is no one-size-fits-all as it relates to best strategies for minimizing the associated risk factors of VT.

Coping Strategies Limit the Symptoms Related to Vicarious Trauma

Coping strategies, like preventative strategies, may require individuals to try different techniques before they are able to settle into a method that fits their needs. Coping strategies are those measures that are adopted to assist with managing the impact of VT in an effort to minimize the effects of VT in an individual's work-life/home life environments. Participant 9 said, "When I was in clinic, I was able to lean on my clinic partner and discuss like what we had gone through working with clients." Participant 10 stated,

> I also sometimes lean on like my professional partner we're also friends, so I sometimes vent to him about what might be going on in a specific client's case so that like I'm not breaking confidentiality. I can really release.

Participant 3 added,

> In my opinion, seeking professional help for the VT, was one of the best things I could have done because I learned some great coping skills and techniques to help identify any onset of emotional and behavioral shifts that may have the potential to negatively affect me both personally and professionally.

Participant 4 also shared,

> It can be really hard, but I believe that it helps when you do have a relationship with God and you're solid in your faith. It helps me to deal with a lot of trauma that I could take home, but I can pray about it and say OK I can release this! I'm just the instrument to help and guide them through their difficult journey to recovery.

Participant 4 also shared,

> Really, crying helps because it's kinda like a cleansing it's like the tears are flowing away the hurt and pain of the experience. I feel emotions like sadness subside and then I feel and know that I can keep going.

Effective coping strategies help individuals traverse through the difficult effects of VT symptoms once they become prevalent. To better cope with VT, some individuals may require a combination of outlets, while others may only need one, to alleviate VT symptoms and maintain professional and personal balance.

Ineffective Coping Strategies Caused Challenges Among Professionals

Coping strategies that do not yield positive results by improving the individual's ability to effectively manage the impact of VT symptoms are deemed ineffective. Sometimes it can become a challenge to find coping strategies that works. What works for some may not necessarily work for others. It is the sole task of the individual to discover coping techniques that work best for them. Participant 2 shared,

> Again, I was naive in my thinking. I thought that since it was through the VA, the counselor would automatically be the right fit for my needs, wrong! I had to go

> through 2 before I got one that I felt comfortable with, and I have been seeing them now for a while.

Participant 8 said,

> I started doing boxing because the gym life is not for me. We actually started to see our pastor for counseling.

Participant 6 offered,

> I try very hard to leave work at work, but I guess because of my occupation and they many things that have to do, I stay at the office longer to try to leave work at work but when I go home, I'm still thinking about what the clients shared with me. Then take it back and still bringing back the next assignment I'm still thinking about the next behavior I'm going to have to come back to try to correct I'm still thinking about the next to work the next day because it's still on my mind.

Ineffective coping strategies render the HSP ill equipped to effectively manage the personal and professional demands of their obligations. Coping strategies that do not work impairs the HSP from being able to effectively address their work-related issues, thereby impacting their ability to provide optimal services to their clients.

Availability of Employer-Sponsored Professional Support Systems

Employer-provided support services offer helping professionals and outlet where they can share issues and concerns with other helping professionals. The services also give helping professionals an opportunity to receive training and discuss strategies for coping with VT and other like issues. Participant 11 shared,

> Our employer has assistance set up for all employees and it's called the employee assistance and we have as a team experienced different situations. If any of the employees are experiencing difficulties with stress or anxiety related to VT, or just need a mental time out, then the employee assistance program is where they can go seek personal counseling for themselves and I think that I have even recommended that to some of the employees and it has been successful for them in seeking a counselor and just discussing some of the more traumatic situations that happen at work to help them better deal with it and their work environment as well as their personal space.

Participant 6 said,

> They have free counseling, but I am not certain about the scheduling times, but they do have it.

Participant 2 said,

> My place of employment does over in house support groups as well as individual counseling.

Participant 4 offered,

> They really don’t have anything within our organization but do offer services outside if employees express the desire to talk with someone. I personally have not used them because I prefer personal outlets instead.

As noted by some of the responses, not all employers offer on-the-job support services for their helping professionals. Organizations that do not offer support services for their HSPs places them at a disadvantage than those that do offer support services.

Professional support services help equip the HSP with strategies and techniques to identify and manage the symptoms of VT.

Challenges the Professional Faces With Employer-Funded Support Systems

Professionals may encounter challenges when deciding to participate in employee-funded support services and when they participate in the services. When deciding to participate, the HSP may question the structure and convenience of the services or may feel that the curriculum does not adequately address the core of the HSP issues. If the HSP does participate, some of the concerns may include feelings regarding lack of privacy, judgement, and criticism from colleagues. Participant 3 offered,

> In my mind it would be more difficult to open up in the professional group ones because after a while I would begin to think is this going to be kept confidential, are more people going to know about this, will I really be able to open up or is someone going to be tattling on me and taking this back to a supervisor or someone else so, there was always a hesitancy, a reluctance to join a workplace group because I didn't really know what was going to be happening in those support groups; it was a concern of trust and a concern of maybe repercussion.

Participant 8 shared,

> It is hard to share your feelings and pertaining to your work with somebody that you feel like you don't even know they or have a connection with. That person has not tried to connect with us.

Participant 10 stated,

> Whereas if I'm going to like someone in the office, I might feel like I need to be very careful about my wording to make sure that just to be careful how I address things.

Some HSPs will hesitate or not participate in employee-funded support services due to the perceived or real stigma that is often attached to those services. The challenges can keep the HSPs from engaging in services that could enhance their ability to function effectively and proficiently with their clients and other work-related task.

Rewards Related to Utilizing Professional Support Systems

Professional support services can be both rewarding and beneficial in helping the HSP understand the signs and symptoms of VT and like impairments. Support services are rewarding because of the skills and knowledge the HSPs gain. The services are beneficial as a result of the training and wellness support the HSPs receive. Participant 5 said,

> I would have to say that because of counseling I am a better helping professional. I have a great supervisor, who promotes holistic wellness in work and personal life. They encourage continuing learning and growth. Overall, the work environment is positive which does help a great deal with the stressors that come with the profession.

Participant 11 stated,

> So, we do have monthly group meetings where everybody can come together and kind of decompress and we discuss specific client cases and allow the entire team to comment, express feelings, and get specific ways to maybe deal with things

> better. Some team members are referred to outside resources for additional help in dealing with their VT. It does help with having a monthly team meeting to discuss some of the more serious, stressful situations with clients. Just knowing that some of your co-workers are dealing with some of the same things you are is reassuring that I am not alone, I am okay, and things will work out.

Working as a HSP serving trauma clients can predispose the HSP to vicarious traumatization. However, some factors increase this risk of suffering from vicarious trauma. These factors have been labelled as VT risk factors, and they include severity of client's trauma, internalization (and being human), prior trauma, stigma and misconception on VT, less working experience, and limited awareness on VT. After exploring the risk factors, it is vital to explore the symptoms for VT as they help indicate if a HSP is suffering from VT.

Summary

This chapter outlined the research setting, demographics, and detailed information about the data collection and data analysis processes. The chapter also presented evidence of trustworthiness, outlining the four elements that strengthened and validated trustworthiness in. the study. Lastly, this chapter provided a thorough synopsis of the results that revealed 13 major themes from the collected data. The themes that emerged during the data analysis process were used to answer with the research question.

Chapter 5 present a more in-depth explanation on the interpretation of the findings as well as discuss the limitations of the study while providing recommendations for future research projects on the topic of human service professionals' coping with VT. I

will present how the implications of this study can encourage social change, and finally, the chapter will end with the study conclusion.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this generic qualitative research study was to investigate HSPs' experiences with VT after working with male IPV victims. The results of this study may play an integral role in guiding future research on HSPs' experiences of VT as a result of working with male IPV clients by providing key information on challenges, early detection, preventive measures, coping strategies, and self-care techniques.

The main themes that emerged from this study included how emotions enable VT vulnerability, how the lack of awareness leads to poor diagnosis, how work experience plays a role in associated risks, how stigma prevents the professional from seeking help, how VT impacts mental and physical health, how VT affects the professional's productivity, how VT improves self-care and services offered, how preventive strategies minimize risks associated with VT, how coping strategies limit the symptoms related to VT, how ineffective coping strategies cause challenges among professionals, how the availability of employer-sponsored professional support systems, how challenges helping professionals face with employer-funded support systems, and lastly, how rewards related to utilizing professional support systems.

In this chapter, I present an interpretation of my research findings, along with the limitations of my study, recommendations, and implications. Finally, I provide a conclusion to the overall study.

Interpretation of the Research Study

The interpretation of qualitative research can play an important part in enhancing meaning in a study. Kiger and Varpio (2020) noted that interpretation of the research is vital to an overall study and that the researcher must accurately describe in detail the participants' accounts of their experiences. Moreover, interpretation of research should demonstrate how the findings of the study aligned with the previous review of existing literature.

Theme 1: Emotions Enable Vicarious Trauma Vulnerability

Theme 1 aligned with the existing literature review presented in Chapter 2 indicates that, over time, HSPs were impacted emotionally by the constant encounters with individuals who experienced trauma. As noted by Williamson et al. (2020), helping professionals who work directly with clients who have experienced trauma could be impacted emotionally from knowing the traumatic events experienced by their clients. Further, Brend et al. (2020) offered that HSPs who consistently listen to the traumatic stories being retold by victims of trauma feel empathy and compassion, which could, in some cases, place them at increased risk of experiencing VT as a result of their exposure. Newell et al. (2016) and Hallinan et al. (2020) also suggested that VT not only had the potential to have long-lasting effects, but also increased the risk of the HSP experiencing mental health problems, if not properly addressed. Middleton and Potter (2015) noted that professionals who do not successfully address their VT are at increased risk for burnout; mental health problems; and medical conditions such as PTSD, cardiovascular disease, and depression. A lack of specialized work-offered support services and training to

properly equip HSPs with the skills and knowledge for early identification, effective coping tools, and self-care techniques contributes to psychological distress. Almost all participants expressed their preference for seeking professional support outside of the work environment and the use of personal support relationships as a means of reprieve from the symptoms of VT.

The emotions enabled VT theme aligned with the CSDT in that the participants found that their perception of the client, work, and themselves were affected because of VT. McCann and Pearlman (1992) discovered that, over time, the helping professionals became so engulfed in their clients' trauma that their own realities were skewed. Further, McCann and Pearlman (1990) noted that the HSP created an alternate method for perceiving and understanding actual events. According to McCann and Pearlman (1992), these complex mental realities altered the HSPs' view of themselves by impacting them emotionally and mentally. VT creates emotional vulnerability, which may manifest through varying emotions such as grief, anxiety, sadness, stress, and even anger (McCann & Pearlman, 1992). Due to their proximity to trauma clients, helping professionals were more likely to experience emotional issues because of their exposure.

Theme 2: Lack of Awareness Leads to Poor Diagnosis

Theme 2 aligned with the existing literature review presented in Chapter 2, specifically regarding instances when HSPs lacked awareness of the signs and symptoms of VT and therefore were impacted by VT for an extended period (Foreman et al., 2020). Some of the study participants reported that even though they were consistently exposed to the trauma recounts of their clients, they failed to recognize the signs and symptoms of

VT. Some of them also admitted that once they realized they had been impacted by VT, they did not take measures to limit the impact; instead, they rationalized that it was either work-related stress or fatigue. Knowing and recognizing the beginning signs and symptoms of VT was important to the severity of the impact and length of the effects of VT (Kundra et al., 2019). Foreman et al. (2020) suggested that VT, left untreated, had the potential to have long-lasting effects on the HSPs. Early identification also affects how an individual responds to VT, which then affects their behavior toward experiencing VT (Straussner et al., 2018). As shown in the literature, lack of identification or denial could lead to a misdiagnosis, which prolongs the impact of VT.

The lack of awareness leads to poor diagnosis theme aligned with the CSDT in that the participants noted that they did not initially recognize the signs and symptoms of VT, denied it by rationalizing with other reasons, or knowingly attempted to hide the signs and symptoms. McCann and Pearlman (1990) maintained that CSDT illustrated the cognitive and perceptual shifts that occurred after exposure to trauma. According to McCann and Pearlman (1990), this meant that individuals often initially did not recognize the signs and symptoms of VT, and when they did, they frequently responded with denial or avoidance. Further, McCann and Pearlman (1992) argued that, without receiving some type of support, the odds of VT negatively impacting the HSP's life both personally and professional increase exponentially. In either instance, avoidance or lack of identification can lead to misdiagnosis of symptoms, delays in getting treatment, and in some cases, reluctance in seeking professional help (McCann & Pearlman, 1990). Some participants shared that, because their perception was skewed, they initially did not

recognize or understand what they were experiencing, which aligns with McCann and Perlman's (1990) theory. The overall quality of life for HSPs who experience VT is increased through early identification, accurate diagnosis, and seeking and getting support for their issues.

Theme 3: Work Experience Plays a Role in Associated Risks

Theme 3 aligned with the existing literature review presented in Chapter 2, specifically as it relates to how the nature of the work that HSPs conduct consistently during a work week placed them in a position of greater risk of experiencing VT. Fox (2019) noted that HSPs were listed among the occupations that were at high risk for experiencing VT, due to their vocation. Fox further posited that individuals who work in professions that place them in constant contact with individuals who had experienced trauma are at a higher risk of experiencing some type of secondary trauma such a VT. Nikischer (2019) offered additional risk factors as being the experience of the HSP and past trauma. Some of the participants recalled that when they first started in the profession, they did not know about or understand the signs and symptoms of VT. Nikischer added that they just assumed their issues were caused by workplace stress. HSPs with low or little work experience are at higher risk for experiencing VT than those who have been in the profession for several years. Nikischer also suggested that helping professionals who were new to the field are highly susceptible to VT. This was especially true if the HSPs had not received sufficient training or lacked sufficient supervision, or if there was no availability of organizational support services for employees.

Work experience plays a role in associated risks theme aligned with the CSDT about how vital it is that individuals in helping professions receive education and awareness training about VT in the work environment. HSPs who had experienced their own previous trauma could be triggered by listening to their client's accounts of trauma. McCann and Pearlman (1992) found that helping professionals who had personal experience of trauma appeared to have higher VT accounts and were more adversely impacted the longer they worked in the profession. McCann and Pearlman (1990) also pointed out that, due to the emotive nature of the HSPs' vocation, it would be difficult to avoid the impact of VT at some point in their professional career. However, McCann and Pearlman (1990) argued that it was more important that all helping professionals were properly equipped with the skills, knowledge, and training to combat its effects. Workplace educational training on psychological impairment from the impact of VT provides HSPs with the necessary tools to withstand the altering impact.

Theme 4: Stigma Prevents the Professional From Seeking Help

Theme 4 aligned with the existing literature review presented in Chapter 2, in that dealing with VT could be very challenging for HSPs. Most of the participants stated that they were reluctant to seek and/or participate in workplace-provided support programs because of the perceived or real stigma regrading being viewed as weak or unequipped to handle their work. Tay et al. (2018) suggested that helping professionals who experienced some type of mental or emotional breakdown, such as VT, sometimes did not seek help or were very hesitant because of the stigma that was often attached to individuals who sought help. Tay further posited that stigma from the fear of being judged, shame, the

possibility of a negative impact on their career, and self-image were identified as some of reasons that helping professionals did not disclose their personal struggles and seek help. Additionally, according to Dewa et al. (2021), mental health issues are common among helping professionals, and it is therefore not unusual for a large majority of HSPs not to seek professional help as they attempt to conceal their problems. Kundra et al. (2019) posited that sometimes HSPs, for fear of being judged and ridiculed, will avoid disclosing their issues with VT, even when they are able to distinguish its symptoms. It is important that on an individual and organizational level struggles with mental health be addressed and that helping professionals be encouraged to seek necessary help without the fear of stigma.

The stigma prevents the professional from seeking help theme aligned with the CSDT through the illustration of McCann and Pearlman's (1992) five frames of reference, two of which were safety and trust. The current culture of breeding distrust in the workplace instead of fostering emotional resilience among human service professionals is a deterrent from seeking help in the work environment. McCann and Pearlman (1990) argued that helping professionals should feel safe in the workplace, and they should not feel stigma from being negatively abled because they sought help. Lastly, McCann and Pearlman (1990) pointed out that creating a judgment-free environment for helping professionals who sought help for their personal issues would increase their confidence and trust in support services. Targeted workplace intervention and educational training programs that specifically address the challenges and stigma help strengthen the helping professionals' ability to provide quality care to clients and overall well-being.

Theme 5: Vicarious Trauma Impacts Mental and Physical Health

Theme 5 aligned with the existing literature review presented in Chapter 2 regarding decreased productivity due to distractedness resulting from symptoms from VT. Pirelli et al. (2020) asserted that when helping professionals became overwhelmed with VT, it planted a level of fear and guilt in the individuals' mind. Ezell (2019) indicated that once fear and guilt lodged in the mind, they altered individuals' normal cognitive processes. Some participants noted that when they attempted to avoid transference of the client's trauma, they felt guilt. Some participants cited that they felt that their mental, physical, and emotional well-being would be in jeopardy if they had not been able to find viable resources to help them. Ezell asserted that VT not only affects individuals mentally, but it also has the potential to affect them physically. Ezell further pointed out that some of those physical impairments were headaches, problems sleeping, and fatigue. Many of the study participants reported having experienced some or all of the physical impairments.

The work experience plays a role in associated risks theme aligned with CSDT. CSDT was used to illustrate that an individual's mental health could be impacted by VT over time (Pearlman & McCann, 1995). VT alters a person's behavior, which causes them to lose interest in their work, resulting in distractedness and decreased engagement with clients, diminished empathy, and perception distortion (McCann & Pearlman, 1990). Pearlman and McCann (1995) further posited that, due to altered mental capacities of some helping professionals, their cognitive schemas change, which may trigger sadness and a loss of interest or indifference in professional and personal engagement with others.

HSPs, by virtue of their choice of vocation, are highly susceptible to the risk factors associated with VT.

Theme 6: Vicarious Trauma Affects the Professional's Productivity

Theme 6 aligned with the existing literature review presented in Chapter 2, as some helping professionals struggled to properly identify the signs and symptoms of VT because there were many and they could sometimes be mistaken for other issues. Chang (2018) noted that, over time, the impact of VT not only caused professional and personal problems, but could also trigger medical issues, such as frequent headaches, anxiety, and insomnia. Louison Vang et al. (2020) and Prapanjaroensin et al. (2017) argued that the symptoms of VT could elicit disruptions in the effectiveness of the HSPs' ability to provide optimal client care. Some study participants shared that that they had experienced frequent headaches, anxiety, and loss of interest in social interactions, and they wanted to isolate themselves from the rest of the world. Some of the participants stated that they had been so depressed that they even considered leaving the profession. Left undiagnosed and untreated, VT has been reported to cause work-related stressors that result in discontentment, lack of enthusiasm, and lack of zest in work (Hazen et al., 2020). Jayasekara and Pushpakumari (2018) stated that high-risk occupations such as those of helping professionals could easily fall prey to workplace VT. This has caused many to decide to leave the human service profession, resulting in decreased availability of qualified helping professionals in the field.

This theme aligned with the CSDT. McCann and Pearlman (1992) used CSDT to illustrate how VT altered the schemas of HSPs as a consequence of their exposure to

clients' stories of experienced trauma. VT impairment poses a real threat to HSPs' ability to maintain professional, personal, and physical health (McCann & Pearlman, 1992). Also noted by McCann and Pearlman (1990) was that HSPs' work performance was affected by VT impairment, which was demonstrated with a visible decline in productivity, work satisfaction, and their overall quality of work. Lastly, the turnover rate among personnel working in helping professions is high because of the stress and other mental, emotional, and physical damage caused by VT (McCann & Pearlman, 1990). Professional competence is important in the field of social support due to the unique populations that are served. HSPs must be efficient and proficient in conducting their work obligations and responsibility to provide excellent support to their clients.

Theme 7: Vicarious Trauma Improves Self-Care and Services Offered

Theme 7 aligned with the existing literature review presented in Chapter 2 regarding how self-care promoted well-being as well as provided a buffer in assisting HSPs' management of the negative effects of work-related mental, emotional, and physical stressors. Self-care potentially improved an individual's overall well-being while providing a barrier of protection from stressors such as VT (Posluns & Gall, 2020). It is important that helping professionals be proactive in addressing their care needs. Butler et al. (2017) noted that incorporating self-care techniques into educational training programs within the field of helping professionals created a culture of positive change and growth. Self-care and support for helping professionals also promotes overall health and wellness (Johnson et al., 2018). Most of all, study participants cited that even when they knew they were experiencing symptoms of VT, they often ignored them and instead

focused on their client's needs and well-being; they placed their clients above tending to their own needs. Most helping professionals overlook their own need for self-care because they are fully engaged with helping their clients cope with their situations and improve their lives (Butler et al., 2017). In helping professions, helping professionals often place the needs of their clients above their own; however, it is just as important for the helper to maintain mind and body health.

This theme aligned with the CSDT. McCann and Pearlman (1992) pointed out that using CSDT to illustrate how it helped in understanding how self-care assisted the HSP in creating a healthy work-life balance, improving their quality of work and their ability to function effectively in other areas of their lives. Pearlman (1995) discussed how self-care was an invaluable resource when exposure to trauma impinged on the helping professionals' personal and professional well-being. Further noted was that the helping professional was able to better maintain a healthy work-life balance, when self-care practices such as peer support, continuing education, and access to new innovative techniques were part of their daily routine (Pearlman, 1995). This may be in part due to some organizations and supervisor stressing the importance of regular self-care as a priority in the helping professionals personal and professional environments.

Theme 8: Preventive Strategies Minimize Risks Associated With Vicarious Trauma

Theme 8 aligned with the existing literature review presented in Chapter 2, as there are many strategies that can be used to minimize the impact of trauma risk, but it is important to note that not all techniques work for everyone. Masson (2019) suggested that the experience of VT did not always result in negative outcomes; it could also be a

means for growth through self-reflection, building self-efficacy, and the development of coping techniques. Some of the key preventive strategies that have shown to minimize the risks associated with VT are professional support, social support, self-care, and propose in life. Giao et al. (2020) pointed out that professional support systems allow helping professionals an opportunity to listen as well as share their different client experiences with colleagues who may be experiencing some or similar challenges. Including preventative measures against VT and other mental health issues in the professional workplace training curriculum equips helping professionals with the tools necessary in identification of VT signs and symptoms and prepares them in handling and possibly minimizing the impact of VT. Brooks et al. (2019) noted that awareness training on the potential risk factors associated with VT psychologically prepares helping professionals work through VT challenges more effectively. Professional support systems that provide channels for open communication, awareness training, and supervisor support create an atmosphere that fosters employee job satisfaction and professional wellness.

Social support or personal support systems have also been identified as a good preventative method for combating the risk factors of VT. An individuals' emotional, physical, and mental well-being is shown to be more balanced when there is a strong social support system in place (Miller et al., 2018). Social support systems function as a buffer against the work-related stressors. Jolly et al. (2021) further noted that positive social support systems lead to better relationships, more favorable responses to the negative effects of work-related stressors, and improved work performance. Although

there are several opinions surrounding what constitutes social support, social support consists of social exchange relationships established between individuals that promotes positive attitudes, behaviors, outlook, and how individuals perceive and handle environmental, personal, and professional stressors (French et al., 2018; Owens-King, 2019). Social support is an invaluable support system that assists individuals to balance the demands of work-related challenges by creating problem focused coping skills, which may increase their ability to cope adaptively, effectively, actively, and proficiently (Agbaria & Mokh, 2022). Although there are varying support systems, social support systems have been proven to have a positive correlation to how individuals view and respond to job induced stressful situations.

This theme aligned with the CSDT. McCann and Pearlman (1992) illustrated that a combination of appropriate training linked with a theoretical understanding of trauma, VT, and active-coping strategies would help to lessen the risk of HSPs experiencing VT. Self-care are preventative measures taken that helped aid in reducing stressors in an individual's personal and professional environments (McCann & Pearlman, 1990). Self-care measures can range from listening to music, attending a sports event, Pilates, playing a round of golf, or ziplining. It is whatever makes an individual feel happy, calm, relaxed, and stress free (Pearlman, 1995). HSPs who are increasingly being exposed to indirect traumatic situations increase their susceptibility rate for exposure. Self-care was noted to slow down the development of indirect trauma such as VT and minimize the impact on work quality.

Self-care involves the intentional and continuing practice of implementing and preserving an individual's health and well-being. HSPs often allow their desire to take care of their clients' needs to overshadow the importance of taking care of their psychological needs (Pearlman, 1995). The need for self-care is broader than preventing the negative impact of the effects of indirect client trauma; consideration of whole self-well-being should also be of importance in managing the negative impact that work-related stress can have on an individual (Pearlman, 1995). Helping professionals who assist trauma-exposed clients are highly susceptible for experiencing VT, which can have lasting effects if not managed appropriately; therefore, it is vital that HSPs acknowledge their impairment and find ways to help manage it. HSPs who engage in self-care activities on a regular basis have a better chance for minimizing the effects of VT.

Theme 9: Coping Strategies Limit the Symptoms Related to Vicarious Trauma

Theme 9 aligned with the existing literature review presented in Chapter 2 related to how effective coping strategies are an essential element for helping HSPs manage the impact and symptoms of VT. This concept, according to Cahill et al. (2021), means that although work-related stress may not be eliminated completely, coping strategies could help minimize those stressors. Some of the study participants stated that once they were able to include coping strategies into their daily routine, they were able to relax, better focus on their work responsivities, and be more attentive with their clients. The participants further reported that finding effective copying techniques that supported their life and interests was important to them as well and helped with improved quality of work and personal life. Further, Schreiber et al. (2019) postulated that not only is

developing effective coping strategies important for helping professional in reducing work-related high-level stressors, but coping strategies also help in maintaining a positive outlook and stabilizing emotional equilibrium. Those same strategies were also effective in lowering the possibility of developing symptoms of psychological impairments, such as VT.

The preventive strategies minimize risks associated with VT theme aligned with the CSDT. McCann and Pearlman (1992) found that maintaining adequate numbers of qualified helping professionals to provide effective client services requires attention to whole person wellness which promotes resilience. CSDT, as described by McCann and Pearlman (1990), provides a framework for the logical appraisal and realistic treatment of emotional and mental aspects of an individual that are impacted by trauma, which include self-capacities, or an individual's ability to withstand hardship or optimistically adapt to adversity. The HSPs' level of adaptability has a definitive impact on their ability to develop positive coping strategies (McCann & Pearlman, 1990). Effective coping strategies create a barrier of protection against psychological impairments like VT at the onset while promoting resilience in stressful situations.

Theme 10: Ineffective Coping Strategies Cause Challenges Among Professionals

Theme 10 aligned with the existing literature review presented in Chapter 2 that highlighted how ineffective coping strategies could lead to additional or in some cases enhanced stress and challenges for helping professionals. Sage et al. (2018) posited that helping professionals who receive education and training about VT coping strategies indicate a decline in VT length and severity. Some participants revealed that they tried

several different coping strategies that were ineffective, which only served to further exacerbated their already fragile situation. They also noted that the coping strategies that were ineffective for them were not because they were not good, but that they were just not the right fit for them. Young Tarli et al. (2018) suggested that some of the most common everyday work stressors for helping professionals included administrative obligations, workload, colleagues, supervisors, and clients. Coping strategies are key in assisting helping professional deal with the challenges of work-related stressors.

The ineffective coping strategies caused challenges among professional's theme aligned with the CSDT. McCann and Pearlman (1992) noted that effective coping strategies were dependent on how well an individual adapted to the circumstances in and of their environment. Pearlman (1997) added that ineffective coping tools produce maladaptive behaviors that may include loss of attentiveness in work obligations, frequent lateness, or absenteeism to work, attempting to deny or justify changes in behavior, avoiding interaction with colleagues, and lack of engagement with clients, all of which can further lead to adverse health issues. Adaptative coping strategies help shield HSPs from the impact of VT (Pearlman, 1998). However, when HSPs do not adopt good coping strategies, they open themselves up to the exposure of harsher longer symptoms of VT and other mental and emotional work-related stressors.

Theme 11: Availability of Employer-Sponsored Professional Support Systems

Theme 11 aligned with the existing literature review presented in Chapter 2, in that it explains how organization support services is one of the most important factors in helping professionals' resilience and work performance. Supervisors in human service

organizations play a role in preparing and helping their support personnel address and better manage any psychological and emotional health issues they may experience from working with trauma clients (Labrague et al., 2020). Establishing policies and measures that are specifically designed to address and support the mental, psychological, and emotional health of its employees fosters a safe and secure work environment (Catton, 2020). Of those participants who stated their organization offered support services for employees, they believed the services were a positive platform for the employees to share and bond with their colleagues and supervisors about work issues, challenges, and other topics impacting the work environment. According to Mo et al. (2020), organizations that provide workplace mental wellness support programs promote resilience and provide protective techniques. These programs also helped personnel effectively cope with the stressors of working in a trauma heavy work environment.

The availability of employer sponsored professional support systems theme aligned with the CSDT. McCann and Pearlman (1992) illustrated how appropriate training would help to reduce the risk of HSPs experiencing VT by using CSDT concepts. McCann and Pearlman (1990) posited that organizational programs reinforce helping professionals' ability to better understand and cope with the stressors of their work. Pearlman (1998) further suggested that having protective outlets on hand readily available to help helping professionals work through the adverse effects of working directly with trauma clients which can threaten their mental and psychological health supports and strengthen resilience. According to Pearlman (1997), organizational support programs, along with support from supervisors, fellow colleagues, and the social support

of family and friends is considered some of the most important elements, contributing to positive outcomes of work satisfaction and longevity and overall personal and professional health and well-being. McCann and Pearlman (1990) proposed that organizational support systems have been shown to be directly linked to higher levels of organizational success, employee job satisfaction, higher levels of job performance, lower personnel turnover, and more helpful interactions with clients, reducing the impact of work-related stressors. Helping professionals need the social support provided from family and friends as well workplace support from their organizations and supervisors in order to construct effective coping techniques and maintain overall health and wellness.

Theme 12: Challenges Helping Professionals Face With Employer-Funded Support Systems

Theme 12 aligned with the existing literature review presented in Chapter 2, which emphasized that although many organizations may offer workplace support systems for its employees, not all workplace programs are effective. Berry et al. (2020) noted an employee's job performance, job satisfaction, job sustainability, and mental health was nested in the workplace conditions and culture. Study participants who acknowledged that, although their organization provided support services, stated they were not helpful because they lacked a holistic construct of whole person wellness. For that reason, all of the participants stated that they opted to seek services outside the workplace. Mills et al. (2020) asserted that organizations could exacerbate or minimize workplace issues and, in some instances, determine the success or failure of an organization. Prioritizing the mental and psychological well-being of the workforce is an

important factor in the satisfaction and sustainment of that workforce (Daniel, 2019). Further, Rangachari and Woods (2020) stated that most employer sponsored workplace employee assistance programs fail because the programs do not embody the whole person concept for addressing issues. Employee support programs should be designed to focus on early identification and intervention initiatives so that it provides optimum services to its employees in areas of most importance, and which address not only professional well-being as well personal well-being (Magtibay et al., 2017). The ability for helping professionals to provide appropriate professional services to their clients is contingent on the mental, psychological, and physical overall well-being of the service provider.

The challenges helping professionals face with employer funded support systems theme aligned with the CSDT. McCann and Pearlman (1992) suggested that CSDT demonstrated how trust and safety were factors that influenced the individual's perception about others including employee training programs. Employees themselves may create barriers resulting from their personal perceptions about the programs offered (McCann & Pearlman, 1990). There are many varied reasons employees choose not to participate in employee sponsored workplace programs, which some may include harboring negative perceptions about the programs, meeting schedules are offered at inconvenient times or locations, or lack of trust in the organization and its leadership, or simply having concerns related to privacy (McCann & Pearlman, 1990). Organizations and leadership that establish stoic employee assistance programs instead of focusing on a more holistic design tend to miss the mark on addressing their employee's needs, which in turn creates barriers in program interest and participation.

Theme 13: Rewards Related to Utilizing Professional Support Systems

Theme 13 aligned with the existing literature review presented in Chapter 2 referencing the advantages for HSPs who participate in professional support systems, whether work-sponsored support systems or personally acquired professional support systems. Zahniser et al. (2017) posited that the most common types of professional support systems were those services that individuals participated in with a professional counselor or employer provided service. Successful workplace employee assistance programs offered a strategic partnership with its helping professionals to collaboratively advance a range of workplace health and wellness initiatives (Voordt & Jensen, 2021). Professional support, according to Posluns and Gall (2020), such as employee supervision could assist in identifying gaps and implement effective relevant training. Supervision was also shown to help in managing client caseload, encourage work-life balance, direct strategic career growth, encourage and recommend self-care techniques, and provide support when their employees experienced adverse professional situations (Zahniser et al., 2017). Effective supervision reaches beyond the impact on the employee; it also influences the relationship between the helping professional and their clients by building stronger working alliances, and increased satisfaction with services (Butler et al., 2017). Client recovery is largely dependent on the helping professional being able to provide maximum services; therefore, they have to always be at the top of their game by staying mentally, physically, and emotionally healthy.

The rewards related to utilizing professional support systems theme aligned with the CSDT. McCann and Pearlman (1992) illustrated through CSDT that the combination

of training supported with a theoretical understanding of trauma reduced the impact of VT. Helping professionals sometimes require help unpacking all of the emotional baggage and mental stress compounded from work responsibilities and stressors in their personal lives. McCann and Pearlman (1990) found that professional support, such as private therapists, was highly recommended because the results were often linked to increased personal and professional development and satisfaction and increased daily work-life. McCann and Pearlman (1990) further suggested that professional support services increased cognitive awareness, enhanced job performance and productivity, and reduced stress and enhanced levels of coping strategies. Professional support systems pay a role in the overall health and wellness of helping professionals' ability to maintain a high level of professionalism and proficiency in their work obligations as well as helping them stay grounded in their personal lives.

Limitation of the Study

Some of the noted limitations of the study may be a result of some of the inclusion criteria that placed parameters on the age and geographical location of participants. In addition, the small sample size may have also been a limiting factor because the size may not have been large enough to be representative of an inclusive study. The intent was to select 10–12 qualified participants for the study, and although 13 individuals responded to the research participant request, 11 of the respondents met the inclusion criteria and were interviewed. No demographic information was collected for this study because all the participants were from central Texas and were U.S. citizens. This could be considered a limitation because the participants represented in the study

were in the same geographical location and may not provide evidence of findings that can apply to other contexts and populations. Expanding the study outside central Texas may have provided a larger population of HSPs' experiences with VT.

Evidence of trustworthiness as it related to researcher biases may have also been a limitation to the study in that I had personal knowledge of the topic and preconceived opinions about how HSPs should handle VT while balancing their work and personal life. Journaling throughout the study helped to mitigate the biases. Gregory (2019) posited that journaling helps the researcher to override formed worldviews and beliefs. The semistructured interviews had the potential to be limiting in that each participant was asked the same questions, which also had the potential to produce similar responses, instead of a wider variation of responses. Originally, face-to-face interviews were going to be conducted with the study participants; however, the COVID-19 pandemic caused a shift in Walden's procedures that required all interviews to take place using some type of virtual platform. This was a limiting factor in that any nonverbal cues from the participant could not be detected by me because there was a limited view of the participant on the virtual platform.

Recommendations

The intent of this generic qualitative study was to explore human services professionals' experiences with VT as a result of working with male IPV victims. Although there is a lot of literature available on the topic of HSPs with VT, there is limited information on HSPs' experiences with VT from the perspective of increased education, detection, and self-care. Further research is recommended with a larger, more

diverse sample and expanded geographic sphere to explore education and training specifically geared toward addressing the needs of HSP's who work primarily with the male IPV population.

Additionally, I would recommend using a different research approach such as a mixed-method study. This type of study would generate quantitative data regarding HSPs' intent to engage in self-care techniques through education on early detection and coping strategies. I also recommend conducting a qualitative study using unstructured interviews to allow more patterns among the participants. The semistructured, predetermined interview questions garnered limited comparison between the participants. Lastly, I recommend a quantitative analysis to determine the relationship between the framework and effectiveness of coping strategies and other variables, such as PTSD, burnout, and secondary traumatic stress experiences of the human service professional to establish an association between the variables, which allows for a larger sample size along with structured research instruments. Although each approach requires separate questions, data collection methods, data analysis, and conclusions, when combined, the constructs offer a research approach that gives the researcher an enhanced knowledge base and more in depth understanding of the topic of the intended research.

Implications

Positive social change is achieved through expanding the understanding of the implications of VT impact on HSPs. The study fosters positive social change as it promotes awareness of how HSPs explore various strategies for identification and management of coping with VT. Addressing the challenges HSPs experience with VT as

a result of working with the male IPV population may lead to the development of more innovative health and human service support programs for male victims, while increasing awareness of male IPV victims and the challenges HSPs experience resulting from VT.

Also, this study could encourage organizations to create new policies to give human service professionals more autonomy related to their work schedule and workload while embracing the whole person wellness concept. The information provided in this study should encourage additional investigation in support increased of awareness for targeted education and wellness needs of HSPs and appropriate support services that promote a healthy work-life balance.

Conclusion

The purpose of this generic qualitative study was to explore human services professionals' experiences with VT as a result of working with male IPV victims. With the personal, individually driven strategies to combat VT being limited and ineffective in some ways, some organizations offered professional support systems as a strategy to tackle VT and assist their staff suffering from VT. Although some participants did acknowledge the availability of some type of work-provided professional support services, most still preferred to seek other services outside the work environment. From the participants' insights, there were two types of support systems offered at the workplace: individual counseling and support groups. According to the participants, the professional support systems were effective in helping tackle and cope with VT. The participants stated that the professional support systems have provided valuable coping skills that helped externalize and not internalize emotions and helped to improve

professionalism. However, the professional support systems lacked in their capacity as a strategy for combating VT. The challenges facing professional support systems were fear for confidentiality, preference for private support groups, and stigma to seeking help.

With both the personal support systems and the professional support systems. being limited and flawed, the study identified some general ways that could help limit the risk and adverse effects of VT in the profession. These ways included awareness of VT in the profession and having and creating positive work environments in the workplace.

The findings of this study have shown that VT had a significant impact on HSPs' personal and professional lives. The HSPs recognized and understood their obligation to provide quality professional service to the clients they served. Many of the participants, once they realized the signs and symptoms of VT, sought help, which resulted in them learning and developing successful coping strategies to combat the VT. The overarching similarity in the findings was that nine of the 11 participants preferred to use personal support systems to help mitigate the effects of VT rather than use available professional resources. The HSPs were able to successfully find effective options, personal and or professional, that worked for them and allowed them to retain their professionalism and work through their VT, while maintaining a productive work-life balance.

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Appendix: Interview Protocol

Interview Protocol

Pre-interview

Thank you for your willingness to share your experiences by participating in the study. The interview will take approximately 60 minutes, and it will be recorded. As a reminder, your participation is completely voluntary, and if you are uncomfortable and want to stop the interview at any time, please just let me know. Before we begin, I would like to review the informed consent one more time and also discuss participant confidentiality and address any questions and or concerns you may have about the interview. The data collected during the interview will be transcribed into codes and themes for data analysis, which will be utilized solely for the study. Your identity will be confidential so no one will be able to identify you through any particular information or answers. I would like to reiterate that the interview should last approximately 60 minutes, it will be recorded, and at any point, if you chose to stop the interview or need to stop and take a break just let me know. If you are comfortable and are ready to begin, let's start the interview.

1. Please share with me in what ways has VT impacted your life?
2. Tell me the symptoms of VT have you experienced.
3. How would you describe your ability to minimize the risk of vicarious traumatization?

4. Tell me about any personal support systems that you use in your personal life, gym, yoga, personal therapy, etc., to manage vicarious trauma and if they are helping and how.
5. Tell me about any professional support systems that are in place at your place of employment, such as individual supervision, group supervision, peer support groups, training, etc.
6. Tell me if and how your experiences with support, training, supervision, etc. in the workplace have affected your ability to manage vicarious trauma.
7. Is there anything else you would like to share about your experience with vicarious trauma that you have not already?

Closing statement

Thank you for taking the time to speak with me about your experiences with this topic. The information that you provided is insightful for others who may also have the same experience with VT after working with male IPV victims. If there is anything else that you remember regarding the topic that you believe is important, please contact me using this information [Provide participant with updated contact information]. As previously stated, the data collected from your interview will be transcribed. Please call or email me if you have any questions. All the collected data will be coded and will not have identifying information about you. The data, along with the recording, will be placed in a limited access secure area. Once the study is completed, I plan to share the results of the study. Do you have any final questions for me? Thank you again for sharing

your experiences by participating in the interview. Take care and enjoy the remainder of your day.

End interview.