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# The Experiences of Male Counselors of Children Who Have Experienced Trauma

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MS, Walden University, 2013

MS, University of Phoenix, 2013

BA, East Texas Baptist University, 2002

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Men are increasingly underrepresented in counselor education and in the counseling profession, with only 27% of members of the American Counseling Association reporting as men. Men in counseling often feel marginalized and isolated. Additionally, they are socialized to be independent, emotionally and physically strong, and to focus on success, while being discouraged from seeking help. Continual exposure to the trauma material of others can cause secondary trauma, with cumulative deleterious effects identified in this study using the Heidegger's hermeneutic phenomenology. The purpose of this qualitative phenomenological study was to explore the lived experiences of male counselors who primarily work with children who have experienced trauma. Using purposive sampling 6 licensed male counselor participants were identified, and semistructured interviews were conducted. A hermeneutic interpretation made through the lens of constructivist self-development theory was used to further elucidate participants' experiences. The 13 themes generated from this data included: (a) counselors' use of an eclectic theoretical approach, (b) majority of the clients had experienced trauma, (c) experiences of vicarious trauma, (d) increased empathy and growth; (e) negative impact of vicarious trauma, (f) help-seeking behavior, (g) denial of help-seeking behavior, (h) additional training, (i) coping skills, (j) supportive supervisors, (k) peer consultation, (l) supervisor role, (m) world is unsafe/people are bad, and (o) increasing knowledge. Implications for social change include empowering current and future male counselors to effectively understand and mitigate negative consequences of vicarious trauma from working with children who have experienced trauma.

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# Dedication

This is dedicated to my family, friends, and colleagues who have traveled this journey with me as much as they could. To my husband Steven, you have been married to a student almost half of our 19 years of marriage. You have edited, supported, cheered, consoled, loved, and praised me during all of those years; you have the patience of Job. To my children Eli and Judah, both of you sacrificed time with your mom so I could pursue my dreams, and I pray that you know every day how much I love you both. I hope that you are learning that persistence, hard work, self-advocacy, and patience do (eventually) pay off. To my parents who supported me through this journey, probably praying for a miracle every day, and never wavering in your faith in me. To my cousin Kari, who through tough love, laughter, distraction, and support has kept me humble and focused on the "why" of my goals and dreams. Finally, to my Walden colleagues and cohort who are always there with answers, encouragement, respect, and praise for each other's successes. You formed my community in a lonely, sometimes seemingly impossible, and often frustrating process.

Acknowledgement

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# Chapter 1: Introduction to the Study

## Introduction

Licensed mental health counselors work with clients who have experienced trauma and suffered from the impact of ongoing traumatic symptoms, physical, emotional, and psychological. Licensed mental health counselors are trained to build rapport with clients and use empathy to understand and share the feeling of their clients so that they can process the clients' trauma stories and work to improve their quality of life (Figley, 2005). However, trauma clients' traumatic stories may impact counselors in a manner that the counselors may vicariously experience their clients' traumatic symptoms, which is considered as secondary trauma (Figley, 2005). According to Figley (2005), when counselors vicariously experience their clients' trauma symptoms, seven major areas in their lives may be cumulatively and detrimentally affected. These areas are emotion, cognition, spirituality, behavior, personal relations, somat, and work performance.

Because of the unique experiences of each person, the development of trauma symptoms from secondary trauma is unique to each counselor, which often makes secondary trauma difficult to diagnose (Figley, 2005). Experiencing secondary trauma can be especially true for male counselors because they learned through socialization to be more self-reliant and strive for achievement in comparison to female counselors (Barry, Bacon, & Child, 1957; Hill & Lynch, 1983). Additionally, male counselors are significantly underrepresented in counseling research making it difficult to normalize experiences of secondary trauma (Adams, Boscarina, & Figley, 2006; Baum, Rahav, and

Sharon 2014; Cieslak et al., 2014; Cieslak et al. 2013; Pearlman and Mac Ian 1995; Trippany, White Kress, and Wilcoxon, 2004).

This gap in the literature exists in regard to information about how difficult it is to identify vicarious trauma in male counselors and ways to help male counselors gain appropriate education and support for their unique challenges.

While research related to male counselors' experiences with secondary trauma is scarce, research in male counselors' experiences in working with children who have experienced trauma is nonexistent. Licensed mental health counselors who work with children experience different challenges than counselors who work with adults (Van Velsor, 2004). Children face issues such as parental divorce, removal from one or both parents due to neglect or abuse, and traumas similar to those of adults, such as natural disasters (Liu et al., 2011; Lonigan, Shannon, Taylor, Finch, & Sallee, 1994; Russoniello et al., 2002; Van Velsor, 2004; Vernberg, La Greca, Silverman, & Prinstein, 1996; Weaver & Schofield, 2015). The difference in working with children verses working with adults is that children lack abstract reasoning and emotional regulation, have limited vocabulary, and have difficulty organizing and categorizing objects and experiences (Myers, Shoffner, & Briggs, 2002; Van Velsor, 2004). Children are also helpless in many aspects of their lives, which makes it difficult for them to learn self-efficacy (Russoniello et al., 2002). The degree of helplessness and the lack of self-efficacy make counselors who provide services to children rely much more on nonverbal communication such as play therapy or behavioral approaches, which forces the counselors to become more involved (Axline, 1947; Weisz & Jenson, 2001).

Additionally, some care givers bring children who are already having difficulties organizing and categorizing the experiences to counseling to change undesirable behaviors as opposed to adults who voluntarily seek help for desired change (Shirk & Karver, 2003).

This study addressed the gap in the literature by exploring the experiences of male counselors who work with children who have experienced trauma. The knowledge gained from the study will inform counselor educators who teach male counseling students about vicarious trauma and the importance of self-care. This chapter includes the background of vicarious trauma , the problem statement, the purpose of the study, the research question, the conceptual framework, the nature of the study, and definitions of terms specific to this study. The chapter also includes assumptions, scope and delimitations, limitations, and the significance of the gap in research regarding the experiences of male licensed mental health counselors who work with children who have experienced trauma, before closing with the summary.

## Background

Vicarious trauma exists for humans all around the world, yet in psychological terms, researchers have only been exploring the concept since the early 1990s (Richards, 2014). In 1998, Saakvitne, Tennen, and Affleck used extensive literature to provide a substantial assessment of secondary trauma reactions that included theories, definitions, list of symptoms, and an applicable approach to secondary trauma of counseling professionals. These researchers and authors specifically focused on the constructivist self-development theory (CSDT) and included a discussion of the five areas of the self

that are affected by traumatic events: (a) memory system, (b) frame of reference, (c) ego resource self-capacities, (d) perception, and (e) central psychological needs (Helm, n.d.; Jankoski, 2010; Saakvitne et al., 1998). Individuals organize experiences by combining the five areas of self with traumatic events into their existing beliefs about the world and others (Saakvitne et al., 1998). Saakvitne et al. discussed the application of CSDT in research regarding thriving, including limitations and resolutions for those limitations. This discussion focused on five primary psychological needs (safety, trust, control, intimacy, and esteem) through schemas emerging from changes that described symptoms of secondary trauma. Saakvitne et al. also described clinical applications of CSDT that focused on helping individuals recover from secondary trauma.

In 2005, Pearlman and Courtois investigated secondary trauma using the CSDT to explain how symptoms of secondary/vicarious trauma can develop. CSDT consists of three self-capacities, which include affect tolerance, self-worth, and an inner connection to compassionate others. Pearlman and Courtois, discussed how early attachment experiences with caregivers can obstruct or enhance these self-capacities. In this article, the authors examined how to apply CSDT with clients who have complex clinical challenges due to experiencing trauma. Other researchers have shown interest in secondary trauma, and the creation of a secondary trauma instrument is one example of how some researchers are attempting to comprehend this phenomenon (Cieslak et al., 2013; Pearlman & Courtois, 2005; Saakvitne et al., 1998). It was not until 2013 when Cieslak et al. (2013) developed a scale to measure prevalence of secondary traumatic stress (STS) as well as self-efficacy in clinical service professionals. These authors were

concerned with self-care practices and protective characteristics that enable professional counselors working with clients' trauma material to prevent symptoms of secondary trauma (Cieslak et al., 2013). The authors in this study established the validity and reliability of the Secondary Trauma Self-Efficacy Scale (STSE) from research.

The literature available to researchers concerning the lived experiences of male mental health counselors who primarily work with children who have experienced trauma is nonexistent. The majority of literature surrounding vicarious trauma included primarily female social workers as participants. Additionally, most research contrasting men and women did not focus on counselors or gender differences within a professional counseling setting. After researching, reading, and analyzing available literature, I concluded that a gap existed in the research regarding licensed, American male counselors who primarily work with children who have experienced trauma. This study was needed to fill the gap in research to help men gain the needed education and training to reduce the impact of vicarious trauma and to give them a voice in the research when implementing and guiding treatment interventions.

## Problem Statement

Continued exposure to the trauma materials, which are the traumatic experiences of others, result in the male counselors acting or feeling as if their clients' traumatic experiences were their own (Figley, 2005). In this case, intense psychological distress or physiological reactions can happen in response to cues that symbolize, resemble, or represent those past experiences internalized while helping others (Figley, 2005). According to Figley (2005), vicarious experiences could lead to reduced involvement or

interest in activities that counselors once enjoyed, such as hobbies, social interactions, or other significant activities that could leave the counselors feeling estranged from humanity, clients, friends, and family. Figley also noted that the result of male counselors experiencing secondary trauma could lead to errors in clinical judgments, such as difficulty in conceptualization of problems and treatment of clients (2005).

This is important, since men are increasingly a minority in professions such as counseling and psychology. Evans (2013) reported that only 27% of the American Counseling Association's members self-report as male. Willyard (2011) asserted that many male counselors described feeling unheard and socially isolated in their career field. These impressions of isolation and underrepresentation include the field of research, as the absence of male voices and escalating marginalization within counselor education and research establishes a gap in how to train and educate male counseling students and clinicians who are at risk of suffering the detrimental effects of listening to clients' trauma, which may generate vulnerability to secondary trauma and burnout (Cohen & Collens, 2013).

Research has demonstrated that men are often traditionally socialized differently than women (Schneider & Cahil, 1996; Evans, 2013) as established by men having more action-oriented and goal-directed behaviors than women (Evans, 2013). Additionally, research has demonstrated that men react to, experience, and process trauma in different ways than women and ostensibly, therefore, require different support and training throughout their education and careers (Anderson, 1982; Schneider & Cahil, 1996; Mejia, 2005). Traditionally men also seek help in considerably different ways than women,

demonstrating ambivalence about pursuing help and maintaining resistance to talking about their emotions (Steen, 2014). According to research findings from a 2014 Center for Substance Abuse Treatment study, "Gender colors the attitudes, feelings, beliefs, and interactions of both behavioral health counselors and clients" (Steen, para. 15). Gender differences were also found in areas such as helping behavior, rumination, agreeableness, emotional expression and experience, communication, sensation-seeking, self-esteem, physical aggression, and focus on things instead of people (Hyde, 2014). These differences create substantial apprehension about applying educational and professional interventions with designs based on research about women to male students and professionals.

Grasping the lived experience of licensed, American male mental health counselors who primarily work with children who have experienced trauma is essential for the creation and implementation of instruction essential to improve the quality of life of male counselors. The creation and application of counseling instructions could use the findings from this research study to include education and normalization of vicarious trauma in men and to focus learning experiences on self-care practices and help-seeking behaviors. The understanding of participants' lived experiences is also necessary to design training that could empower male counseling students to become proficient in the identity, prevention, diagnosis, normalization, and treatment of vicarious trauma in their own lives as they join the counseling field and initiate work with children who have experienced trauma. Training experiences for male counselors might include role-modeling and role-playing skills male counselors can use to avoid vicarious trauma and

could focus on strategies such as self-assessments that acknowledge men's socialization to be independent. The lived experience of licensed male counselors in America who primarily provide professional mental health counseling services to children who have experienced trauma was the focus of this research study. This research problem necessitated a qualitative research approach to understand the phenomenon of vicarious trauma in regard to the form of therapeutic interventions male counselors use with traumatized child clients. When researching a phenomenon that has not been fully explored, Creswell (2009) asserted that a qualitative approach would be best to discover participants' perceptions, feelings, and actions. By using a semistructured approach during interviews, I was able to record the perceptions, feelings, and actions of male counselors to elicit thick, rich, descriptive data that spoke to each question as a guide to not only gather participants' experiences, but also their feelings, perceptions, actions, and insights into those experiences. My research question was studied using a qualitative approach because there is a dearth of empirical research findings and because human behavior is problematic to quantify (Cohen & Collens, 2013).

## Purpose of the Study

The purpose of this hermeneutic qualitative phenomenological study was to gain insight and understanding after exploring and interpreting the experiences of licensed, American male counselors who primarily work with children who have experienced trauma. According to Figley (1999), vicarious trauma is the cumulative, natural, and negative impact that occurs when counselors vicariously experience their clients' traumatic symptoms. Results from this study could inform educators about how some

male counselors experience clients' trauma material and could highlight the importance of building resiliency to vicarious trauma and promoting self-care among male crisis counselors.

## Research Question

RQ: What are the lived experiences of licensed, American male mental health counselors who primarily work with children who have experienced trauma?

## Conceptual Framework

Heidegger's phenomenology provided the conceptual framework for this study. Phenomenology seeks understanding through participants' meanings that are created as a result of experiencing the identified construct. Phenomenological reflection contributes to knowledge as *being* (Heidegger, 1962) and increases understanding of the experience(s) shared by participants. I used hermeneutic phenomenology as the qualitative design to investigate the first-hand experiences of participants (Heidegger, 1962; Smith, 2007; van Manen, 1997). The hermeneutic approach examines the *Lebenswelt* or life-world of individuals as they intentionally and consciously reflect on a particular phenomenon (Husserl, 1989). The phenomenon in this study was the lived experiences of male counselors of children who have experienced trauma.

Hermeneutics is a theory focusing on interpretation and is the phenomenological design I chose to use in this study. The primary concepts of hermeneutic phenomenological research design involve two questions that ask participants living in the phenomenon (a) what is this experience like, and (b) what is the meaning, essence, or nature of this experience (Laverty, 2003; van Manen, 1997)? Heidegger (1962) stated

that individuals' reality is created by how they experience and then define their world using coconstruction between them and their constructed world. For my study, I chose a hermeneutic phenomenological design to achieve in-depth insight into how male counselors experience the trauma of their clients. I explored how male counselors interpret their experiences within the context of their personal and professional lives and within their historical, cultural, and social backgrounds. Hermeneutic analysis applies a two-fold interpretation in which each participant generates meaning from their experiences, and then the researcher interprets that created meaning (Bontekoe, 2000; Heidegger, 1962; Smith, 2004). Heidegger stated that joining these frameworks impacts how participants understand and create meaning from experiences (1962). Therefore, a hermeneutic phenomenological study of male counselors of children who have experienced trauma complements an interpretivist paradigm that examines lived experiences from each participant's individual sociocultural context.

Hermeneutic phenomenology is a qualitative research method that attempts to understand the essence of a phenomenon that several individuals have experienced (Creswell, 2013; van Manen, 1990). Phenomenology originated from amalgamating schools of psychology and philosophy. Creswell (2013) applied phenomenology to research that created the study of the nature and meaning of a phenomenon (Finlay, 2009). Heidegger (1962) defined the essence of a phenomenon as "the way in which it remains through time as what it is" (p. 3). Additionally, van Manen (1990) asserted that

> A good [phenomenological] description that constitutes the essence of something is construed so that the structure of a lived experience is revealed to us in such a

> fashion that we are now able to grasp the nature and significance of this experience in a hitherto unseen way. (p. 39)

Phenomenology recognizes that individuals interpret their experiences and create their worldviews making this approach unique in research (Heidegger, 1962). Researchers encourage participants to tell their stories to learn how they have interpreted and assimilated those experiences into their daily lives and created their worldview. According to Patton (2002), phenomenology accepts that "there is an essence or essences to shared experiences," that are the "core meanings" that are jointly understood through the phenomenon that participants experience and the researcher studies (p. 106). Van Manen (1991) further asserted that phenomenological research encourages participants to contemplate their orientation to the phenomena and question that orientation through reflective inquiry. In order to gain a more intimate understanding of participants' experiences with the phenomenon under study, this research method allows exploration of data that is rich and in-depth.

Phenomenological research aims to explain, explore, and describe the phenomenon being studied (Patton, 2002) using an interpretive position to examine in what manner participants experience, interpret, and create meaning in their worlds (van Manen, 1997). Researchers using a phenomenological approach explore the shared experiences of several people by asking open-ended questions created to enable a comprehensive understanding of the experience participants have shared (Creswell, 2013; van Manen, 1997). Phenomenological research is based in philosophy and seeks to discover "what is it like" to be part of a group that shares experiences of a phenomenon

in common (Vagle, 2014, p. 20). When choosing phenomenology, the researcher intends to discover the substance of a phenomenon and to learn through perception, as perception is the primary source of knowledge (Moustakas, 1994). "The first principal of analysis of phenomenological data is to use an emergent strategy, to allow the method of analysis to follow the nature of the data itself" (Waters, 2016, p. 1) and then apply an iterative process of data immersion and analysis of themes present to explore participants' experiences of interpretation (van Manen, 1997). My goal was to illuminate the process and meaning of male counselors who provide counseling services to children who have experienced trauma through gaining an understanding of the perceptions of participants.

A second conceptual framework used to guide this phenomenological study came from Saakvitne et al. (1998): CSDT. Saakvitne et al. merged the cognitive development theory, psychoanalytic theory, social learning theory, and constructivist thinking, and emphasized the individual within the constructs of their developmental, social, and cultural backgrounds when using the CSDT, which came from Jean Piaget's constructivist views about how people develop meaning from their experiences and ideas. The application of the CSDT has also been revised and edited by other researchers. Trippany et al., (2004) used the CSDT theory to explain vicarious trauma symptoms as a self-protective, adaptive, and natural mechanism, which after recurrent exposure to others' trauma begins creating distorted perceptions that can become pervasive and cumulative. The researchers used the CSDT to explain how individuals develop perceptions of self and reality by using five components that included (a) psychological needs, (b) memory, (c) self-capacities and ego-resources, (d) frame of reference, and (e)

cognitive schemas and perception (Trippany et al., 2004). McCann and Pearlman (1990) combined the object relations theory with the self-psychology and the social cognition theories to revise how they used the CSDT. People who experience vicarious trauma appear to create a paradox between survival and adaptation, contrasted with traumatic loss and suffering (Saakvitne et al., 1998). Researchers and clinicians used the CSDT to help clients resolve their experiences from traumatic losses and sufferings as a theory of personal development and a clinical trauma theory (Giller, Vermilyea, & Steele, 2006; Saakvitne et al., 1998). Researchers gain understanding about their clients' experiences by recognizing the conscious and unconscious instruments of change and identifying the unique development of self affected the greatest by trauma (Saakvitne et al., 1998). I used the CSDT as the conceptual lens to interpret participants' experiences with vicarious trauma.

## Nature of the Study

Miles, Huberman, and Saldana (2014) asserted that researchers used different research methods when choosing between structured and unstructured studies. Maxwell (2013) encouraged less prestructuring when researching from one site, especially when the goal is to stay flexible enough for revision while remaining equipped to consider consequences and implications for the design that the researcher applied. Moreover, researchers used semistructured interviews with open-ended predetermined questions to add new questions determined by the information given during the interview (DiCicco-Bloom & Crabtree, 2006). DiCicco-Bloom and Crabtree (2006) stated that the most commonly used format in qualitative research is semistructured in-depth interviews,

which give the researcher more opportunities to assemble more comprehensive data during individual interviews. Researchers use in-depth individual interviews "to co-create meanings with participants by reconstructing perceptions of events and experiences" (DiCicco-Bloom & Crabtree, 2006, p. 316). Open-ended questions give participants the chance to speak in depth and in their own words (Qu & Dumay, 2011), which helps the researcher create awareness of participants' understanding of the phenomenon (Bostedo, 2009).

I invited six participants to share their individual experiences during interviews in a safe environment that provided confidentiality. After I interviewed the six participants, I found recurring themes and no additional insight and determined that I had met saturation, thus ending the interviews. This study was limited to English-speaking, licensed, male mental health counselors who held a master's degree in a counseling field and who worked with children who have experienced trauma. I used the qualitative phenomenological hermeneutic approach to conduct this research study. According to Creswell (2013) and van Manen (1990), Edmund Husserl developed phenomenology from an amalgamation of psychology and philosophy, and when transferred to research, this became a method to study of the nature and meaning of a phenomenon (Finlay, 2009). Heidegger (1962) asserted that the essence of a phenomenon is "the way in which it remains through time as what it is" (p. 3). Van Manen (1990) stated that

> A good [phenomenological] description that constitutes the essence of something is construed so that the structure of a lived experience is revealed to us in such a

> fashion that we are now able to grasp the nature and significance of this experience in a hitherto unseen way. (p. 39)

Researchers use phenomenology to concentrate on the lived experiences of participants, regarding essence, meaning, and structure of the shared phenomenon (Patton, 2002) as observed through participants' consciousness and experiences (Finlay, 2009). Additionally, van Manen (1991) asserted that phenomenological research has allowed participants to reflect on their orientation of the identified phenomena and further consider that orientation through reflective inquiry. Researchers use phenomenology to explore how participants internalize a shared experience into consciousness. The researchers use in-depth interviews to observe how each participant feels about, describes, makes sense of, remembers, and talks about a shared experience with others (Patton, 2002). Van Manen stated that a clearly defined theoretical framework should be used by researchers to strengthen the phenomenological approach and to consider how the framework impacts the findings discovered.

Because researchers have used phenomenology to acknowledge how individuals interpret their lived experiences into a worldview, it is unique in research. Participants telling their stories help researchers identify how participants have interpreted and assimilated everyday experiences into their lives and worldviews (van Manen, 1990). According to Patton (2002), researchers use phenomenology to understand that "there is an essence or essences to shared experiences" that are the *core meanings* that are jointly understood within the phenomenon experienced by participants and studied by the researcher (p. 106).

## Definitions

I used the following operational terms and phrases throughout the study:

*Affect:* Affect refers to a general control of mental functioning and is often used as an adjective (Duncan & Barrett, 2007).

*Constructs:* Constructs refer to the elements of formation obtained by the researcher (Groves et al., 2009).

*Counselor:* Counselor refers to a licensed mental health professional who holds a master's degree in the field of counseling as well as licensure to practice counseling in their state of residence.

*Emotional contagion:* Emotional contagion is a process phenomenon through which the emotions of a person or group influences the emotions and affective behavior of a person or group either consciously or unconsciously, with some individuals being more susceptible to emotional contagions than others (Doherty, 1997).

*Hermeneutic*: Hermeneutics is "the study of written texts and their meaning, in which they are understood" (Hermeneutic, n.d).

*Hypervigilance:* Hypervigilance is "the condition of maintaining an abnormal awareness of environmental stimuli" (Hypervigilance, n.d.).

*Paradigm:* A paradigm is "a model or pattern for something to be copied" or "a theory or a group of ideas about how something should be done, made, or thought about" (Paradigm, n.d.).

*Participant:* A participant is "a person who takes part in or becomes involved in a particular activity" (Participant, n.d.).

*Phenomenon:* The medical definition of phenomenon is "an observable fact or event" or "an object or aspect known through the senses rather than by thought or intuition" or "a fact or event of scientific interest susceptible of scientific description and explanation" (Phenomenon, n.d.).

*Phenomenological research:* "Phenomenological research is a strategy of inquiry in which the researcher identifies the essence of human experiences about a phenomenon as described by participants" (Creswell, 2009, p. 13).

*Qualitative:* Qualitative refers to the "quality of an experience or situation rather than to facts that can be measured" (Qualitative, n.d.).

*Trauma:* "Trauma is an emotional response to a terrible event like an accident, rape or natural disaster" (American Psychological Association, 2017, para. 1), which is reflected with a clinical diagnosis that reflects traumatic experience(s).

*Vicarious trauma:* vicarious trauma is an emotional contagion, which is a "natural, predictable, treatable, and preventable unwanted consequence of working with suffering people" (Figley, 1999, p. 41).

## Assumptions

There are several assumptions included in this research study. There was an assumption that the research participants would be honest about their experiences. Another assumption was that the semistructured interview approach and research questions would empower participants to provide rich description through open-ended responses. A third assumption was that my sampling strategy would provide a large and diverse enough population to provide practical and sufficient information to attain

saturation. The final assumption from this research study was that the data collection and interpretation procedures would provide an accurate understanding of participants' experiences in response to the research problem and research questions.

## Scope and Delimitations

The scope of this research study was the exploration of licensed male counselors who work with children who have experienced trauma. I looked for common themes and used the CSDT to interpret meaning to help understand the participants' vicarious trauma experiences. Transferability of this hermeneutic phenomenological study was not the goal; however the results may be applicable to studies with similar sample populations. The dissemination of the research findings through local, state, and national presentations will serve as contributing research for social change.

Delimitations of this study included using only licensed male counselors who work with children who have experienced trauma and using snowball and purposive sampling with no restriction on ethnicity. Additionally, I did not include participants who did not a sign an informed consent form, were female, were non-English speakers, were non-licensed counselors, or were counselors working only with adults.

## Limitations

Typical to qualitative studies, small sample sizes are limitations. The sample was generalizable to all licensed, American male counselors working with children who have experienced trauma. Once I met saturation from the interview responses, I resolved this limitation. The manner participants adapt and cope with their experiences were limitations based on different variables such as race, ethnicity, or family experiences. To

resolve this limitation, I elected not to use the CSDT to interpret those experiences or demographic data to determine racial or ethnic variables. I considered financial incentives and time as limitations to accessing a representative population of licensed male counselors who work with children who have experienced trauma. To resolve these limitations, I chose not to provide financial incentives to potential participants, and I was flexible to allow participants to schedule interview times at their convenience.

## Significance

The significance of this dissertation is a direct result of social change implications that include educating male counselors on the symptoms and effects of vicarious trauma on men and increasing awareness and advocating appropriate self-care strategies specifically targeting male counselors. Using qualitative phenomenological hermeneutic research methods, I explored a gap in the literature to contribute to the understanding of the vicarious trauma experiences of licensed male counselors who provide professional counseling services to children who have experienced trauma. By generating awareness for counselor educators about the impact client trauma can have on male counselors, the educators could provide more in-depth education to emphasize the possible challenges that male counselors encounter, which contribute to their increased susceptibility to additional stressors or vicarious trauma. The findings from this study could contribute to positive social change by introducing a platform to recognize the experiences of male counselors who work with traumatized children, to add to the literature, and to provide more insight and understanding for any male who may experience the vicarious trauma phenomenon. The overall goal from this study is that the findings could lead counselor

educators, counselors of counselors, and counselor supervisors to creating a healthy and safe environment where male counselors can understand and openly communicate about their vicarious trauma experiences. The findings from this study could also specifically benefit the counselors, counselor educators, and counseling supervisors who will guide future generations of male counselors with a focus on the well-being of male counselors.

## Summary

Secondary trauma occurs as a natural and cumulative experience due to working with others' trauma (Figley, 1995). The research findings in this chapter have captured the male counselors' vicarious experiences and allowed them to describe unheard and isolated feelings they experience within their career field (Willyard, 2011). Moreover, the research findings showed that men are traditionally socialized to experience, react to, and process trauma differently than women as well (Schneider & Cahil, 1996; Evans 2013). The literature discussed in this chapter also indicated that men approach seeking help significantly differently than women and seem ambivalent to seeking help and talking about their emotions (Steen, 2014), thus male counselors require different education, training, and support during their education and careers to deal with hearing clients' trauma (Anderson, 1982; Schneider & Cahil, 1996; Mejia, 2005).

I used a phenomenological qualitative method to explore the vicarious trauma experiences of male counselors who work with children who have experienced trauma. This chapter also included a few assumptions, and if managed properly the assumptions should not cause any problems. Data from the participants' interview responses provided a unique opportunity to gain insight and understanding into their lived experiences.

Chapter 2 included an in-depth review of relevant literature to support the conceptual framework (CSDT) and the study.

# Chapter 2: Literature Review

## Introduction

Licensed, male mental health counselors who work with children who have experienced trauma continually find themselves exposed to their clients' trauma material. This level of exposure can cause the counselors to suffer from psychological or physiological symptoms of vicarious trauma (Trippany et al., 2004). Moreover, being a minority in the profession of counseling compounds the traumatic experiences and leaves the male counselors underrepresented in the research. This can lead them to experience an increased marginalization within the field of counseling and counselor education. The purpose of this hermeneutic qualitative phenomenological study was to gain insight and understanding after exploring and interpreting the experiences of male counselors who primarily work with children who have experienced trauma.

Current literature includes the definition, causes, and symptoms of vicarious trauma almost exclusively in terms of women, and most studies focus on social workers specifically (Adams et al., 2006; Cieslak et al., 2013). Many of these studies have excluded both counselors and specifically men in the knowledge gained from research in this area. Addressing the gap in literature required exploring the experiences of male counselors to understand similarities and differences in the way they experience their clients' trauma material. This chapter includes the literature search strategy, the conceptual framework used to identify, define, and explore the phenomenon, and the limited amount of literature from studies about vicarious trauma before ending with a summary and conclusion.

## Literature Search Strategy

To locate peer-reviewed articles, I utilized the following online databases and search engines: Academic Search Complete, Educational Resource Information Center (ERIC), Expanded Academic ASAP, EBSCOhost Online Research Database, ProQuest Central, PsycINFO, Science Direct, and Google Scholar. The key search terms, phrases, and combinations of search terms that I used in these databases included: *vicarious trauma, secondary trauma, paradigm shift, counselor, male counselor, compassion fatigue, constructivist self-development theory, worldview, trauma, transmission of trauma, post-traumatic stress disorder, posttraumatic stress disorder, resilience, second-hand experience of trauma, cumulative trauma, trauma material*. I also used combinations of terms, such as *male counselor* and *client trauma*, *counselor* and *vicarious trauma*, *counselor* and *secondary trauma*, *counselor* and *compassion fatigue*, *counselor* and *resilience*, *counselor* and *trauma material*, and *counselor* and *paradigm shift*.

Most of the literature included in the literature review was published between 2007 and 2017. However, seminal works used to establish and define the conceptual framework dated from 1962. I used older articles to define the Heideggerian hermeneutic approach to phenomenological qualitative research and to define and justify the use of the CSDT. However, literature on the experiences of male counselors who work primarily with children who have experienced trauma is limited. To expand the literature review, I included some older articles that included information about the phenomenon of vicarious trauma, although some did not include men or counselors.

## Conceptual Framework

The conceptual framework chosen for this study is phenomenology authored by Heidegger (1962). Phenomenological research seeks to explain, explore, and describe the phenomenon under study (Patton, 2002) using an interpretive position to investigate in what manner participants experience, interpret, and create meaning in their worlds (van Manen, 1997). Researchers implementing a phenomenological approach explore the shared experiences of participants by asking open-ended questions created to enable a comprehensive understanding of participants' shared experiences (Creswell, 2013; van Mann, 1997). Phenomenological research is based in Heidegger's philosophy and pursues "what is it like" to be part of a group that shares common experiences of a phenomenon (Vagle, 2014, p. 20). Researchers choose phenomenology to discover the substance of a phenomenon and to learn through participants' perceptions, as perception is "the primary source of knowledge" (Moustakas, 1994, p. 52).

The CSDT served as another conceptual framework for this research study. In an article by Saakvitne et al. (1998), the authors proposed a new theory to overcome the weaknesses of other theories to study posttraumatic growth and change. Saakvitne et al. referred to the CSDT as a clinical trauma theory and integrative personality theory. The authors asserted that the use of CSDT provided a template for identifying both damage and growth after trauma, by integrating constructivist thinking with psychoanalytic theory and cognitive developmental theory (Saakvitne et al., 1998). The main use of CSDT was to understand the development of self during trauma (Giller et al., 2006; Saakvitne, et al., 1998). The researchers accomplished this understanding through

identifying unconscious and conscious mechanisms of change to find the unique aspects of self that are most affected by the trauma (Saakvitne et al., 1998). There also appeared to be a paradox between adaptation and survival juxtaposed with suffering and traumatic loss (Saakvitne et al., 1998), however the use of the CSDT helps resolve that paradox. The use of this theory could also determine which aspects of personality or self that would have been most impacted by trauma (Saakvitne et al., 1998). The researchers used the CSDT to consider individual experiences during childhood and early development as important to how individuals interact with self or others, and how they experience the world and integrate new experiences (Saakvitne et al., 1998).

According to Trippany et al. (2004), vicarious trauma is a cumulative and progressive negative condition that shifts due to the continued exposure of the trauma material of clients. Although the shift can be an adaptive process; repeated exposure to others' trauma material can cause a maladaptive response in the form of vicarious trauma (Trippany et al., 2004). The identified areas of self that can be changed due to exposure to trauma include self-capacities, ego-resources, frames of reference, cognitive schemas, memory, perception, and psychological needs (Trippany et al., 2004). Moreover, the exposure to trauma material created an opportunity to incorporate that material in a positive or negative way in the identified areas of self, causing either adaptive growth or maladaptive vicarious trauma. Thus, the trauma material can be explained by CSDT to help researchers understand the individuals' experience of that trauma material.

I chose to use the CSDT for its capacity to help describe how trauma impacts people. The goal of this research study was to explore the experiences of licensed, male

counselors who were consistently exposed to their clients' trauma. I used an interpretive approach to gain insight and understanding about how the trauma material impacted the participants. The CSDT supported the information gathered from the research questions and empowered the interpretation process within the Heideggerian approach.

## Literature Review

### Trauma

Trauma has been defined several ways to include "serious injury to the body, as from physical violence or an accident," "severe emotional or mental distress caused by an experience," "an experience that causes severe anxiety or emotional distress, such as rape or com/bat," and "an event or situation that causes great disruption or suffering" (Trauma*,* 2003*)*. Other definitions include "physical injury caused by violent or disruptive action or by the introduction into the body of a toxic substance" or "psychic injury resulting from a severe emotional shock" (Trauma, 2009). However, the most succinct definition I have found was offered by Paulson and Krippner (2007) who wrote, Trauma is an event that occurs to the body or mind that can create lasting repercussions on several areas of human subsystems, such as physiological, psychoneurological, social-emotional, and/or spiritual functions. Because of the multiple areas potentially impacted by trauma, it can be difficult to determine exactly what the outcomes of trauma were for an individual. Additionally, Paulson and Krippner asserted that changes in each subsystem can create a unique constellation of maladaptive behaviors due to trauma. The depth of the impact of trauma can also differ from individual to individual, even if the event was the same for several individuals.

Jones and Cureton (2014) reported that research has indicated that within community mental health clinics, clients with a history of trauma represent over 80% of the total client population. However, trauma is not a new concept nor a new domain in research, and it is mentioned in written works of the ancient Greeks using the English word *wound* to indicate trauma (Jones & Cureton, 2014). Moreover, there is a correlation between war and increased research into the causes and treatment of trauma (Jones & Cureton, 2014). Traditionally, medical professionals diagnosed any maladaptive changes following a negatively impactful event as either trauma- and stressor-related disorder or a form of anxiety disorder (Jones & Cureton, 2014). However, more recent research showed the original trauma event or material as the trauma and not the effects (Jones & Cureton, 2014). Focusing on the precipitating traumatic experience has helped to define trauma in a more person-centered way to allow individuals to consider whether an experience is traumatic versus the historical focus where a committee of educated professionals had to clinically diagnose the degree of trauma experienced (Jones & Cureton, 2014.).

Kira et al. (2008) explained that The American Psychological Association Trauma Group defined a traumatic stressor as,

> A process that leads to the disorganization of a core sense of self and world and leaves an indelible mark on one's world views that psychological disorders often follow upon exposure to. Examples of such traumatic stressors included combat, rape, child abuse, life threatening accidents, and death of loved one, domestic violence, and prolonged exposure to harassment. (p. 63)

Ibrahim et al. (2008) identified several examples of trauma that include

> cumulative prolonged exposure to harassment, abandonment, incest and most kinds of sexual abuse, as well as, historical collective identity traumas such as genocide and holocaust that goes beyond the threat to the individual's physical integrity to the existential threat to his or her group. (p. 63)

Ibrahim et al. also defined additional examples of trauma that included "racism which is ongoing traumatic stress, cross-generation transmission of severe poverty or relative deprivation, torture, and genocide that threaten the collective identity of the individual" (p. 63). These authors asserted that a single traumatic event is the exception rather than the rule, and that multiple or ongoing stress becomes cumulative trauma (Ibrahim et al., 2008). There are two types of cumulative trauma: core trauma creates biases or sensitivities toward triggering or retraumatizing events, while triggering trauma is the stressor or traumatic event that precipitates the postcumulative trauma reaction (Ibrahim et al., June, 2008). The triggering trauma is the stress or traumatic event that seems to create an identifiable and diagnosable condition such as post-traumatic stress disorder (PTSD), which can impact mental and physical health in areas such as brain structures, nervous system, memory, cognitive deficits, immune system compromises, seizure disorders, executive functions, endocrine systems, and amygdala, hippocampus, neocortical, encephalin, and corticosteroid functioning (Ibrahim et al., 2008).

Ibrahim et al. (2008) also espoused a two-way taxonomy of identifying trauma where type 1 included the developmental functions due to attachment traumas and type 2 included cumulative stress trauma consisting of internal, man-made, and nature-made

traumas (Ibrahim et al., 2008, p. 64). Man-made traumas are traumas that are "person-made and socially made" (Ibrahim et al., 2008, p. 64). Within person-made traumas, there are two subtypes, which are single episode and complex trauma (Ibrahim et al., 2008). Moreover, complex trauma can further be broken into two subtypes that include "repeated similar traumatic episodes that ceased" and "repeated and ongoing" trauma (Ibrahim et al., 2008, p. 64). Cumulative trauma is the fourth type within the complex trauma subtypes and includes "a sequence of similar and or dissimilar traumas from any previous types that happened to the individual across his or her life span" (Ibrahim et al., 2008, p. 64).

The *Diagnostic and Statistical Manual Fifth Edition* (DSM-5) included an updated definition of trauma and the criteria for identifying and diagnosing emotional or behavioral problems directly related to trauma (American Psychiatric Association [APA], 2013). In this fifth edition, the definition of trauma includes both indirect and direct exposure to trauma experiences (APA, 2013). Criterion A in the DSM-5 includes information about what constitutes trauma under the diagnosis of PTSD, which is the

> exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: 1) directly experiencing the traumatic event(s), 2) witnessing, in person, the event(s) as it occurred to others, 3) learning that the traumatic event(s) occurred to a close family member or close friend (in cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental), or 4) experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human

> remains; police officers repeatedly exposed to details of child abuse). Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work-related. (APA, 2013, p. 271)

In assessing the impact of the trauma there are two considerations, which are proximity and levels of exposure (APA, 2013). Levels of exposure can be separated into two formats, including direct and indirect exposure to the trauma event (APA, 2013). Additionally, direct exposure to trauma can be broken down by whether the trauma was experienced firsthand or was witnessed while happening to another or others (APA, 2013). Moreover, indirect exposure to secondhand trauma might include hearing about it, seeing it on television, having it played out in reenactment in any form, or events that were work related (APA, 2013).

**Vicarious Trauma**

The DSM-5 includes information about how indirect trauma has been labeled as secondary trauma and is traumatic material that was not experienced or witnessed firsthand, but as being exposure to the trauma material through another source (APA, 2013). The phrase secondary trauma is included in the DSM-5 and professionals often use this term in reference to other professionals who have indirect exposure to others' trauma material and defines this type of experiencing traumas as "repeated or extreme exposure to aversive details of the traumatic event(s) (APA, 2013, p. 271). This indirect exposure of trauma material would mean that the measure of proximity would be low due to not being physically at the location of the traumatic event (APA, 2013). Indirect exposure however, precludes experiencing the tactile sensations (sights, smells, physical

sensations, sounds, etc.) that can be or become triggers to the original trauma (APA, 2013). Other ways to reduce the measure of proximity and increase the risk for vicarious trauma is through witnessing the traumatic event through media, and the DSM-*5* stated that secondary trauma can occur from media formats if work related (APA, 2013).

Adams et al. (2006) studied compassion fatigue in social workers who lived in New York City and who were current members of the National Association of Social Workers. Participants were randomly selected, with 236 responding. Participants in this study consisted mainly (over 80%) of older White women with more than 20 years of experience practicing social work. The Institutional Review Board of the New York Academy of Medicine approved the study. The study measured two dependent variables, which included conceptual constructs of compassion fatigue (CF) measured by a 30-item CF Scale and psychological distress measured by a 12-item version of the General Health Questionnaire (GHQ-12). Independent variables included exposure to stressors, demographics, and psychological resources. Using a multivariate model, the authors found two dimensions measured by the CF Scale. The first included job burnout and secondary trauma, which they linked to psychological distress even when other risk factors were controlled. The findings demonstrated high reliability as well as concurrent and predictive validity. Additionally, the study showed that the CF-Short, Secondary Trauma, and Burnout scales could provide clarity between conceptual differences among burnout, secondary trauma, and CF, which could help clinicians diagnose and treat those suffering from one or more of these disorders. This study filled a gap in literature related to the emotional responses of formal caregivers working with traumatized clients,

whereas most studies have not focused on such a specific sample population. The authors were thorough in defining CF, burnout, and PTSD to enhance clarity of the terms. There was also a discussion regarding the results of this study to help professional caregivers work with traumatized clients to meet clients' needs, while avoiding CF.

Baum, Rahav, and Sharon (2014) conducted a meta-analysis that compared the susceptibility to vicarious trauma of men and women using 12 studies with 1,623 participants. There were 1,114 women resulting in 68.8% and 509 men resulting in only 31.4% of the sample population. The authors highlighted the unique manifestations, processes, and sources of vicarious trauma and provided clarity in the definitions of burnout, vicarious trauma , compassion fatigue, and STS. Baum et al. used seven criteria to review the studies for appropriateness and inclusion in this study. Findings demonstrated moderately higher susceptibility to vicarious trauma for women than men, as demonstrated by the results of a random effects analysis (Baum et al., 2014). Specifically, findings from a moderator analysis indicated that there were greater gender differences in the constructs of intrusion compared to avoidance and total Post Traumatic Stress Disorder (PTSD) symptoms (Baum et al., 2014). Moreover, these authors discussed differences between gender reactions to exposure to trauma material through stress theories, cultural expectations, and reporting behavior.

Cieslak et al. (2013) conducted a study using social workers and substance abuse counselors. The problem identified by the authors was the lack of an appropriate scale to measure self-efficacy as well as an inability to measure the prevalence of STS in clinical service professionals. The gap in the literature found by the authors related to the self-

care practices and protective characteristics that affect outcomes of clinical professionals working with clients' trauma material to ultimately experience symptoms of secondary trauma or growth (Cieslak et al., 2013). In this study, the authors created the STSE and tested it with participants. Cieslak et al. discovered the primary findings in their study by using exploratory and confirmatory factor analysis of the STSE, which demonstrated unidimensionality, high internal consistency, high correlation with symptoms of STS, and stability over time. Cieslak et al. conducted two studies, the first study included 247 participants and the second study included 306, and to summarize the results section, the researchers confirmed all hypotheses.

Cieslak et al. (2014) conducted a literature review consisting of 41 original research studies with 8,256 participants. According to Cieslak et al. (2014) the mean sample had 59.3% women with participants reporting professions such as mental health professionals, counselors, and therapists, emergency, ambulance, or rescue workers, child care workers and child health care providers, chaplains, forensic specialists, and non-categorized professionals. Cieslak et al. affirmed previous research by asserting the impact of STS and burnout, through a meta-analysis, and found that vicarious trauma in men and women is higher in the United States than in European countries. They also found decreased differences between genders among levels of vicarious trauma between men and women (Cieslak et al., 2014). The compassion fatigue framework was utilized to identify if a correlation existed between STS and burnout with the Professional Quality of Life, which was used to measure specific symptoms. Compared to other approaches

the Professional Quality of Life showed results of a stronger association between STS and job burnout than other measures (Cieslak et al., 2014).

Cohen and Collens (2013) conducted a metasynthesis study using a metaethnographic method to explore the effects of vicarious trauma in 20 published qualitative articles. Four major separate, but interrelated themes emerged within the study, including "emotional and somatic impact of trauma work, coping with the emotional impact of trauma work, changes to inner schemas and behaviors as a result of the trauma work, and the process of schematic change" (Cohen & Collens, 2013, p. 572). The findings of these articles identified the impact of vicarious trauma on professionals working with clients' who experienced trauma and found that this work can increase levels of distress as well as both short-term and long-term symptoms (Cohen & Collens, 2013). These authors also found that extended exposure to others' trauma does not imply a correlation between vicarious trauma and a preclusion of growth, and changes to schemas due to vicarious trauma can be either positive, negative, or both (Cohen & Collens, 2013).

Mailloux (2014) contended that vicarious trauma occurs after prolonged and repeated exposure to others' trauma, which causes the altering of professionals' beliefs and perspectives. Re-traumatization might also occur if counselors have experienced their own traumatic event or trauma with risk factors, such as the amount of exposure to the trauma material, decreased boundaries with clients, the therapists' own experiences, and the level of empathetic involvement with the client and their trauma material (Mailloux, 2014). I chose this article because it included a definition of vicarious trauma,

which previous articles had not, and provided a greater clarity and depth of the concept, causes, and mitigating factors of vicarious trauma .

Neumann and Gamble (1995) provided a definition, risk factors, and symptoms of vicarious trauma, and they examined how new trauma counselors experience their clients' trauma material and how that relates to vicarious traumatization. Neumann and Gamble contended that *traumatic transference* is another name reflective of the traumatizing process of working with clients' trauma materials. Moreover, counselors who experienced vicarious trauma begin to feel helpless or pessimistic about their abilities to help (Neumann & Gamble, 1995). Symptoms experienced by new therapists can include anxiety, somatic symptoms, and depression with an increase in traumatic imagery related to the clients' trauma material (Neumann & Gamble, 1995). The authors also asserted that new therapists are at a higher risk of vicarious trauma due to a lack of support, difficult clients, expectations of perfection, worry about professional marketability, death of mentors, lack of training in normative experiences of vicarious trauma , anxiety about repercussions in the workplace that prohibits help-seeking behaviors, and weak or vulnerable professional identity (Neumann & Gamble, 1995). The importance that this article places on educating counseling students is one important aspect, which I hope to incorporate in the discussion of findings section of my dissertation. This article also provides additional clarity regarding vicarious trauma and provides enhanced understanding regarding the deleterious effects of vicarious trauma and the importance of my research project.

An article by Saakvitne et al. (1998) helped to define and explain CSDT. This article gave a thorough exploration of secondary trauma reactions and trauma theory. This article used a plethora of literature to support the definitions, theories, list of symptoms, and approach to secondary trauma of clinical professionals. Specifically focused on CSDT, the authors also discussed the five areas of the self that are affected by traumatic events, including frame of reference, self-capacities, ego resources, central psychological needs, and perceptual and memory systems. Because of these self-capacities individuals can organize experiences by integrating the traumatic event into their existing beliefs about themselves, others, and the world (Saakvitne et al., 1998). One of the main strengths of this article is the thorough discussion of the application of CSDT and the research about thriving despite limitations, as well as creating solutions to those limitations. This discussion revolves around five primary psychological needs that included control, trust, intimacy, safety, and esteem, with schemas growing from changes that explain symptoms of secondary trauma (Saakvitne et al., 1998). The most pertinent discussion in this article surrounded the applications to applying CSDT clinically to help individuals recover.

Pearlman and Mac Ian (1995) explored the effects of trauma therapy on therapists' psychological well-being and found that new therapists and those with a personal trauma history are at a higher risk of experiencing symptoms of vicarious trauma. Participants included 132 (72%) women and 52 (28%) men self-identified as trauma therapists, with 93% White, ranging in age from 23 to 74. The researchers used three assessments scales, which included the Impact of Event Scale, Symptoms

Checklist-90-Revised, and the Marlowe-Crowne Social Desirability Scale. Pearlman and Mac Ian used the CSDT to understand and define vicarious trauma. They found that the risk of vicarious trauma is increased when a therapist has many traumatized clients, personal trauma history, poor or limited professional development, a self-sacrificing defense approach, current stressors, lack of supports, a stressful work setting, stressful client behaviors, and difficult social-cultural contexts (Pearlman & Mac Ian, 1995). The results from the Traumatic Stress Institute Belief Scale, for example, showed a score of 190 (SD=38) for therapists with a personal history of trauma versus a score of 174 (SD=34) for those without, indicating a significant difference (Pearlman & Mac Ian, 1995).

Sexton (1999) identified two types of countertransference reactions that therapists who work with traumatized clients may experience, which include over-identification reactions and avoidance reactions. Over-identification reactions might include excessive advocacy, idealization, or enmeshment, while avoidance reactions might include detachment, denial, distortion, disengagement, minimization, feeling guilt over perceived inability to help, loss of empathy toward the client, or a counter phobia (Sexton, 1999). Sexton also provided a pertinent discussion regarding the use of individual strategies for minimizing the symptoms of vicarious trauma for therapists, which primarily surrounds education about symptoms, causes, early warning signs, understanding of personal tolerance for hearing trauma material, and identification of experiences and feelings about trauma. Using individual strategies to minimize vicarious trauma symptoms can

help enhance clarity of the definition and symptoms of vicarious trauma as well as how to educate new counselors to prevent and minimize the effects of vicarious trauma .

Pearlman and Courtois (2005) also explored secondary trauma and used CSDT to help explain how individuals can develop symptoms of vicarious trauma. According to Pearlman and Courtois the CSDT included three self-capacities, which included self-worth, affect tolerance, and an inner connection to benevolent others. Early experiences with attachment to caregivers can contribute to or hinder the self-capacities. In this article, the authors discussed how to apply CSDT to working with clients who have experienced trauma and have complex clinical challenges (Pearlman & Courtois, 2005). Although this article did not involve a study, it was helpful in defining CSDT and will be helpful in justifying the use of CSDT in research regarding vicarious trauma.

Trippany et al. (2004) conducted an evaluation of recent research surrounding vicarious trauma where they applied the CSDT. Trippany et al. defined and differentiated between vicarious trauma, countertransference, and burnout. Moreover, Trippany et al. ascertained that cognizance changes, in areas such as psychological needs or the five components of the self can help prevent vicarious trauma. Identification of the symptoms of the three separate but similar constructs discussed in this article can help clinicians work with helping professionals through more efficacious diagnosis and treatment (Trippany et al., 2004). This article was chosen to inform the reader about the definitions of the three main trauma reactions in counselors who work with the trauma material of their clients, to enhance clarity, and to reduce confusion.

**Male Counselors**

One of the common assumptions held within society today is that men are different than women (Barry et al., 1957; Hill & Lynch, 1983). It is generally acknowledged that men are socialized differently than women and face different privileges and struggles than women (Barry et al., 1957; Hill & Lynch, 1983). Research from the 1950s on 110 cultures demonstrated basic differences in the way children were socialized in most cultures, such as teaching girls obedience, responsibility, and nurturing, while pressuring boys to strive for achievement and self-reliance (Barry et al., 1957). These researchers did observe a few cultures however, that did not have differences in the way children were socialized and even fewer that had the roles opposite from the majority, speaking to the importance of socialization as opposed to biology as the initiator of societal gender roles (Barry et al., 1957). Most researchers of gender-related development theories attempted to explain why there are differences between men and women's behaviors and choices, and the gender intensification hypothesis is used in one article. (Hill & Lynch, 1983). This developmental perspective explained that as children age and mature, their gender-differential socialization accelerate with girls identifying increasingly with female stereotypes and boys identifying increasingly with male stereotypes (Hill & Lynch, 1983). This research has been supported by additional research adding factors such as self-image and school achievement (Roberts, Sarigiani, Petersen, & Newman, 1990), the identification of the sex role(s) (Galambos, Almeida, & Petersen, 1990), parent-child relations (Crouter, Manke, & McHale, 1995), and problem behaviors (Windle, 1992). Researchers have used the gender intensification hypothesis

to demonstrate that girls increasingly develop emotional expression and helplessness coping styles, while boys develop assertiveness and action-oriented coping styles (Hill & Lynch, 1983).

More recent research using the gender intensification hypothesis has revealed that the pressure to conform to culturally defined gender roles can also help to explain the differences in the prevalence in depression among genders in adolescence (Priess, Lindberg, & Hyde, 2009). Historically parents with traditional gender roles have encouraged girls to focus on interpersonal relationships, be more accommodating, be more self-conscious, be more compliant, and have lower self-esteem with more focus on their physical appearance, while parents of boys encouraged competitiveness, achievement, independence, and self-confidence (Hill & Lynch, 1983). Shanahan, McHale, Crouter, and Osgood (2007) conducted research that also supported the familial socialization of traditional gender roles as girls reported less warmth from their fathers and more warmth from their mothers through their adolescence. Although not all research on the impact of gender roles on depression is consistent, the predominance of findings with older adolescent women has pointed to an increased risk of depression surrounding constructs of feminine qualities such as helpless coping types, caring for others, and difficulty with assertiveness (Priess et al., 2009).

**Counseling Children**

Counseling adults is different from counseling children, because counseling children creates unique challenges for the children's counselors that counselors who counsel adults do not experience (Van Velsor, 2004). Research have shown that one of

the first ways to successfully counsel children is by acknowledging that children have unique and different cognitive levels as well as a limited vocabulary (Van Velsor, 2004). The struggle that children's counselors face is children's continuous developmental growth throughout their physical growth (Myers, Shoffner, & Briggs, 2002). Piaget (1962) asserted that children between the ages of around one until around age six are in a pre-operational thought period, and therefore are unable to organize or categorize objects that they encounter, and their thinking is egocentric, inflexible, and irreversible. At this age children will often demonstrate egocentric thinking, continual body movement, and a short attention span (Myers, Shoffner, & Briggs, 2002). Before age 11, children have not fully developed the ability to think abstractly and so often find verbal communication surrounding abstract concepts very difficult (Piaget, 1962).

Between adolescence and early adulthood children begin to move into more formal operations, meaning that they can now think increasingly in abstract forms (Piaget, 1962). Myers, Shoffner, and Briggs (2002) asserted that this movement between stages can move forward at differing speeds and can be cyclical. Ivey (1993) said that young children are egocentric and often cannot adopt a dialectic or systemic way of perceiving themselves. The inability to perceive oneself creates an environment where additional care must be given to teach and encourage children to consider the perspectives and feelings of others as well as how they impact others and are impacted by others and the environment (Ivey, 1993). To think dialectically empowers older children and adults to recognize others' thoughts, views, and experiences as distinct and apart from theirs and to learn that they, too, are valid (Myers, 1998). To use basic counseling

skills with adults, verbal reflection and confirmation are enough, however, children communicate through actions or play, so the counselor must implement behavioral tracking as reflection (Van Velsor, 2004).

Another challenge in working with children is that they often have not learned emotional regulation (Semple, Lee, Rosa, & Miller, 2010). Additional research with children has shown that their natural way to experience and express what they experience is through play, as opposed to adults who can express their experience much more verbally (Axline, 1947). Additionally, research findings showed improved treatment outcomes from psychotherapy with children when counselors used behavioral approaches versus non-behavioral interventions (Weisz & Jenson, 2001). Van Velsor (2004) asserted that children verbalize content, which always has underlying emotion, and it is often necessary to help clients learn self-awareness and a feeling vocabulary to express their affect that reflects the verbalized content. Shirk and Karver (2003) noted the added importance of rapport between children and their counselors, which is more indicative of counseling outcomes than is rapport between adults and their counselors. This could be the case because children are often brought to counseling by their parents as an external stimulus to resolution of problem behaviors, as opposed to adults voluntarily seeking help for recognized problems for which they desire change or resolution (Shirk & Karver, 2003).

One of the stressors that creates trauma in children is natural disasters. Research in children after natural disasters have predominantly demonstrated that children experience symptoms of PTSD, anxiety, and depression (Liu et al., 2011). Further

research has shown that children experience psychological symptoms after disasters that can include phobias, temper tantrums, changes in eating, enuresis, irritability, and sleep disturbances while symptoms of PTSD can include distractibility, anxiety, hypervigilance, depression, and crying (Zhou, Wu, An, & Fu, 2014). Wolmer, Laor, Dedeoglu, Siev, and Yazgan (2005) further contended that because children have not fully developed their coping skills or cognitive abilities, these symptoms can be persistent for a significant amount of time. Opdenakker confirmed this, asserting that exposure to a natural disaster significantly increases children's risk of developing pathological anxiety and depression (2006). Dass-Brailsford, Thomley, Talisman, and Unverferth (2015) conducted a study of children who had experienced a 7.0 earthquake causing destruction, injuries, and a high death toll. These authors reported that proximity to the epicenter of the earthquake was not a significant predictor of symptoms, however correlation was found between children living with their biological parents and children living in an orphanage, with much lower deleterious effects within children living with their parents (Dass-Brailsford et al., 2015).

Another issue that children face that can cause trauma is separation from one or both biological parents due to divorce or removal of children by social services (Lonigan et al., 1994; Russoniello et al., 2002; Vernberg et al., 1996; Weaver & Schofield, 2015). According to Bowlby's attachment theory, children can suffer significant psychological trauma when they are separated from a parent or from both parents (1969). Research has also included place attachment, which is the bond created with the home and community that contributes to a child's identity, when discussing the trauma of separation (Osofsky

et al., 2009). Separation trauma can be seen in research on children who have been displaced due to various reasons, but all research studies have similar findings (Lonigan et al., 1994; Russoniello et al., 2002; Vernberg et al., 1996). Children who have experienced a parental divorce demonstrated a persistent and significant increase in behavior problems at home and school, increased internalizing, increased externalizing of problems, and decreased academic performance with protective factors of increased mother's sensitivity as well as higher IQ in the children (Weaver & Schofield, 2015).

A study of children of divorced families over 25 years has shown the significant impact of divorce on children that included both short and long-term consequences (Wallerstein & Lewis, 2004). One of the primary themes that these researchers found in children in the early stages of their parents' divorce that persisted over the course of the study was of a new belief that "Personal relationships are unreliable, and even the closest family relationships cannot be expected to hold firm" (Wallerstein & Lewis, 2004, para. 20). Children from the divorced families in this study reported long-term feelings of loss, abandonment, fear, loneliness, guilt, shame, helplessness, nightmares, feeling a loss of childhood, greater responsibilities, less protection, fewer rules resulting in increased acting out and resulting consequences, increased drug use including amount and frequency, increased sexual activity, and increased aborted pregnancies (Wallerstein & Lewis, 2004). These children also reported feeling deprived due to decreased interaction with enrichment programs, after-school activities, extracurricular activities, or community events (Wallerstein & Lewis, 2004). As adults these participants also reported feeling unprepared for parenting due to not having had a stable, loving, and

supportive two-parent homes, and therefore choosing not to have their own children (Wallerstein & Lewis, 2004). Additionally, compared with children of intact families, children of divorced parents reported significantly lower college attendance, and among those who began college the children of divorced families had a much higher dropout rate (Wallerstein & Lewis, 2004). The primary finding of this study is that children from divorced families are negatively impacted and struggle to be loved and in turn love within long-term, committed relationships (Wallerstein & Lewis, 2004).

According to the Administration on Children Youth and Families (2015), nationally in 2015 there were approximately 683,000 child victims of neglect or abuse reported and investigated by Child Protective Services. In Arkansas 34,246 reports of abuse or neglect were investigated resulting in 10,370 children considered victims of abuse or neglect and 3,797 children removed from their family of origin and placed into foster homes or group placements (US Department of Health and Human Services, 2014). Ko et al. (2008) reported that almost 25% of adolescents and children within most communities experienced at least one traumatic event and indicated that repeated exposure can impact psychobiological development. Not surprisingly, among children in foster care research has demonstrated that trauma is cumulative and chronic and has a much higher occurrence than children who have not been removed from their home and placed into foster care due to neglect or abuse (Dorsey et al., 2012). Most often these children are not the victim of only one incident of neglect or abuse but have experienced several occurrences over the course of weeks, months, or years causing toxic stress (Ko et al., 2008; Shonkoff et al., 2012). Forkey, Morgan, Schwartz, and Sagor (2015) defined

toxic stress as "the physiologic result of extreme, frequent or extended experience of trauma due to activation of the stress response without the buffering presence of a supportive adult" (p. 1480). Ongoing research into toxic stress in neuroscience, genomics, molecular biology, and immunology has linked early toxic stress with subsequent illness and symptoms within mental and physical realms (Forkey et al., 2015; Shonkoff et al., 2012). Areas that have been impacted by toxic stress include reduced emotional regulation, memory, cognition, behavior, learning, as well as a lifelong impact that increases the risk of obesity, chronic obstructive pulmonary disease, depression, diabetes, cardiovascular disease, suicidality, and other behavioral and physical health outcomes (Felitti et al., 1998).

## Summary and Conclusions

Male counselors are vulnerable to vicarious trauma because of ongoing exposure to their clients' trauma material. The experience of these male counselors historically has been overlooked in the research, resulting in marginalization of male counselors within counselor education as well as within the field of professional counseling. The gap in literature was the lack of research studies about the experiences of male counselors, specifically their experiences of vicarious trauma. This study addressed that gap in the literature by exploring the experiences of licensed, male counselors who work with children who have experienced their clients' trauma material, as well as any potential development of symptoms of vicarious trauma. In the next chapter, I presented the methodological strategy for this research study. I implemented a qualitative phenomenological hermeneutic research study to address the lack of knowledge and

research regarding the experiences of male counselors working with children who have experienced trauma. In the next chapter I also presented descriptions of the research design and rationale, role of the researcher, methodology, and issues of trustworthiness. I also discussed more details regarding recruitment of participants, data collection, and the data analysis plan before closing with a summary.

# Chapter 3: Research Method

## Introduction

The purpose of this hermeneutic qualitative phenomenological study was to explore the lived experiences of licensed male counselors who primarily work with children who have experienced trauma, and to gain insight and understanding into how male counselors experience the trauma of their clients. The insight and understanding gained from this study could potentially inform and educate male counseling students about how they might experience their clients' trauma and highlight the importance of self-care with these men. Due to the paucity of research in this area the gap that I identified in research demonstrated the importance of research with this population. The lack of research was also the reason it was necessary for me to conduct a qualitative study.

The major sections included in this chapter are the research design and rationale, which includes research questions, central concepts, research tradition, rationale for the tradition chosen, description of my roles as researcher, exploration of biases, and other ethical issues. I use the methodology section to identify the population, justify the sampling strategy, state criteria for participation selection and number of participants as well as how they would be included, review the relationship between sample size and saturation, and detail the data collection instruments and data sources for collection instruments. Further, this chapter covers issues of trustworthiness, which includes a discussion about credibility, transferability, dependability, confirmability, intra- and

intercoder reliability, ethical procedures that cover treatment of participants, and data collection. A summary includes the main points of the chapter.

## Research Design and Rationale

### Research Question

RQ: What are the lived experiences of licensed male counselors who primarily work with children who have experienced trauma?

### Central Phenomenon

The central phenomenon under investigation was the lived experiences of male counselors who primarily work with children who have experienced trauma. According to information about the CSDT, vicarious trauma occurs as a progression of constructed realities and perceptions that have been changed due to a counselor's exposure to clients' trauma material (Trippany et al., 2004). Normally vicarious trauma is an adaptive function that creates realistic experiences and expectations of the world; however, upon exposure to repeated trauma it becomes a self-protection against these emotionally traumatic experiences and can become pervasive and cumulative (Trippany et al., 2004). When counselors experience vicarious trauma, their views of the world become distorted and their identity, worldview, and belief systems can change. Trippany et al. (2004) used the CSDT to further identify five components that explained how the self and one's perceptions of reality were developed: (a) frame of reference; (b) self-capacities; (c) ego-resources; (d) psychological needs; and (e) cognitive schemas, memory, and perception.

Figley (2005) reported seven areas in which symptoms of secondary trauma might occur that included (a) cognition, (b) emotion, (c) behavior, (d) spirituality, (e) personal

relations, (f) soma, and (g) work performance. Moreover, the specific conditions and symptoms vary among individuals, traumatic event(s), disaster phase, moral perspective, ethical dilemma, philosophical questions, existential meanings, spirituality, and reflex response (Figley, 2005). The traumatic event can create a unique constellation of symptoms for the individual, which can make the identification of secondary trauma difficult to identify. Using a qualitative phenomenological research study, I was able to gather more information specific to symptoms participants experienced.

**Research Tradition and Rationale**

I used a hermeneutic phenomenological design to explore the experiences of participants from a first-hand point of view (Heidegger, 1962; Smith, 2007; van Manen, 1997). This approach highlights what Husserl (1989) referred to as the "life-world" of participants who consciously and intentionally consider a phenomenon, which in this study is the lived experiences of male counselors who primarily work with children who have experienced trauma.

Hermeneutics is the theory of interpretation. The central concepts of hermeneutic phenomenological research designs involve two primary questions that ask participants who are living the experience: (a) What is this experience like? and (b) What is the nature, essence, or meaning of this experience? (Laverty, 2003; van Manen, 1997). Heidegger (1962) defined the individual's reality by how that person experienced and then defined their world in the context of the coconstruction between the individual and the world. I selected the hermeneutic phenomenological design to gain an in-depth understanding of how male counselors experience the trauma of their clients.

Additionally, I sought to understand the ways in which these male counselors interpreted their experiences in the context of their professional and personal lives and within their social, cultural, and historical frameworks. The nature of the hermeneutic analysis engaged a two-fold interpretation, wherein each participant created meaning from his experiences, then the researcher interpreted each participant's created meaning (Bontekoe, 2000; Heidegger, 1962; Smith, 2004). Heidegger (1962) asserted that combining these frameworks influences how individuals understand and make meaning of their experiences. Therefore, a hermeneutic phenomenological study of male counselors who primarily work with children who have experienced trauma corresponded with an interpretivist paradigm that explored the lived experiences within each participant's unique sociocultural context.

Hermeneutic phenomenology is a qualitative research method that researchers have used to comprehend the essence of a phenomenon that has been experienced by several individuals (Creswell, 2013; van Manen, 1990). Phenomenology originated from blending schools of philosophy and psychology (Creswell, 2013), and when applied to research, it is the study of the meaning and nature of a phenomenon (Finlay, 2009). Heidegger (1977) defined the essence of a phenomenon as "the way in which it remains through time as what it is" (p. 3). Additionally, van Manen (1990) asserted that

> A good [phenomenological] description that constitutes the essence of something is construed so that the structure of a lived experience is revealed to us in such a fashion that we are now able to grasp the nature and significance of this experience in a hitherto unseen way. (p. 39)

Phenomenology is unique in research because researchers use it to acknowledge how individuals interpret experiences into a worldview (Heidegger, 1962). Allowing participants to tell their stories helps researchers understand how participants have interpreted and assimilated experiences into their daily lives (van Manen, 1991). According to Patton (2015), researchers use phenomenology because "there is an essence or essences to shared experiences," which are the "core meanings" that are mutually understood through the phenomenon being experienced by participants and studied by the researcher (p. 106). In fact, van Manen (1991) further explained that phenomenological research allows participants to consider their orientation to the phenomena and further question that orientation through reflective inquiry. This research method allowed me to explore data that is rich and in-depth and allowed a more intimate understanding of each participant's experiences with the phenomenon being studied.

The purpose of phenomenological research is to explore, explain, and describe the phenomenon under study (Patton, 2015) through an interpretive role of how participants experienced, interpreted, and made sense of their world (van Manen, 1997). Researchers conduct phenomenological studies to investigate the shared experiences of a group of people by asking open-ended questions designed to facilitate a comprehensive understanding of the shared experience (Creswell, 2013; van Manan, 1997). Based in philosophy, researchers conduct phenomenological research to discover "what is it like" to be part of a cohort or group that shares an experience in common (Vagle, 2014, p. 20). In choosing phenomenology, the intention of a researcher is to discover the essence of a phenomenon and to learn through perception, since perception is "the primary source of

knowledge" (Moustakas, 1994, p. 52). It is fundamental within phenomenological analysis for a researcher to implement an emergent approach relying on the data to precede the method (Waters, 2016.) and then implement an iterative process of data immersion and thematic analysis to explore participants' interpretation experiences (van Manen, 1997). Through gaining an understanding of perceptions of others, my hope was to provide more insight and understanding on the meaning and processes of licensed, male counselors who provide counseling services to children who have experienced trauma.

## Role of Researcher

Because this study was qualitative, my role as the researcher was that of an instrument for data collection. As the instrument for this study, I gathered, mediated, and reconciled data, as recommended by Denzin and Lincoln (2003). When using hermeneutic interpretations, the researcher is required to use a constructivist perspective as the participant and researcher codefine meanings and themes (Heidegger, 1962). Because I was acting as an instrument in this research study, I informed the stakeholders that I would be the instrument as opposed to utilizing instruments such as assessments, inventories, or questionnaires, which was based on ideas of Denzin and Lincoln. It was also this role as instrument that necessitated my acknowledgement of biases, expectations, assumptions, and experiences that demonstrated my ability to complete this research project, as recommended by Greenbank (2003).

As the researcher for this study, I maintained a blended perspective. According to Pomerantz (2016, p. 73), an emic perspective "emphasizes the similarities between all

people," and asserts universality with all people regardless of culture; whereas an etic perspective focuses on differences between people and their cultural norms. An aspect of my role as a human instrument with this qualitative research study was my responsibility to inform others that I am a licensed and certified counselor and therefore partially emic, as I have also experienced the phenomena under study. However, I made the distinction that I also maintained an etic perspective as I am not a man, and I will be viewing the research as an outside observer, as recommended by Creswell (2009). Identifying the perspective within the role of researcher as interacting with participants as interviewer and interpreter necessitated that I to identify my perspective as well as biases that could impact the results.

**Researcher Bias**

Disclosing biases is one of the primary ways in which I demonstrated my openness to hearing information that may exceed or contradict my experiences, beliefs, or opinions regarding the phenomenon under study. Creswell and Miller (2000) called this validity procedure "researcher reflexivity." The validity procedure enabled me to disclose my biases, beliefs, and assumptions that could shape the inquiry and should occur early in the process of research (Creswell & Miller, 2000).

I chose to study the experiences of male counselors because of professional encounters with male counselor peers who worked with children who have been traumatized. In working with male counselors, I have noticed differences in how they talk about their clients' trauma versus how I and other female counselors talk about our clients' trauma. This made me wonder if these men also experience clients' trauma

differently. I also wondered if the way men experienced their clients' trauma is directly related to the way people socialized them to experience and react to others' trauma. I questioned if a difference might be due to how people in society often socialize men and boys to avoid admitting weakness and avoid help-seeking behaviors. I was uncertain if my participants would identify these experiences as affective in how they experience and react to their clients' trauma. This concerned me because if this is true, male counselors might not seek or invite help in reducing the negative impact of others' trauma or implement self-care, and could, as a result, experience greater vicarious trauma. Additionally, men within counselor education programs and the field of counseling are a minority. This minority status could exacerbate the experience of isolation due to limited interactions with other male counselors who could normalize trauma reactions or experiences and help reduce vicarious trauma.

**Ethical Issues**

Informed consent is one of the primary ethical concerns in this study, which was addressed through a comprehensive informed consent. This consent form included information that informed participants about the volunteer nature of participating in the study and assurance that they can stop their participation at any time with no adverse consequences. Another ethical concern was the risk to participants who could potentially experience psychological stress greater than what they might experience in their daily lives, specifically participants who could experience anxiety when asked about the traumatic experiences of their clients. Also, there could have been minor negative effects to participants' health as increased risk of vicarious trauma due to talking about clients'

trauma. If a participant were to appear to be distressed because of participating in an interview with me, I would have referred him to Mental Health America at www.mentalhealthamerica.net/finding-therapy or called (800) 969-6642 to help him find an appropriate counseling agency where he could have received counseling services. To protect the anonymity and confidentiality of each participant, I asked each participant to choose a pseudonym, and I am the only person to know which pseudonym represents each participant. Data integrity was also an ethical concern, which was minimized through recording and storing data on a password protected flash drive that will be stored in a lock box and the files password protected. Additionally, raw data was transferred onto an encrypted and password protected flash drive and locked in a fireproof safe for at least five years. If the raw data is no longer needed after five years, I will delete all information from electronic devices.

## Methodology

### Population

Licensed American male counselors are the participants in this study, and the states of their licensures determine where they practice. To determine the eligibility of each potential participant I asked him for his licensure type and confirmed this with his state's licensing board. Each participant verified that he currently is counseling children who have experienced trauma. I discussed this requirement with potential participants as well as ensured that participants who are referred through snowball sampling met these criteria. Initially, I sought participants through social media, a list serve in the Arkansas Mental Health Counselor's Association (ArMHCA). I followed all protocols with this

organization and maintained a contact person. I contacted each potential participant through telephone and/or email to seek their participation, and I followed up to ensure contact was made if there was no reply. I recruited potential participants utilizing purposive and snowball sampling, and interviewed six participants, which allowed for saturation to occur in concordance with previous research (Charmaz, 2014; Creswell, 2009; Miles, et al., 2014). Moreover, the virtue of a smaller sample size allowed me to use data collections approaches that enabled a more in-depth understanding of the phenomena under study, as recommended by Patterson and Williams (2002).

**Exclusion criteria.** Study exclusions included participants who would not sign an informed consent. Additionally, non-English speakers, women, non-licensed counselors, and counselors working only with adults were not included in this study.

**Sampling**

I have chosen two primary methods of sampling (purposive sampling and snowball sampling). I used purposive sampling because of the logistical feasibility of my sample population, which could incorporate sampling bias. Due to the qualitative nature of my study and the utilization of small sample size, I minimized fortuitous bias. I pursued participants' lived experiences in my study which precludes sampling bias from impacting the study (Groves et al., 2009). Creswell (2013) discussed adequate sample size by advising the qualitative researcher to gather adequate participants to answer the research question, but to focus on gathering participants' specific information that will elucidate those details. In fact, the number of participants Creswell reported observing in phenomenological studies fluctuate from one to 325, further emphasizing the need to

customize the number of the sample to reflect the research question and overall goal(s) of the study.

**Purposive sampling.** I used purposive (or purposeful) sampling because of the logistical feasibility of my sample population, which could incorporate sampling bias. I used purposive sampling so that future researchers can repeat my study and verify or refute and accurately interpret my findings (Coyne, 1997; Patton, 2015). Patton (2015) stated that purposive sampling allows the researcher to hand-pick participants based on specific characteristics. Purposive sampling is considered the most rigorous type of sampling in qualitative research (Marshall, 1996; Patton, 2015). Locating a participant pool for a purposive sample can be challenging (Rudestam & Newton, 2015; Miles et al., 2014), therefore I also used snowball sampling.

**Snowball sampling.** I utilized snowball sampling in my study because I live in a rural area and because of the unique target population I hoped to interview for my research study. Creswell (2013) stated that the snowball sampling approach, "Identifies cases of interest from people who know people who know what cases are information-rich" (p. 158). While this definition may seem perplexing, in this approach the researcher simply asks current participants in the study to refer other potential participants. The researcher gathers participants by asking current participants if they know someone who fits the study's requirements and might be willing to participate. Patton (2015) identified snowball sampling as occurring when current research participants refer additional appropriate individuals who most likely meet the criteria of the study, to the researcher, in the hopes that they also agree to participate. Snowball sampling is a natural fit to reach

the specific target population sample in my qualitative phenomenological study, because I did not require a population-based sample size, as recommended by Sadler, Lee, Lim, and Fullerton (2010). The snowball sampling approach helps to allay difficulties researchers may have attracting appropriate participants because of the specific characteristics of the target sample, and it improves participation by potential participants (Black, 1999; Coyne, 1997; Miles et al., 2014). Snowball sampling also allowed me to identify participants who would otherwise not have been identified because they were not members of professional association, social media site, or on other lists that I may have searched.

**Procedures for Recruitment, Participation, and Data Collection**

The participants in this study included six American licensed male counselors who primarily work with children who have experienced trauma. The recruitment of potential participants consisted of sending an email to all members of the ArMHCA with a description of the research study and my contact information. The inclusion criteria for participants included (a) living in and being an American citizen, (b) being a licensed male counselor, and (c) currently working primarily with children who have experienced trauma.

I conducted an exploratory, descriptive research study using interviews, which Maxwell (2013) asserted enhances deep rich data that improves transferability. Interviews allow the researcher to observe social cues such as body language, intonation, and voice (Opdenakker, 2006). Miles et al. (2014) asserted that during open-ended interviews a significant amount of observation occurs. Maxwell (2013) noted that

interviews allow researchers to draw inferences based on body language and behavior in context to gain participants' perspectives that they might not state directly in the interview. The authors also discussed the need for more preparation than a single-case study, which allows the researcher to compare these cases (Miles et al., 2014). Maxwell asserted that questions during a face-to-face interview should focus on specific events and actions, rather than questions that elicit generalizations or abstract opinions (2013). Interviews provide spontaneous responses and can lead to the emergence of new information (Opdenakker, 2006).

Within data collection, researchers use hermeneutic research to primarily explore how each participant interprets the research question(s) and to clarify and interpret participants' responses (Heidegger, 1962; Patterson & Williams, 2002). In-depth interviews are traditionally the response to this directive, allowing researchers to "control, assess, and take advantage of their role in data production" (Patterson & Williams, 2002, p. 25). I collected data using semi-structured interviews with each participant who voluntarily participated and satisfied the inclusion criteria. Participants were advised that they were participating voluntarily and could withdraw participation at any time during the study with no adverse consequences. I contacted each participant personally to set up the date and time of the individual's interview. All interviews took place in a safe location where each participant and I could ensure safety and privacy such as in a private room in the public library. Each interview was recorded and lasted approximately 60 minutes. I collected the data and transcribed each interview. I emailed each participant a copy of the themes found from each transcribed interview response to

review for precision or clarification as member-checking to enhance credibility, based on recommendation from Maxwell (2013). I provided each participant with my contact information, which included my phone number and email address, to contact me with any requests, questions, concerns, or comments. I also provided each participant the contact information for the university's Research Participant Advocate, Dr. Leilani Endicott, as well as the approval number from the Institutional Review Board.

**Data Analysis Plan**

I used interpretative phenomenological analysis (IPA) to implement Heidegger's philosophy (1962) while applying it to data analysis. I followed this approach by identifying all preconceptions throughout the reflexive process of the study through an emic perspective (Finlay, 2008). Horrigan-Kelly, Millar, and Dowling referred to Ricour, who gave analytical stages supporting hermeneutical circular interpretation, that include "distanciation, appropriation, explanation, understanding, and interpretation" (2016, para. 30). These steps helped me, as researcher and co-interpreter to remain open and not seek premature understanding as recommended by van Manen (1997). Additionally, I used the CSDT as a lens through which to analyze and interpret the raw data I gathered. CSDT, is a framework to assess aspects of individuals' self, based on personal history, cognitive schemas, and self-capacities and interpret their current experience (Trippany et al., 2004). I used this framework to interpret each participant's lived experience of working with children who have experienced trauma.

I transcribed and exported interview data to NVivo software to aid in analysis. The NVivo software was created to analyze, organize, and store qualitative text through

coding and sorting to find themes (n.d.). My role of researcher in the analysis of data was working within NVivo to determine themes as I reviewed interviews individually and then together. Using NVivo additionally allowed me to identify when saturation had been reached.

Because hermeneutic epistemology is an ongoing circular process, data analysis begins when the first data is collected to identify emergent themes and guide future interviews (Heidegger, 1962; Patterson & Williams, 2002). Each interview was transcribed verbatim and I entered the raw data into the NVivo software, where I read and coded the data. I created categories and themes, which were supplemented as I collected additional raw data. I categorized each group or theme using words or phrases, incorporated quotes from participants to demonstrate themes, and used the CSDT as a lens to interpret participants' created meaning to explore how the self and creation of reality were developed (Bontekoe, 2000; Heidegger, 1962; Smith, 2004; Trippany et al., 2004). Within the data analysis process, I implemented CSDT tenets of how identity is created through participants' perceptions and constructed realities because of exposure to their clients' trauma material. I evaluated participants' experiences based on the five components that explain the development of self and identity previously identified and within the seven areas in which symptoms of secondary trauma might occur. This evaluation occurred after I entered all the raw data and identified groups and themes. I then began to determine if any of these groups or themes reflected an impact on participants' perceptions and reality; specifically surrounding their identity, worldview, or beliefs, and how this could be cumulative within their lives, based on views from

Trippany et al. (2004). By incorporating the CSDT, I was able to identify how participants created meaning based on exposure to clients' trauma and specifically how that meaning impacted their lives.

## Trustworthiness

According to Patterson & Williams (2002), "hermeneutics maintains no single set of procedures for establishing validity is possible, because there is no single correct interpretation of phenomena…" (p. 31). Fortunately, there are several ways to improve trustworthiness. To increase credibility within my study, I found six participants to increase confidence in my findings as well as the trustworthiness, validity, stability, and precision by following a replicable strategy, as recommended by Miles et al. (2014). Although generalizability does not improve using this strategy, generalizability is not important to my central research question regarding the lived experiences of participants, based on views from Miles et al. (2014). I also gained greater depth because participants were articulate, understood the importance of the phenomena, and appreciated my goal to improve the education of new male counselors. Heidegger (1962) touted practical utility within research as the evaluative criteria to interpretation of others' experiences; which was highlighted by Packer and Addison (1989) whose applicable interpretation is "one that uncovers an answer to the concern motivating the inquiry" (p. 289).

## Ethical Procedures

I implemented ethical procedures to ensure the protection of the participants and data. Initially, I provided all potential participants with a recruitment letter that identified my name and contact information, the nature of the dissertation research study, the details

about the importance of the research study and the nature of data collection, and the voluntarily bases for participation and the freedom to stop at any time with no adverse consequences. I followed the approved interview protocol with all interviewees, and I only interviewed participants who signed an informed consent. I asked each participant to choose a pseudonym by which to identify himself and to be able to differentiate participants in the study while maintaining confidentiality. If a participant would have experienced anxiety based on the material in the interview, I planned to refer him to Mental Health America at www.mentalhealthamerica.net/finding-therapy or (800) 969-6642 for an appropriate referral for counseling in his area.

To ensure accuracy of data, I created audio recordings of every interview and used member checking by sending a summary of each transcribed interview to participants asking for clarification, additional information, or correction(s). I will continue to store the raw data collected from the recorded interviews on an encrypted and password protected data storage device, which will remain locked in a safe for five years and then destroyed if it is not needed.

## Summary

The research methodology section included an introduction to define the research problem, the central phenomenon to be studied, and the choice of research design. The research question was about how male counselors experience the trauma of their clients. The insight and understanding gained from this qualitative study will inform counselor educators, who teach male counseling students, about vicarious trauma and the

importance of self-care. The use of qualitative research enabled me to answer the research question while filling a gap in the literature with this unique population.

The major sections of this chapter included the research design and rationale, including research questions, central concepts, research tradition, rational for tradition chosen, description of my roles as researcher, exploration of biases, and other ethical issues. In the role of researcher section, I defined emic and etic, and discussed the necessity to acknowledge my biases, experiences, and assumptions. The methodology section included the population, the sampling strategy, and the criterion for participation selection, the number of participants and how they will be included, and details about the relationship between sample size and saturation.

Next, I explored issues of trustworthiness. This included a discussion of credibility, transferability, dependability, confirmability, intra-and inter-coder reliability, and ethical procedures that cover treatment of participants and data collected. I included a comprehensive informed consent and monitored participants for psychological distress. To increase credibility and increase deep rich data, I interviewed six participants using exploratory, descriptive face-to-face interviews, based on sampling recommendation by Maxwell (2013). I also disclosed my own biases to demonstrate researcher reflexivity and used bracketing to improve openness about information that may exceed or contradict those biases. Member checking is another validity procedure I implemented to ensure accuracy. Triangulation and member checking were implemented as well as participating with my dissertation committee to provide support, challenge assumptions, identify themes, and confront inconsistencies. I used a computer-assisted qualitative data

analysis software (CAQDAS) to help find themes, store, code, sort, and index the raw data and enhance the rigor of the study. I addressed data collection and storage by recording and storing data on a password protected flash drive that I will store in a locked fireproof safe for at least five years. Chapter 4 will include the results from the interviews.

# Chapter 4: Results

## Introduction

In this chapter I present the findings from this qualitative hermeneutic phenomenological study of the lived experiences of licensed male counselors who primarily work with children who have experienced trauma. I also report data collection procedures that include sample size, the duration and frequency of data collection, the method of transcription, and variations in the data collection process from those discussed in Chapter 3. I present data analysis processes. I also summarize the themes and issues of trustworthiness with special attention focused on credibility, transferability, dependability, confirmability, intra- and intercoder reliability, and ethical procedures that cover treatment of participants and data collected. I close this chapter with a summary of the research findings.

## Research Question

The purpose of this qualitative hermeneutic phenomenological study was to explore the lived experiences of licensed American male counselors who primarily work with children who have experienced trauma. I sought to understand how male counselors experience their clients' trauma. The RQ for this study was: What are the lived experiences of licensed male mental health counselors who primarily work with children who have experienced trauma?

## Demographics

### Biographical Sketches

At the beginning of each interview I asked participants to choose a pseudonym by which to identify themselves in the study. Each participant created the pseudonym by which he would like to be identified and verbalized agreement with spelling when I asked for confirmation of the name and how to spell it.

**Vincent.** Vincent holds the terminal counselor licensure in Arkansas of Licensed Professional Counselor with a specialization in supervision. Vincent has been counseling for over 25 years, and has worked with adults and children, but primarily children in a clinic setting.

**Willy.** Willy holds the provisional counselor licensure in Arkansas of Licensed Associate Counselor and has almost three years of experience in working primarily with children in school and clinic settings. He works in Central Arkansas in a community mental health setting. Willy provides counseling to children who have primarily been referred to counseling by the school due to behavioral challenges.

**Cheapy Peepy (C. P.).** C. P. holds the terminal counselor licensure in Arkansas of Licensed Professional Counselor and has over three years of experience in working primarily with children both in a clinic setting as well as in clients' homes several times a week. He works in Central Arkansas in a community mental health setting, specifically in the Intensive Family Services program. He provides counseling to children who have been removed from their primary caregiver and home due to neglect or abuse. The goal in this program is to reunify the children into their home, family of origin, and school.

**Mark.** Mark holds the terminal counselor licensure in Texas of Licensed Professional Counselor with a specialization in supervision. Mark currently maintains a private practice, but has experience working in an inpatient hospital setting as well as in an agency setting. He has worked primarily with children, but also works with adolescents and adults.

**Biff.** Biff holds the terminal counselor licensure in Arkansas of Licensed Professional Counselor with a specialization in supervision, as well as certification in eye movement desensitization and reprocessing (EMDR). Biff has over 25 years of experience working with children who have experienced trauma in several settings, including schools, clinics, in clients' homes, and in a private practice.

**Lee.** Lee holds the terminal counselor licensure in Ohio of Licensed Professional Clinical Counselor, and he is also a Registered Play Therapist with a specialization in supervision. Additionally, he holds a Ph.D. Lee has worked with children who have experienced trauma for over 20 years in child welfare, community mental health, and in a child advocacy center.

## Data Collection

I identified six participants for this study through posting a letter to potential participants on social media, a letter on my behalf through the Arkansas Mental Health Counseling Association (ArMHCA) professional association, and through snowball sampling. All communication with stakeholders and participants was through social media, e-mail, or phone. I sent a follow-up e-mail that included the informed consent document to those who expressed interest in participating, information on how to consent

to participate, and my contact information. If a participant verbalized someone they believed fit the criteria, I gathered his professional contact information and sent him an initial e-mail introducing myself that included the purpose of the study, the name of the participant who referred him, and the informed consent document attached. A leader I know in the ArMHCA sent an e-mail on my behalf to potential participants.

**Sample Size**

The participant recruitment process generated six male counselors who expressed interest in and qualified to participate in the study. After phenomenological interviews began, I continued to recruit participants if additional interviews were needed to accomplish saturation. Ultimately, I had eight individuals express interest; however, one participant failed to follow-up with by signing and returning the informed consent and one participant did not qualify as his client population was not primarily children.

**Location, Frequency, and Duration**

I requested that participants commit to one 60-minute interview as well as a follow-up e-mail that would include a summary of the interview, to which they could respond with additional comments, clarification, corrections, or additional information that they would like to share. All interviews that I conducted occurred within a secure and confidential setting. I used the office of four out of six of the participants. This included Vincent, Willy, and C. P., which occurred during office hours in an agency setting. Biff used an office in his private practice. Interviews with Mark and Lee were conducted via Skype, and in both instances, I was in my office with the door closed.

Mark conducted the interview from his home office while no one was home, and Lee also conducted the interview from his home while he was home alone.

**Transcription**

I transcribed each phenomenological interview by hand. All data gathered during each interview was transcribed verbatim by me within 6 days of its collection, but in most cases within 1 to 2 days of data collection. I implemented this window of time for transcription to enhance clarity and conciseness of my recollection of each interview. After transcription, I would wait 1 day, then read the transcript while simultaneously listening to the corresponding taped interview. This was to ensure accuracy, correct mistakes, and confirm nonverbal communication such as crying or laughing. I saved each interview transcript with the pseudonym as the title (i.e., "Mark") in the folder labeled as the participant's pseudonym on the password protected flash drive. The audio recording of the interview, the interview transcript, a copy of the signed informed consent document or the e-mail agreeing to consent to participate, and additional documented communication such as a copy of the e-mail response to the member checking e-mail was saved in each participant's folder. Biff's folder additionally held the self-portrait he drew to visually represent his pseudonym and reflect his counseling identity. This self-portrait is included in Appendix B.

**Variations in Data Collection**

There was only one variation to the data collection procedures that I had originally planned. This was that I did not seek participants from the Association for Child and Adolescent Counseling within the American Counseling Association (ACA).

This occurred because saturation was reached before I received a response to my request to send an e-mail on my behalf through their list serve seeking potential participants.

**Unusual Circumstances During Data Collection**

During the interview with C. P. a colleague interrupted the interview by walking into the room. The colleague began giving C. P. vital information about a client transfer that C. P. would need for a meeting later that day, but which the colleague would not be available to give to C. P. at any other time. I pushed the "stop" button, believing I had paused the interview, however, the recording device did not stop. I therefore did not transcribe the data represented by the interruption in the interview between the times from 5 minutes and 02 seconds into the interview to 7 minutes and 11 seconds. When the colleague left the room and had again closed the door for privacy, the participant began where he left off and collection resumed in a normal manner.

## Data Analysis

I used interpretive phenomenological analysis to analyze data. According to Smith (2004) and Eatough and Smith (2008), interpretive phenomenological analysis is implemented by analyzing each interview transcript individually, and then analyzing all transcripts together to view relationships between the datasets. I did this initially by completing each interview, transcribing each interview by hand, verifying their accuracy, and reading them two to three more times. I did this to ensure that the participant was the focus of each analysis as suggested in an article by Smith (2004) and to examine the language and semantic content with an exploratory approach. I looked for metaphors, notable words or phrases, and pronoun choices to highlight focus or clarification of a

thought, feeling, or experience also as recommended by Storey (2007). I then uploaded each interview transcript into NVivo software as source information.

Next, I began organizing the data from each interview transcript. Initially, I looked for emerging themes within each of the 11 questions I asked participants during the phenomenological interview process. These were given a parent code in NVivo, and I began to assign representative phrases or sentences to the parent codes. These parent codes provided me with general themes from which I could analyze the data and then potentially create more specific subthemes. I did this by focusing on how each participant answered each question and then seeking similarities or differences among participants' meaning and experiences with the construct identified in the question. I accomplished this by implementing three strategies that included numeration, contextualization, and abstraction to bring themes together as demonstrated by Smith (2012). For example, participants were asked if they felt that they had experienced vicarious trauma based on the definitions I previously gave at the beginning of the interview. The broad theme was that each participant answered affirmatively, that they had experienced vicarious trauma. Upon further analysis, I found that the majority of participants interviewed reported specific areas of their life that were impacted by vicarious trauma negatively, but also that they gained empathy and personal growth as a result of experiencing vicarious trauma. As a result, I created a theme of "increased empathy and growth."

Once all appropriate data was separated into codes, I began clustering data that were similar into themes. To extrapolate the data that was most consistently mentioned

during the process of the interviews, I chose to remove codes that were mentioned only once. This resulted in the exclusion of one code, which left 13 remaining codes. One code, "affirmation of vicarious trauma," was clustered into the following two themes: "increased empathy and growth" and "negative impact(s) of vicarious trauma."

## Results: Emerging Themes

### Central Question

The following definitions of trauma and vicarious trauma were given to participants:

*Trauma*: According to the American Psychological Association, "Trauma is an emotional response to a terrible event like an accident, rape, or natural disaster" (2017, para. 1), which is reflected with a clinical diagnosis that reflects traumatic experience(s).

*Vicarious trauma*: vicarious trauma is an emotional contagion, which is a "natural, predictable, treatable, and preventable unwanted consequence of working with suffering people" (Figley, 1999, p. 41), potentially impacting seven areas of life including emotion, cognition, spirituality, behavior, personal relations, soma, and work performance (Figley, 2005).

**Eclectic theoretical approach.** All six participants identified as having an eclectic theoretical approach to working with clients. In fact, Willy identified his theoretical approach as, "That *nasty* word eclectic." He stated that he combines a person-centered approach with his new trauma focused-cognitive behavioral therapy training. Lee identified an eclectic approach stating, "I typically classify my theoretical orientation as one of a prescriptive nature. So, I pull from various theories." Vincent identified his

primary approach as person-centered, with implementation of additional reading about trauma. “I read some stuff . . . I think his name’s John Bradshaw, read some of his stuff. And that . . . kind of got my feet wet as far as some of that … just dealing with that inner.. . . . stuff.” Biff identified his primary approach as person-centered and Rogerian, although he reported that approach was not enough. “I . . . think for me it’s necessary but not sufficient.” He added, “I . . . combine the Rogerian pieces with . . . the person-centered play, the person-centered approach with . . . basically EMDR and some somatic techniques.” C. P. indicated, “I would say I'm very, very person-centered as a counseling approach. I throw some motivational interviewing in there too because I like to be real . . . solutions-focused as well.” Mark also indicated an eclectic approach:

> So, we'll use those other elements . . . in order to get them . . . to a point where they can verbalize some of it. . . . and we use those . . . various techniques and interventions to . . . try to . . . help identify some of the . . . patterns within their life.

**Majority of clients have experienced trauma.** One of the first themes identified based on all six participants’ answers to the first question was that the majority of clients that participants have seen have experienced some form or multiple forms of trauma. Willy stated:

> I've been a therapist for 3 years and I've seen children for that 3 years and in that, a large number of them have trauma symptoms or … traumatic experiences in their life. So, I feel like I work with a large number of traumatic clients.

And he added: “So it's about being prepared for that every time you sit down with a client.” Vincent highlighted this by stating:

> I would say the majority of the people that I've worked with over 18 years or so here, there's a lot of trauma involved. There's a lot of trauma. . . . and these kids not only experience their own traumas and their own vicarious trauma because of stuff that's happened with their parents or other family members or something like that. It's just trauma, trauma, trauma all over . . . and you know people are retraumatized over, and over, and over again. And I think with a lot of these families, that becomes part of their, how they work. You know they, they work from within the trauma out.

Lee affirmed that saying, “in order to access services at our agency there has to be a history of trauma. So, 100% of my cases.” And he clarified this by stating “100% of my caseload is trauma but probably 85% of my caseload is . . . sexual trauma, sexual abuse.”

Although C. P. does not have the years of experience that Vincent has, he also expressed that the majority of his clients have experienced vicarious trauma: “I mean it's likely the root reason why I'm seeing them in the first place and so if we're not dealing with that the correct way, then we’ve got a problem,” adding:

> I am coming up on my 3-year counseling anniversary. I have not worked with kids who haven't had trauma. I mean that's . . . I think 95% of the cases that I deal with have trauma. I mean all of these . . . to me, you tick all the boxes; an accident, rape, natural disaster, abandonment, neglect, sexual abuse, physical abuse. Yeah. I've seen it all.

Biff also commented on the large number of clients he served early in his counseling career who experienced trauma.

> I think this may be an exaggeration, but when I started my counseling career I used to say, there was a hell of a lot of parents that came in that would talk to me privately. Their kid had been sexually abused. I used to say there was 100 of them, and there may have been. There was a crap load of them.

Although Mark did not provide a specify number for his clients who had experienced trauma, he did state: "As we talked . . . several instances came . . . to mind again of probably older adolescents . . . came to me in their older adolescence, who had experienced . . . various levels of trauma throughout their childhood," relaying that most of his clients had experienced at least some level of trauma.

**Participants' experiences of vicarious trauma.** All six participants agreed wholeheartedly that they had experienced vicarious trauma. Mark, Vincent, C. P., and Biff answered "Absolutely", with Biff and C. P. re-affirming this stating: "Absolutely. Absolutely." Vincent stated "Absolutely. 100%," and "Absolutely, I have." This node was clustered into two themes that include "negative impact(s) of vicarious trauma" and "increased empathy and growth." Vincent summed up the cumulative and pervasiveness nature of vicarious trauma in his own experience, reporting:

> And really, I think part of it was . . . I mean I guess I thought technically, yeah a person could . . . there could be such a thing as vicarious trauma. But I don't know. I didn't think about it . . . it's affecting me that way . . . I just didn't. So, for a long time . . . I didn't even notice it. And I think when . . . well, over time

> especially, I began to notice it. And when I had some major things happen in my life, then I realized. And it was pretty obvious then . . . at that point.

Affirming the cumulative nature of vicarious trauma on his life, Lee said:

> [O]ne of the most . . . profound cases at work was that of children who witnessed . . . their mother's . . . strangulation. Dad strangled mom in front of the kids who were three and five at the time. . . . Dad then took . . . the children and mom's corpse to his place of employment where he dismembered mom in 138 pieces. . . . as the children's therapist, . . . the children disclosed that in counseling. . . . Dad had admitted to the murder, but claimed the children were asleep . . . and as the children started to provide very graphic, very vivid details in counseling, obviously I was pulled into the criminal investigation and the prosecution. . . . that was a situation where not only did I have to go to . . . The children were from another state they were placed with an aunt here locally, so I had to go to the other state to testify. . . . [P]ersonally, it was . . . feelings of physical exhaustion, mental exhaustion, changes in my sleeping patterns, I believe I dropped 25 or 30 pounds in the month surrounding the trial . . . personally . . . it impacted my appetite . . . and it was all relative to the case at hand. . . . To add to that, there were several other difficult cases that I was working on around the same time. So, it was very much a cumulative effect.

Lee added that he had experienced additional negative impacts of vicarious trauma:

> I think it's an experience that . . . we can pretend that . . . we leave it at work. Or we can pretend that . . . the more we practice, the better we are. But the reality is .

> . . it always affects us. So yes, I think about clients after hours. . . . I have had situations where . . . I've desperately needed to take a vacation, utilize my supervision as a means of self-care . . . again, working with the [place of employment], 100% of my caseload is trauma but probably 85% of my caseload is . . . sexual trauma, sexual abuse. So, . . . I'm working with pretty . . . tragic cases. And at times I can find myself getting more irritable when I leave work, more . . . feeling very drained physically and emotionally.

When asked what it means to him to experience vicarious trauma vicarious trauma, Lee stated:

> I think what it means to me is . . . it kind of serves as a really a warning . . . sign. . . . much like the lights on the dash of your car. . . . you need to check your engine. You need to . . . take care of yourself. . . . I have to be very honest. There was a time in my life I remember going to a training very early in my career and they talked about vicarious trauma. And . . . the presenter said every day before she leaves the office she does something that's symbolic of her day . . . as a preventative technique. And I remember thinking to myself, "that's the corniest thing I've ever heard of in my life." But I can tell you, every day before I leave the office now, I do something symbolic of my day. . . .So, vicarious trauma, the meaning to me is really . . . I have allowed things to go a little too far personally and I need to monitor that. I need to implement some self-care strategies if I'm going to be effective to the children that I serve. . . . I have to take care of myself.

To normalize vicarious trauma, Mark made the point,

> No, not at all. (laughs) I don't think that you can experience these things with these children and . . . not be changed. . . . [A]nd if you do, . . . go find some therapy for yourself because something is seriously wrong with you.

In the same theme, C. P. stated,

> [A]nybody that has seen trauma go off in a kid's eyes . . . you see it . . . you see . . . their pupils narrow, and they're looking around, they don't know what's going on or what to expect; man if that doesn't shake you I don't know if you're human.

Willy also normalized the impact of vicarious trauma in his own life, stating:

> You know that you can't hear these stories and not have some amount of… some amount of trauma yourself because you are sitting around picturing this and going through this with this person and seeing their pain. So, there is some amount of vicarious trauma, whether it's a small amount or a large amount depending on the story. So, there is some of that in there.

Vincent normalized vicarious trauma as well, saying:

> For a long time, for years, I really didn't think it was affecting me. And not that one day I woke up and decided that I wanted it to affect me . . . but yes, it was affecting me. And I guess I just felt that this was all . . . I mean this was part of it. This came with the job.

**Increased empathy and growth.** One of the themes that became apparent during the phenomenological interviews was the idea that participants gained empathy and grew professionally because of experiencing vicarious trauma.

Willy stated it several ways: “I guess I have become a lot more empathetic and sympathetic to kids and a lot of the things that they go through.” He continued the thought later stating:

> For empathy, for showing them the proper emotional response yourself as to how they should be responding as role-modeling. So, at the same time I try not to let myself go overboard. There's sometimes I almost feel like I need to sit here and cry with this kid, but at the same time I have to keep myself in check enough to be able to continue the session.

He added:

> processing of an emotional event, because you need to have some emotional connection there. So, I've had to work on myself to be able to kind of allow some of those feelings to come in. And when I do get to those really emotional points with them, I have to let myself go ahead and feel some of that in order to understand where my client is. But there's kind of nuances in there that you have to experience some of it with them.

Biff identified his own growth in the form of seeking additional education and training to empower him to work with children who have experienced trauma in a more effective way. “…you know as far as work performance it makes… that one thing that really stands out because I feel like it pushes me to try to become the better clinician, to work harder to be able to understand and work with those clients and gain more knowledge and more abilities to help them as best I can.”

Vincent also talked about learning empathy for clients and growing through experiencing vicarious trauma by stating:

> If a person . . . if a therapist comes into this business and doesn't become more open-minded with each year and with your experience. . . . It has opened me up and made me so much more of an accepting person. And accepting of other people. So, it really helped me. I think it opened up my understanding more to people.

Mark discussed not only gaining empathy, but also discussed his personal and professional growth to meet the needs of his clients who had experienced trauma within the context of his Christian faith. He said:

> [H]opefully I'm meeting every client at that point of need. And assessing their situation, not through the lens of what I believe, but through what that client needs. I think that that's a Biblical example of how Christ meets us because we're met at our point of need, but what we receive is what we need at that time. And I think that these situations I've experienced, and a situation any counselor experiences, should change how we approach our theory and our beliefs.

Lee simply stated: "I am much more attuned to life events," and then added:

> To a certain respect that has changed. It's changed in the sense that I've seen many survivors of trauma, they are so resilient that my belief is that children can, . . . I don't want to use the word overcome, . . . but children certainly can cope with some very difficult circumstances. And I think that turns to … the belief in one

> state. I think that turns to the belief in family values. . . . so yes, I would say that's impacted my belief system.

C. P. also had an optimistic view of growth through experiencing vicarious trauma to be able to help his clients. He stated:

> I think when you deal with somebody who has a lot of trauma, I think it's really important that you're able to.. . . . stay with them. . . . They can say whatever they want and you're able to stare right back into the face of it and be like "it's not shaking me. I'm still here. You're not going to run me off." So, I think it's really important that I be 100% genuine, I be 100% in the moment, I be 100%, sort of unflappable because they need somebody who's 100% stable and I can be that person for them and I'm happy to do that.

Biff made the point that:

> One piece of it is with children, really when you watch a child face down stuff that's happened that would freak out 20 Navy Seals or Special Operations truly, and take it on, . . . like when we did the Burger King method of EMDR when we let the kid pick targets. They picked the worst thing and often that would be the worst thing you could imagine happening to a human being. And they have the energy, the chi, the whatever to do that. That really says something that goes well beyond words.

Biff also discussed that he has grown through experiencing vicarious trauma, and watching his clients overcome their trauma, stating, "I think it also gives me. . . I think it also lets me really . . . understand . . . more about the resilience of human beings, and

more . . . about the . . . innate capacities." He continued to express how grateful and honored he feels to be doing the work of helping children who have experienced trauma to resolve that trauma and move forward with resiliency.

> But all this negative stuff's coming out in working with them and that crap goes out of them, and they can basically be who they are and express their gifts. That's one of the things that is really cool about working with trauma. And one of the greatest gifts to me is when you take that stuff out of them. Well, for the kids when the shit melts away, then you've got the gold. That gold starts coming pretty quick, but positive stuff starts becoming apparent pretty quick. That's a really beautiful thing to observe. Is to observe somebody that's unencumbered by the crap that's typically there in life that's happened…that's been put there by overwhelming things and you got the gold. Doing trauma work is effectively turning the lead into gold or you see the gold. You're not telling them, "that's your gold" you know, "you can jump high, you're artistic," kids know. Kids know. They feel that. It becomes apparent. They feel like that's out of their way now. So, it's not like feeling grandiose about this, it's just feeling really, really lucky and really, really good to have been able to do stuff like this in the world.

Biff additionally made the point that although working with children who have been victims of trauma is "difficult" and even "heartbreaking," he could not imagine feeling successful in any other job regardless of the monetary success, stating:

> I look at some of them and I look at that and think "would I like to . . . look back on my life and think about whether . . . I've got 20 trucks you know, and I did 10

> million dollars' worth of business last . . . you know every year . . . or whatever." I'd rather look back and have done what I've done. I'd rather look back and have done what I've done! I think it'd really suck for me to get down to the end of my life, and you know … and not have done the stuff I've done. I just feel very fortunate to be able to not only . . . treat trauma but again . . . put the tools out there where others . . .can effectively treat it.

**Negative impact of vicarious trauma.** When discussing the negative impact of vicarious trauma, two participants had similar visual representations of a feeling of being drained. Biff reported that vicarious trauma "would feel like somebody had cut off my heels and my soul had drained out." C. P. said, "It's just like I keep filling up the bucket, but there's a hole in the bottom," and added "Maybe just like a tired feeling. Just like a worn-out . . . it's like there's no tread left on the shoes right then. You know like it's all worn out." Lee also used the "feelings of physical exhaustion, mental exhaustion."

The intensity of that feeling was best described by Biff as, "It just literally just does things to my body, my spirit, my soul that . . . were just amazing in the intensity of it. It defies rational logic. It defies . . . my ability to explain it," and he goes on to add:

> It's almost like you know the energy, there was some sort of energy that passed . . . with it. Or it could be mirror neurons lighting it up, I mean it's a physiological explanation, but it just feels like . . . feeling awful, feeling terrible . . . it felt like I had died.

C. P. added a component of the amount of time that one interaction with a child describing extreme trauma can last for him, stating, “And that's just something that sits in the pit of your stomach. And it just kind of . . . lingers there for a couple of days.”

Willy and C. P. spoke about the attachment they feel toward their clients and how that impacted their experiences of vicarious trauma. Willy said, “I could say . . .how emotional it becomes more difficult to hear those stories as you become more emotionally attached to those clients,” and C. P. mirrored that sentiment:

> I get attached to these kids very quickly. …I've been in situations where I can see a kid, the trauma was being re-lived in their eyes and . . . I've canceled people coming over to the house because it's like I just can't do it tonight. . . . I need a little time for me. I need a little time . . . but it sticks with you a little bit.”

**Help-seeking behavior.** Only two participants said that they ever sought help for dealing with the symptoms of vicarious trauma. Lee simply said: “there was a point . . . that I did seek . . . some professional counseling as part of vicarious trauma as well.” Although Mark initially denied seeking help, he later said that he often experiences vicarious trauma through somatic symptoms and he had sought help to alleviate them medically. Mark said:

> So, again it comes . . . through those physiological, the somatic . . . complaints that I'm able to identify. So, generally . . . mine usually is first sought though medical means because I'm trying to figure out what's going on. And that person goes, “Well, ok we don't see those things that you're describing as . . . a medical . . . root cause, so what else is going on in your world?” and you go, “Okay oh, well

> yeah by the way I'm . . . dealing with pretty significant issues at work this week," or maybe you need to look into that. So . . . so that's generally how I found those things. . . . So, it's been . . . where have I sought help, well many times it began with a medical diagnosis.

**Denial of help-seeking behavior.** One theme found in four of six interviews was denial of having sought help even though they said that they had experienced vicarious trauma. Biff simply stated, “No, I haven’t gone and done work on it.” C. P. also answered very simply “No I haven't.” He later added:

> No . . . I guess to my point I was saying I feel like I handle it pretty good on my own. If that ever becomes not the case, then I've got no issues with seeking any type of help, but I think it would be tremendously helpful for me to do that.

Almost all participants did verbalize that they would not oppose seeking help, they just have not yet sought help. C. P. also stated:

> And so, I'm very open to it, but I guess not open enough to actually do it (laughs). I think it would be very helpful for me in a lot of situations, but as far as work-based, I don't think I've ever seen it as necessary.

C. P. also gives the reason he feels that he has not sought out help:

> I think that the reason I don’t have to go for help is because I have an excellent supervisor. I have an excellent support group. I have a really strong relationship with my wife. I have a really strong relationship with one of my brothers. I have a really strong relationship with my parents, and my family, and my supervisor, and I feel like when you’ve got all those people propping you up, it’s hard to get

> down. . . . and so just as I would tell clients, "man, your support system's got to be huge in all of this. And I think that's the same way with vicarious trauma."

Willy reflects those sentiments, stating, "I don't guess I have sought help for myself at this point. I see where it could eventually become a compounding problem of just dealing with it on a daily basis." And he added, "So I see it being something to definitely be aware of but have not sought it myself, not necessarily at this point."

Although Mark verbalized seeking help for his somatic experiences of vicarious trauma, he had more to say on the reason he had not sought emotional help for his experiences with vicarious trauma:

> I think all that again comes back to us as therapists, is that we do not necessarily . . . deal with those situations as they come in our own lives. . . . because of time and resources. But two because, you know, we do think that we are Captain America at times and, we can handle those things. And as a male therapist we probably are more guilty of that, . . . just simply because of that . . . ego and macho-ism. You know, where we're capable of dealing and don't necessarily have to seek that supervision or consultation . . . because of that. But that's why I, probably why, I've chosen . . . an informal consultation more than anything is because . . . I feel better about talking about it within community . . . rather than saying "um, yeah, I need formal help to deal with this" . . . supervision is a formality where uh, coffee is a little bit easier for me to accept for myself.

Vincent additionally stated: "No . . . I haven't. I've thought about it though. I've thought about it and maybe, maybe at some point I will." And he clarified:

I'm not above it, opposed to it, and . . . I'm very much for it. If . . . I felt like it was impacting me in several of those areas more frequently than it needed to be, and it was really affecting some stuff I would totally run it out, I would totally seek it.

**Additional training.** One of the themes that all six participants identified in their interview was the theme that they each sought out additional training to work with children who have experienced trauma, as they felt that their initial education and training were not adequate to meet these children's' needs.

Vincent did not specify his approach other than "person-centered," but then he added "minimally directive," and asserted that he "read some stuff" about trauma as well as about "the inner stuff." He also learned more about how PTSD and how trauma "affects . . . just regular people."

Lee summed up his experience by saying:

> I would love to tell you that I had . . . some wonderful training in graduate school but . . . ironically . . . the first job that came open . . . after graduate school was as a child therapist. And I mean, I don't want to downplay my graduate training, but a lot of my training came really on the job. . . . turning to other clinicians, seasoned clinicians. . . . I'm also one that . . . really . . . likes to kind of immerse myself and do research, so I attended a lot of trainings, read a lot of books, read a lot of research articles, . . . and of course working at [place of employment] . . . that is our specialty in working with traumatized families. So, we definitely take advantage of training opportunities; . . . implementing those in the clinical practice.

He added that he had additional training specifically for children: “I'm a registered play therapist supervisor . . . So, . . . there's a lot of really great research.”

Willy stated this succinctly, “So as I got into practice, it became more of an idea that I needed to get some extra education to help me with it.” Biff related that he completed a voluntary internship on his own before he completed his master’s degree, as he felt unequipped to work with children.

> I did that . . . internship post-masters because I wanted to learn how to work with children, specifically. There wasn’t the opportunity to do that before I graduated . . . you know, before I’d completed all the requirements.”

C. P. was more pointed in asserting that graduate education did not prepare him for working with children who have experienced trauma in these ways. He said, “I mean there's all kind of trauma-related stuff that you'll go over in school and I mean I could probably list you classes, but in my opinion, I think you learned very little in school that actually applies to doing counseling. But, sure I had classes, but I don't . . . give much credence to those.” And he stated, “I wouldn't say that I learned anything in school that helped me to be able to empathize with a kid that was talking about being raped.”

Mark had similar feelings of needing additional training after his master’s degree. He said:

> I would love to say I came out of grad school with my exact . . . theory and that . . . it's exactly what I stick to on a day-by-day basis. Well, that's bull and I am constantly evolving the theory . . . based on new research, based on new intervention methods, … based on individual clients. . . . hopefully I'm meeting

> every client at that, that point of need. . . . and assessing their situation, not through the lens of what I believe, but through what that client needs.

He made the point that he has continued to learn, stating "So the majority of my training came through that time. Everything outside of graduate school came through continuing education credits . . . or just reading and using specific interventions." To clarify, he said: "And then of course, continuing education units. . . . and then individual research. Mainly . . . and most of that came as a direct result of needing a specific intervention to deal with . . . a specific case."

Willy also asserted that he recognized his need for additional training from meeting his very first client. "And so, my very first time to meet somebody I was thinking I was going to have a 5 or 10-minute quick conversation to introduce myself and I ended up having a 30-minute session just to make sure they were ok before I let them go. So, in a way it kind of jarred me into that reality of "you've got to prepare yourself for this constantly." He related, "So as I got into practice, it became more of an idea that I needed to get some extra education to help me with it," so he sought specialized training to work with children who have experienced trauma: "Then I've also had my EMDR training and I'm working through my TF-CBT training right now."

Biff also sought additional training in order to help his clients:

> I started thinking I really want to work with children. I think one of my friends was an intern with Dorothy Mercy doing Play Therapy. And . . . I thought you know I really want to do that because maybe if you intervene early you could . . . prevent all the balling up, the harm, the negative events that kept cascading.

Willy said, “I got trained in EMDR and it’s like ‘ok it’s night and day,’ . . . and I thought ‘wow, I wish I had had this when I was doing play therapy.”

**Coping skills.** Another theme that was identified early in data analysis was that of participants implementing coping skills to alleviate the impact of vicarious trauma. C. P. identified self-care as one of the ways that he implements coping skills, giving this example: “I feel like I am pretty excellent at self-care. It's one of the things that I'm really good at.” He gave examples of coping with the impact of vicarious trauma including, “I've canceled . . . people coming over to the house because it's like I just can't do it tonight. I need a little time for me. I need a little time,” and “I think it affects me when I get home. I mean I . . go home and I'm just like let's . . . turn on the Xbox. Let's go. I need to go.”

Vincent pointed out that the impact of vicarious trauma on him depends on the other aspects of his life, mentioning:

> Depending on the day, I handle it better some days than I do others. So, on those days when I'm feeling it, and it’s really kind of hitting me.. . . . I do kind of step back and say “What the heck? What’s, what all, what else is going on?” you know. It's usually . . . you know, I can usually tie a few things into . . . what's happening. So, if things are chugging along pretty good and it happens. . . . I want to be aware of it and, and then kind of check it from there type thing.

Willy gave two ways that he copes with the deleterious effects, which include, “I sit down and process it, go through it and allow my sick sense of humor to kick in a little bit,” and he added:

> When it's warm enough and dry enough, it's roll down the windows on the truck and turn up the radio on the way home. It's . . . those different self-care aspects. You know, sitting in the back yard and listen to some music, and hang out, and visit with the family, and just enjoy those times. That's the self-care that comes in to kind of get through those kinds of things, so there's . . . a lot of things that go into that.

Mark mentioned the added value he finds in his family, which he sees as a way to cope:

> I . . . think you would hear just about anyone say you go home and you hug your children tight or on those nights that you have to deal with that. You spend a little more time specifically dealing with, family situations in those moments. . . . at times the harder ones, you use a recovery process for you that is greater. You . . . need that moment to come home, . . . and to wash the day off of you and . . . to engage differently with your family after that.

Mark also mentioned his faith community and his Christian faith as a source of resiliency to cope with aspects of vicarious trauma:

> [t]hat I'm able to identify those things and actually take it to a step where I can . . . begin to work through those. . . . whereas.. . . . in my belief system if we were working with the community, and for me it's the Believers, even if I'm not talking to them about those specific aspects of my professional life, … there are things that I'm doing naturally through my own self-care to help rebuild that . . .

> resiliency on a daily basis so that these things impact me less. Now I didn't say they wouldn't impact me, I said they impact me less.

Lee also discussed his use of coping skills:

> I really try now to do a lot of proactive self-care. . . . even if I have family members or . . . friends that . . . want to talk about … pretty traumatic things. . . . My viewpoint is, if I want to hear awful things, I'll go to work. . . . that has certainly changed.

**Supportive supervisors.** Having supportive supervisors was one of the themes that continued to be expressed among participants; with all six verbalizing positive experiences when working with supervisors. C. P. gave the most positive affirmations of working with his past and present supervisors by initially stating, "I had a great supervisor. I have a great supervisor now who is always willing to staff any cases." Then he clarified this by saying:

> My current supervisor and the one before, have been phenomenal at me being able to come into the room and just unload a lot of negative emotions. And then being able to sit with that and say, "Okay you just, just vomited all those negative emotions out into the room. Do you feel better now?" And typically, I do. So, them being able to sit with that. It's been great.

He went on to add "How do you seek supervision and consultation? I go straight to my supervisor. . . . really, really, super empathic, really, really compassionate, . . . good rapport with her, so anytime I need something . . . that is where I go. Straight to her." And when he seeks supervision, his experiences have been excellent. He stated:

> I email, and call, and text my supervisor . . . she is absolutely wonderful at being able to sit, and hear what I'm saying, and give me the perspective of somebody who is outside of that situation and able . . . and peering in, and going in, and going, "This is what you're telling me. This is what I'm hearing. These are the things that I know. Have you thought about it this way?" and, she . . . another thing is, she really pushes . . . self-care as well.

Mark also experienced positive interactions with a supervisor when he was first practicing and continued with this relationship, reporting: "But early on I would go back to my supervisor . . . and talk . . . with her. . . . even after receiving my full licensure. . . . So, I sought out that supervisor."

Vincent also reported positive experiences with supervisors:

> It's generally pretty, I think pretty receptive, . . . for the most part. It's never "Oh well you should know . . . you should know how to deal with that, or you should know how to handle . . . that." I think you know it's generally . . . pretty good. It's been a pretty good experience.

The lack of negative interactions with supervisors in the past seems to be more the focus of Biff's experiences with supervisors as he pointed out by saying:

> You know, it's been really good. Nobody's ever told me . . . I'm just gonna be frank. . . . nobody's ever been a dick to me. Nobody's ever been a . . . an ass to me. . . . if somebody's putting out stuff that . . . I just don't think, "That doesn't quite fit." That . . . just doesn't seem to be a really bright camper, I just probably don't go . . . talk to them again.

Willy also had positive experiences with supervisors, stating, “I have a wonderful group of supervisors around here,” adding, “So it comes out as a little bit of everything as far as how they help me walk through some of these things.” And he finally stated, “Most of the time it's very positive . . . the supervisors I have around me.”

Lee identified that he currently has a good supervisor:

> Well, I'm very fortunate … currently my director is a colleague that I have known for 25 years. . . . she and I have worked in . . . various . . . jobs . . . that we worked in community mental health together, so I've known her for some time. . . . she's very, very supportive.

He added that in his “current role it has been . . . very beneficial. . . . as I said, my director is one that is very, very supportive.”

**Peer consultation.** Four participants identified implementing peer consultation as a way to work through the trauma of their clients and to prevent or decrease the impact of vicarious trauma. Vincent briefly commented on the need to consult with other professionals who have also worked as a counselor for several years, as they have had similar struggles: “Just talking to other . . . clinicians that have been around here for a long time, you know.” Biff was more specific in why and how he seeks consultation, asserting:

> I’ve got several folks who are considered experts in their field that I’m lucky enough to know . . . many of them with connections in the EMDR community and serving on a humanitarian organization’s board for a long time. . . . If I really

> want to ask something, I can . . . or connect with somebody I can . . . get consultation.

He additionally stated:

> I think we both, the folks that I seek consultation with . . .it's a mutual experience. I mean we're not like doing a tally: you're 51%; I'm 49 . . . but I think there's a good give and take in that we seek each other's counsel, that we know we can approach each other and it's a valuable part of what we do, I'd say.

Mark also discussed how and why he seeks consultation as a part of his help-seeking choices, stating: "But that's . . . probably why . . . I've chosen . . . an informal consultation more than anything is because . . . I feel better about talking about it within community than saying, "I need formal help to deal with this," And he clarified by stating:

> [T]hen secondly . . . was kind of again . . . processing through with the . . . more informal … relationships with other therapists . . . across the spectrum . . . of professionals. Not just licensed professional counselors, but across the spectrum. . . . and having those . . . opportunities to sit down and process that.

Lee also has sought informal consultation stating, "Well informally I have certainly . . . sought help through supervision, through peers, through colleagues. . . . and that's proven most recently to be very, very beneficial." And he added:

> I also have other colleagues outside of the field and . . . sometimes I'll just make a phone call and say, 'hey . . . do you have time for lunch?' Really needing just to . . . blow off some steam. I also have . . . standard supervision, formalized

> supervision but my director is also available even outside of that. So, I am not shy about initiating that.

**Supervisor role.** One theme that was identified for participants who have several years of experience as counselors as well as a specialization to provide supervision to newly, provisionally licensed counselors was one of enjoying and benefiting from the supervisor role. This was noted by Mark and Vincent as one of the ways that they can reduce vicarious trauma. Mark spoke about his ability to process difficult cases with his supervisees:

> I am a LPC [Licensed Professional Counselor with a specialization in supervision] supervisor in Texas, so I will meet with my interns weekly to provide their supervision. . . . so much of what I've done is as far as the supervision side is, I will present them . . . a case that we work through together. . . . And many times, whenever I'm dealing with something difficult … it's best for me to process through it . . . with them. . . . not in a way to say "Yeah this is my therapy. Let's, let's do this together." But in a way to work through and . . . verbally process this all together in a group.

Mark also identified a third way that he seeks help: "And then . . . that third is . . . using that within . . . how I approach my interns from a supervision perspective to be able to talk through and . . . have . . . those moments of . . . looking over cases and . . . discussing those together."

Vincent identified the role of supervisor as a way of his seeking additional support:

> I am an LAC [Licensed Associate Counselor] supervisor. So not saying that I can get some supervision there, but what I will say is since I've been doing that; I've been doing it for I guess about 5 years or something like that, the supervision part of it. . . . So, since I started doing that . . . I think . . . it's helped me. What has helped me is hearing and seeing how it … really does affect people. And then being able to reflect on my own thoughts and . . . of course, you know in supervision I can throw in stuff too. I mean that's helpful too.

**World is unsafe/People are bad.** One of the primary themes that five out of six participants identified as cognitive changes due to vicarious trauma was the idea that the world is unsafe, and that people are bad; particularly for children. Lee said:

> It has also changed my worldview . . . in the reality of just how prevalent trauma is. . . . another example . . . my mother just recently with the . . . case of the . . . U.S. Gymnastic teams' physician that was . . . charged with sexual abuse. . . . I had a conversation with my mother and . . . my stance was . . . I understand that this is very horrific, but you also have to understand that this happens every day. . . . I think as . . . just the average citizen we only hear about those high-profile situations. When you work in the field of trauma you certainly become much more aware that trauma is unfortunately . . . a very real and very frequent event in the lives of children.

C. P. identified the main change in him as normalizing poor parenting:

> I've . . . lowered the bar for competent parenting...A lot. Because what I see on a daily basis is incompetent parenting. And so, when I see . . . the mom who isn't

> handling the kid in Walmart, . . . that's throwing a fit, I think there was a time in my life where I would've been like, "What a terrible parent," you know? "What a terrible parent. I can't believe that they're . . ." you know, whatever it is. But now I go, 'Well, they're probably not involved with DHS. She probably hasn't beat that kid." And so, I think that my (laughs), my bar for competent parenting has been lowered quite a bit just due to, I'm . . . inundated with it, you know. That's all I ever see, so when I see something that I feel like is wholesome or just average, I'm just like "Yeah, that's good stuff!" You know? "I can live with that."

Willy also said that he has a new suspicious nature toward parenting as well as an overall feeling of being jaded: "I've seen some of that already; become very maybe jaded on some of that." And later asserted:

> So, those two for sure, personal relations and behavioral.. . . . you know, in some ways maybe they have because you start to get suspicious of people you see. You see someone in the grocery store or disciplining their kids, you start to 'hmm have they, are they abusing that child or not?" Or "What kind of a parent are they outside of this situation?" . . . those kind of things. You start looking at those things; maybe even with your friends, maybe just acquaintances, or just that person you see in the grocery store with the kid that's going crazy because they want that thing in the store.

He then generalized more to the nature of the way people treat children, just in the world:

> [B]ut from the way I see the world, I understand there's a lot of bad things that happen in this world. There's terrible things that happen to children. I have seen myself become a little more aware I guess, of what goes on, and understand that there's a lot of people out here that . . . their . . . entire world revolves around what evil can they do to their child.

Mark took a more theological approach to the cognitive changes in him due to the impact of vicarious trauma. He said: ". . . You know how you view man both from a theological perspective of a fallen man, but . . . also a level of trust . . . as you look at other situations." And then he further went on to specify:

> We think that we're stronger than we are in many cases and … it impacts us negatively because . . . we do tend to question God in those moments and say, "Why is this what it is?" . . . Especially with children. . . . Because we don't want to believe that man is capable of the types of things that we deal with on a daily basis . . . and even though we don't believe we could ever be surprised, there are often times where we see . . . man at . . . an even lower state.

Biff also said:

> I think that's . . . something that . . . we just are not aware of in life. Just the . . . depth of harm. It's kind of like . . . when this kind of stuff happens, the pervasiveness of that when you really start understanding . . . this is not like one in a million. This is . . . one in three or whatever.

He added:

> But with children I think it told me the world was not as … it exposed me to things, that . . . the world is not like we think it is. . . .You knew once you've been exposed that, you never would go back.

Biff went on to ask similar questions of God as Mark: "My God, how can humans . . . do this new way . . . find this new way I'd never even though about hurting other humans?" And went on to give an example of the vicarious trauma:

> I think the main way I experience it is, "How can I live in a world like this where this crap happens, and we do a shit job of protecting the children? We blame them, we . . . don't believe them. We don't protect them. We just do a shitty job of protecting them." And we do… in the past we've done a shitty job of . . . taking that trauma out of them. . . . part of that is . . . when we're looking at the systems issues with it, or the failure to protect, it's like watching a . . . station wagon full of kids on a train tracks, waiting to get hit by the train over, and over, and over again.

Biff additionally stated:

> I just know from doing this that . . . there's just a whole lot of bad in the world. And that you can't tell who's bad. People who are really bad probably look like better than the people who are good. Honestly. And . . . really in terms of people harming children or harming others that … people who do that shit . . . find all sorts of ways to protect themselves and make the other people look like shit. You know, . . . pathologize them, so . . . it's not a . . . really not a world I want to live in. You know it's not . . . a world anybody would want to live in.

Biff finally asserted:

> I think the last piece of that is just . . . means moral failure . . . we say we value children but . . . we make kids as property, kids as less than, kids as a pain in the ass, kids as stuff for, you know, someone we don't think about a lot even though, . . . on the one hand . . . we love them more than anything and we'd throw ourselves in front of a bus. But on the other hand, pragmatically day to day, folks that are hurting them, the experiences that hurt them, we just don't have a real good handle to protect them before it happens unfortunately.

**Increasing knowledge.** Two participants identified the increase in knowledge over the past years in professional counseling regarding traumatology and how to treat those who have experienced trauma. Biff pointed that out:

> [R]eally there was so much we didn't know . . . I didn't . . . I'm sorry, I didn't know, and we didn't know because traumatology wasn't covered. And it was just like a freaking desert. I mean, I . . . had the feeling that Developmental Psychology or the developmental theory we were studying was just like Beaver Cleaver stuff, it didn't cover what happens when overwhelming events occur. I tried to discuss that with professors and say, "You know I really think there's a difference here. I really think there's a different thing going on." And they either basically thought I was nuts or, just . . . looked at me like I was crazy. They did not understand.

He added:

> When I first started this quest, it was like . . . we had an emergency room that . . . the only thing they could do was put a band-aid on it. You know, I mean we had no effective treatment for all this other stuff, and there is effective treatment now. So, I guess that . . . both gives me hope and also gives me a mission to … why don't we use these effective techniques we know instead of just like being like the old school days of: "We cannot treat trauma. . . . We don't know what it is. It doesn't exist."

Vincent also asserted that information is increasingly becoming available to treat trauma:

> Luckily, thankfully, there is so much more information starting to come about . . . trauma in general. And, . . . about how trauma affects . . . just regular people. And it is very much the same thing because it produces the same physiological responses in people. . . . you can have a woman here who has never come close to anything military or warlike or anything, has the same physiological responses to another woman who's been in the middle of . . . battle and that sort of thing. And it is the same thing and just understanding the impact. The impact on people's lives and . . . their other mental health issues whether they have depression or some other anxiety or . . . developing a personality disorder because of it and all that sort of thing.

## Evidence of Trustworthiness

Within qualitative research, researchers can achieve trustworthiness by implementing verification strategies during the research process (Miles et al., 2014). For

research to have credibility, dependability, and confirmability, the researcher must apply protocols that include several verification strategies that build upon the other to ensure rigor (Maxwell, 2013). In this study, I implemented strategies that ensured issues of credibility/validity, dependability, transferability, and confirmability.

**Credibility/Validity**

I used several approaches in my study to increase credibility. First, I recruited six participants, which research has indicated increases confidence in my findings (Miles et al., 2014). This approach also enhanced the trustworthiness, stability, validity, and precision in that I followed a replicable strategy to increase the credibility of my study (Miles et al., 2014).

Second, for member-checking, I emailed each participant a copy of a summary, which I wrote of his interview to review for precision, and as an opportunity to provide clarification, correction, or confirmation of that summary to enhance credibility as suggested by Maxwell (2013). As previously identified in this study, I conducted member checking following data collection, analysis, and identification of themes. This was done to ensure that transcripts from interviews were accurate. I accomplished this by emailing each participant a summary of study findings that included the themes that emerged during the data analysis and asking for feedback regarding the accuracy of the transcript and interpretation, as well as the veracity of these findings. In this email, I also invited participants to confirm, clarify, or correct any information they felt would enhance an accurate reflection of their experiences or to add information they felt was important. Two members responded by email and four members responded by phone.

All six members confirmed the accuracy of the quotes and agreed that the interpretations were an accurate reflection of their experiences.

My third approach to ensuring credibility was to establish my openness to hearing information that may contradict or exceed my beliefs, experiences, or opinions regarding the phenomenon under study through disclosing my biases. I completed this step before the data collection began as suggested by Creswell & Miller (2000). This validity procedure has been called "researcher reflexivity" (Creswell & Miller, 2000, p. 128), and this process allowed me to disclose my assumptions, biases, and beliefs, that could influence the data collection and analysis.

**Dependability**

I implemented IPA to apply Heidegger's (1962) philosophy to my data analysis. I used this to enhance consistency in the research findings and ensure dependability. I followed this approach by identifying all preconceptions throughout the reflexive process of the study through an emic perspective (Finlay, 2008). Ricour proposed five analytical stages that support hermeneutical circular interpretation, which include "distanciation, appropriation, explanation, understanding, and interpretation" (Horrigan-Kelly, Millary, & Dowling, 2016, para. 30). These stages empowered me in the roles of researcher and co-interpreter to remain unrestricted by bias and avoid premature interpretation (van Manen, 1997). Additionally, I applied the CSDT as a lens through which to analyze and interpret the raw data I collected. CSDT is a framework that can be used to assess aspects of individuals' self, based on self-capacities, cognitive schemas, and personal history and then interpret their current lived experience (Trippany et al., 2004). I applied

this framework to interpret participants' lived experience of providing counseling to children who have experienced trauma.

**Transferability**

I conducted an exploratory, descriptive research study using interviews, which Maxwell (2013) asserted enhances deep rich data that improves transferability. Tracy (2010) agreed with the use of thick description as enhancing transferability based on the use of first-hand, direct testimony and then transferring participants' experiences and stories to a broader population. The assumption that is central to my research study is that my participants' experiences distinguished in my study would be like others in the identified population and that a researcher implementing this approach to the same population would yield similar themes. The outcome of communicating my participants' stories to a larger population is called "evocative storytelling," which Tracy (2010) asserted is an effort to evoke an emotional response from the reader. By using thick, rich, descriptive data I attempted to elicit an emotional response from my study's readers to resonate with the lived experiences of male counselors who primarily work with children who have experienced trauma.

**Confirmability**

To establish confirmability of this research study's findings, I implemented two strategies designed to ensure that the data collected was free of researcher bias and was neutral. The first activity was to use several methods to seek participants using purposive sampling on a social media page, asking a contact at the ArMHCA to email a request for participants from the list serve, and through using snowball sampling. This yielded a

geographically diverse participant pool from three states that included Arkansas, Texas, and Ohio. This was not initially identified as a goal to improve confirmability, however it did create additional themes and contribute to the richness of the data. For example, Mark from Texas added information that allowed me to use two themes that would have only been discussed by one other participant and therefore, excluded from use in this study. These included "Help seeking" identified first by Mark and supported by Lee, and "Supervisor role," initially discussed by Vincent then supported by Mark.

Additionally, I used quotes from each participant to support each theme I identified. In several instances I created themes based directly from a word or phrase used by a participant and then echoed by additional participant(s). Other times, I created a theme according to a denial or affirmation of an experience that was verbalized by participants, and then I expanded or clarified that theme based on each participant who also affirmed or denied the experience. I was able to ensure confirmability by including raw data as quotes to support my choices of themes.

## Summary

In Chapter 4, I summarized the results of my qualitative hermeneutic phenomenological study on the lived experiences of male counselors who primarily work with children who have experienced trauma. Based on the themes that emerged, I found that male counselors reported that they had experienced vicarious trauma due to their work with children who have experienced trauma.

There were some positive outcome themes that surfaced such as gaining empathy, seeking additional training, and recognizing the progress that has been made in the field

of traumatology. There were also several negative outcome themes that were identified. These included symptoms within all seven areas of life that were identified previously in the study, which include cognition, emotion, soma, work performance, behavior, spirituality, and personal relations.

Additionally, more specifically within the emotional and spiritual areas, the theme emerged that the world is unsafe, and people are bad, particularly to children. This specifically speaks to the pervasiveness of neglect and abuse that adults inflict on children that makes people bad and the world unsafe to children. Participants also identified building or implementing coping skills to deal with the impact of vicarious trauma, including seeking consultation, self-care, spending more time with family, and spending time alone such as driving alone with the windows down listening to the radio or playing video games as a single player.

These themes ultimately became the answers to this study's central question and will serve as the foundation for Chapter 5. In the next chapter, I will interpret the findings from this study by analyzing them through the lens of the CSDT, which was the conceptual framework that I posited in Chapter 1. I will also describe the limitations of this study as well as recommendations for future research. Finally, I will discuss the potential impact of this study for positive social change as well as recommendations for applying the results of this study to counseling or educational practice.

# Chapter 5: Interpretation

## Introduction

The purpose of this qualitative hermeneutic phenomenological study was to explore the lived experiences of licensed male counselors who primarily work with children who have experienced trauma. I sought to understand perceptions that male counselors had regarding experiences with symptoms of vicarious trauma in areas such as help-seeking, supervision, and learning to work specifically with children who have experienced trauma. I conducted this study to fill a significant gap in the literature related to how male counselors experience hearing the trauma of their child clients. Understanding the experiences of these men and the meaning attached to their experiences was necessary in the development of evidence-based therapeutic and educational interventions for male counseling students and licensed counselors who work with children who have experienced trauma.

I conducted this study by implementing a qualitative hermeneutical phenomenological methodology. I recruited six licensed male counselors who primarily worked with children who have experienced trauma. All participants were American citizens and most of the participants were from Central Arkansas, but the group included one participant from Texas and one participant from Ohio. I used a semistructured, qualitative interview process to collect data for this study. I invited participants to share their stories of working with children who have experienced trauma, and to explore how these experiences have impacted seven areas of their lives, including (a) emotions, (b) cognition, (c) spirituality, (d) behavior, (e) personal relations, (f) soma, and (g) work

performance, based on views of Figley (2005). I transcribed all the interviews and then entered and initially coded the data collected using NVivo software. After performing rigorous data analysis, the data resulted into the development of the following themes: (a) eclectic theoretical approach, (b) majority of clients have experienced trauma, (c) increased empathy and growth, (d) affirmation of vicarious trauma, (e) help-seeking behavior, (f) denial of help-seeking behavior, (g) additional training, (h) coping skills, (i) supportive supervisors, (j) peer consultation, (k) supervisor role, (l) world is unsafe/people are bad, and (m) increasing knowledge.

Table 1

*Themes Experienced by Male Counselor Participants*

| Identified theme | % of participant responses | # of participant responses |
|---|---|---|
| Increased empathy and growth | 100% | 6 |
| Affirmation of vicarious trauma | 100% | 6 |
| Denial of help-seeking behaviors | 100% | 6 |
| Supportive supervisors | 100% | 6 |
| Eclectic theoretical approach | 83% | 5 |
| Majority of clients have experienced trauma | 83% | 5 |
| Additional training | 83% | 5 |
| Coping skills | 83% | 5 |
| World is unsafe/people are bad | 83% | 5 |
| Peer consultation | 67% | 4 |
| Help-seeking behaviors | 33% | 2 |
| Supervisor role | 33% | 2 |
| Increasing knowledge | 33% | 2 |

The purpose of this chapter is to explain my findings from this study based upon the existing scholarly literature on interpreting experiences of vicarious trauma through

the lens of the CSDT and through themes identified during data analysis. I analyze and interpret the findings based on existing literature regarding the lived experience, symptoms of vicarious trauma, and the conceptual framework identified in Chapter 1. I address the limitations of this study and offer recommendations for future research. Finally, I summarize the implications of social change from the findings in this study.

## Interpretations of the Findings

The results from this qualitative hermeneutic phenomenological study matched the definition Figley (1999) gave of vicarious trauma as a "natural, predictable, treatable, and preventable unwanted consequence of working with suffering people" (Figley, p. 41) through participants' hearing the trauma of their clients. One participant, Lee, exhibited Figley's definition of vicarious trauma in that his overall experience of vicarious trauma was "very much a cumulative effect." Participants gave examples of each of the seven areas of life previously identified, thus supporting the existing scholarly literature.

### Seven Areas of Life Impacted

**Cognition.** All six of the participants, I interviewed, agreed that they had experienced symptoms of vicarious trauma in more than one of the previously identified seven areas of their lives. This was demonstrated in my study as evidenced by five out of six participants identifying cognitive changes due to vicarious trauma. They expressed the idea that the world is unsafe and people are bad, particularly for children.

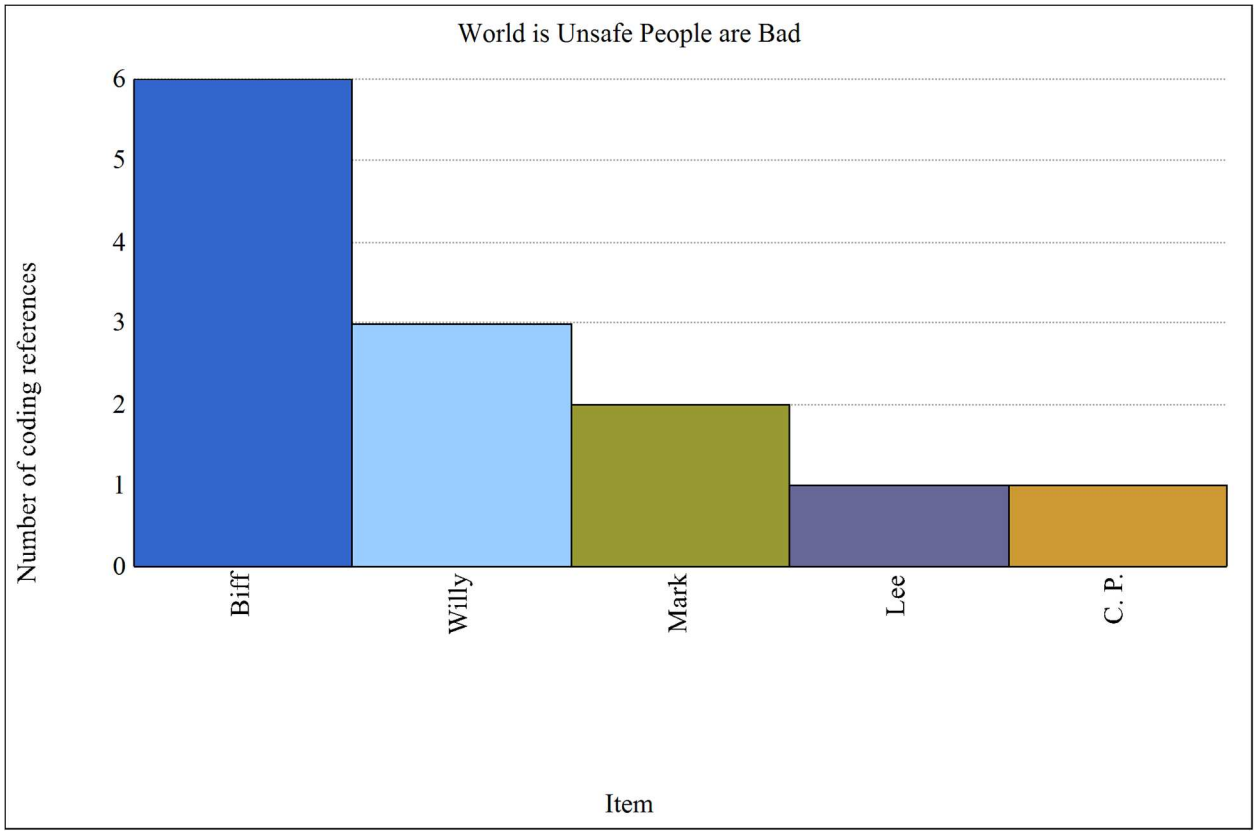


Figure 1 World is unsafe, people are bad

Two participants specifically indicated that they have increased empathy, open-mindedness, and acceptance of others (Willly and Vincent). Lee and Biff identified that they had increased their understanding and appreciation for the resiliency of children. C. P. specified that he had grown professionally to be able to be "unflappable" and "genuine" and present so that he could hear his clients' trauma and not become overwhelmed. Willy also discussed his ongoing growth in his ability to be genuine with his clients. Mark reported that he had grown in his ability to meet his clients "at their point of need" as an example of growth both in his approach to his professional theory and his personal beliefs.

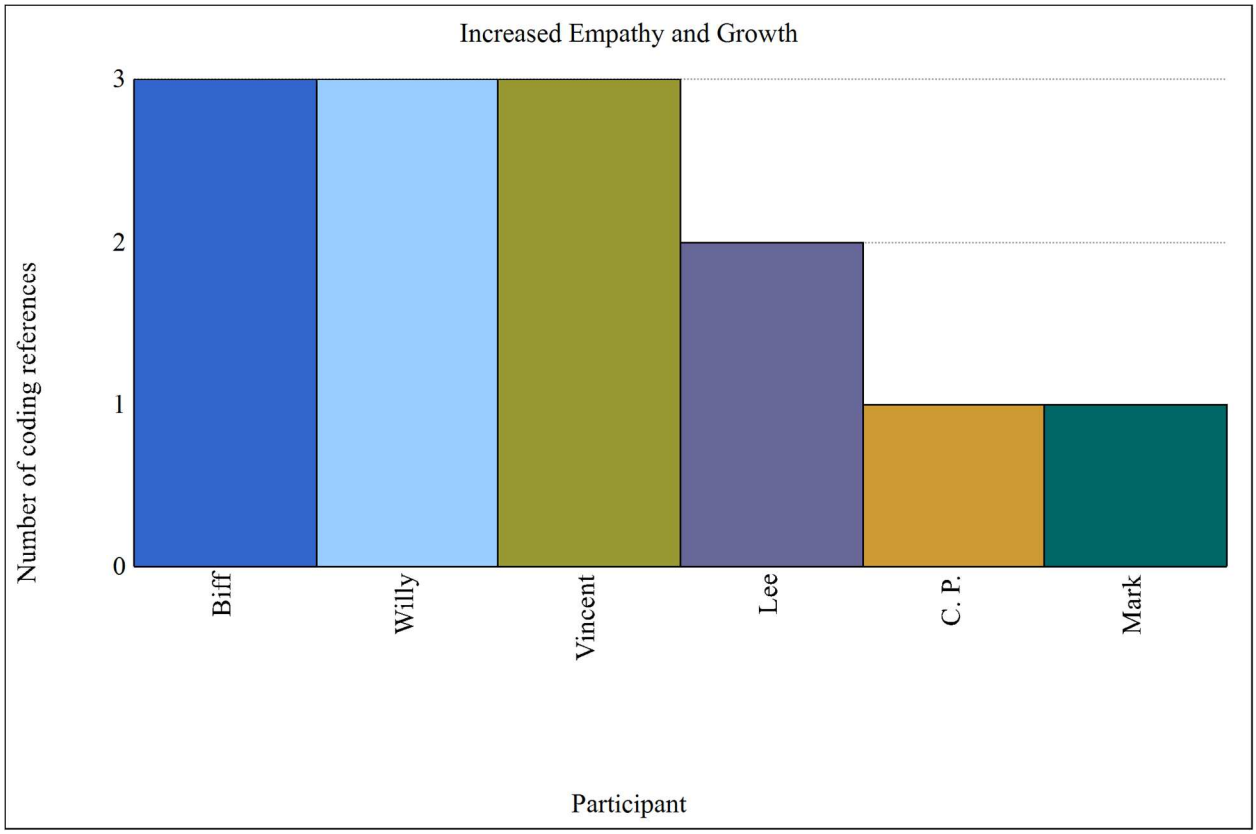


Figure 2 Increased empathy and growth

**Soma.** Additional areas of life impacted by vicarious trauma, as identified by participants, included physical/somatic as specifically reported by Biff, Mark, Lee, and C. P. Biff stated, "My body was just lit the hell up . . . It felt like I had died," and "feeling awful, feeling terrible." Lee summed physical or somatic effects by identifying them as "physical exhaustion" and asserting that sometimes when he leaves work he experiences "feeling very drained physically." C. P. summed up his physical experience of vicarious trauma as "I feel that in the pit of my stomach for a day or two." He added, "Maybe just like a tired feeling. Just like a worn-out, like you've been, you know, it's like there's no tread left on the shoes right then." Mark said that he experienced vicarious trauma most prevalently as physical symptoms. "My body tends to be more of the barometer of what's

going on in my life. . . . my stomach will hurt, my head will ache, and just overall body struggles, aches, pains, issues."

**Spirituality.** Biff and Mark reported a spiritual component that was impacted by vicarious trauma Biff commented, "It feels spiritual," and "It would feel like somebody had cut off my heels and my soul had drained out." Biff reported, "It just literally does things to my body, my spirit, my soul that were just amazing in the intensity of it. It defies rational logic. It defies my ability to explain it." Mark also reported a spiritual change because of vicarious trauma. He said there were "spiritual aspects . . . you question God sometimes to say 'How is man capable of this? Why is this even a part of creation?'"

**Emotion.** Emotional or mental was the other area of life most identified as being impacted by vicarious trauma, with five out of six participants reporting symptoms in this domain. Lee reported, "And at times I can find myself getting more irritable when I leave work, more feeling very drained emotionally." C. P. asserted, "I definitely see that there's an emotional aspect." He related that sometimes "you feel ineffective." When asked what it means to him to experience vicarious trauma, Mark stated, "To not necessarily experience the event but to have mental and emotional impacts related to the event."

Willy also reported some emotional impact of vicarious trauma stating, "I could say that probably they have emotional. It becomes more difficult to hear those stories as you become more emotionally attached to those clients." He stated, "I know a lot of people tend to really internalize it, and it becomes part of who they are, and it really

affects them deeply; and I do have those experiences when I hear some really deep disturbing stories."

Mark also identified that hearing clients' trauma can, if not dealt with, "stunt some level of growth and maturity in me because I find that it's a sticking point. Instead of processing through other things, I'm stuck processing through those things that I heard." Mark went on to say, "Those are obviously very difficult situations to process just simply because our minds don't deal with that on a daily basis." He added, "Those are the things that you have to process there yourself as a therapist or it will continue to have more negative impacts on your life."

**Behavior.** Three of the participants identified the behavioral aspect of life as one of the areas impacted by symptoms of vicarious trauma. Biff said that vicarious trauma has increased his identity as a play therapist and EMDR counselor stating,

> It's a big part of who I am. It's a big part of how I relate to children. It's maybe a big part that affects other aspects of my life; interacting with adults or interacting with day to day life.

Lee indicated that "I can find myself getting more irritable when I leave work." Lee also noted "changes in my sleeping patterns. I believe I dropped 25 or 30 pounds in the month surrounding the trial. So, it impacted my appetite, and it was all relative to the case at hand."

C. P. identified several ways that his behavior changes when he is experiencing vicarious trauma from hearing children's trauma material, including being "a little short with my wife." "I'm definitely more reclusive." "I reach out a lot." "I go to bed 30

minutes early." "I'm kind of short with everybody." "It's tough to sleep." Interestingly, he stated, "I know it's gonna happen," identifying that he is aware that his behavior will be different due to the trauma he has heard throughout the day.

**Personal relations.** C. P. asserted that his personal relations are impacted. He said, "I'm more short, but I'm reaching out. I reach out a lot. I reach out to my wife to cuddle on the couch for a little while." C. P. also plays video games, and when he is experiencing vicarious trauma he will "go offline so they can't see I'm online, and I'll play by myself" as he feels that he doesn't "need any more interaction that day." He also said that he will cancel plans with friends and be "reclusive" because of feeling overwhelmed.

Mark also specified how he is often impacted in his personal relations, identifying times when his wife will come to him because she has noticed that he is "quieter, processing, and focused inward," and that she wants him to know that she recognizes that he is "going through something."

**Work performance.** Mark specified how he is impacted in his work performance:

> I mean work performance; times where you've booked your schedule too tightly and the next person walks in and you haven't been able to process through what you've just heard. And you're not cognitively aware what the individual is saying that's right in front of you because you're still focused on the client that just left the room or even sometimes days later, you're still trying to process through what it is that you heard.

Willy asserted that one of the positive outcomes of him experiencing vicarious trauma was that it "in a way, it kind of jarred me into that reality of you've got to prepare yourself for this constantly," making him realize that he needed more training:

> A]s far as work performance; that's one thing that really stands out because I feel like it pushes me to try to become the better clinician, to work harder to be able to understand and work with those clients and gain more knowledge and more abilities to help them as best I can.

## Conceptual Framework Findings

In addition to validating the findings in the existing scholarly literature regarding the areas of life impacted by vicarious trauma (Figley, 2005). The main component of this study's conceptual framework was the CSDT, which was a lens through which I interpreted participants' experiences. This lens allowed me to use a hermeneutic approach to interpret the raw data into themes during the data analysis step (Trippany et al., 2004). These themes included using self-care to prevent or mitigate symptoms of vicarious trauma, applying CSDT to creating perceptions of reality and self, which includes a discussion of how researchers used CSDT to explain how individuals create perceptions of reality and self, using five components (Giller et al., 2006; Saakvitne, et al., 1998). These components include (1) psychological needs, (2) cognitive schemas, memory and perception, (3) ego resources, (4) self-capacities, and (5) frame of reference (Trippany, et al., 2004).

**Self-Care to Prevent or Mitigate Symptoms of Vicarious Trauma**

This study's findings aligned well with Cieslak et al. (2013) views about the use of self-care practices to prevent or minimize the symptoms of vicarious trauma (Cieslak et al., 2013). Saakvitne et al. (1998) focused on the CSDT which demonstrated how individuals organize experiences through the specific areas of self from one or more of five areas into their existing beliefs about the world and others. The progress of symptoms of vicarious trauma are adaptive, self-protective, and a natural mechanism in response to recurrent exposure to others' trauma (Trippany et al., 2004).

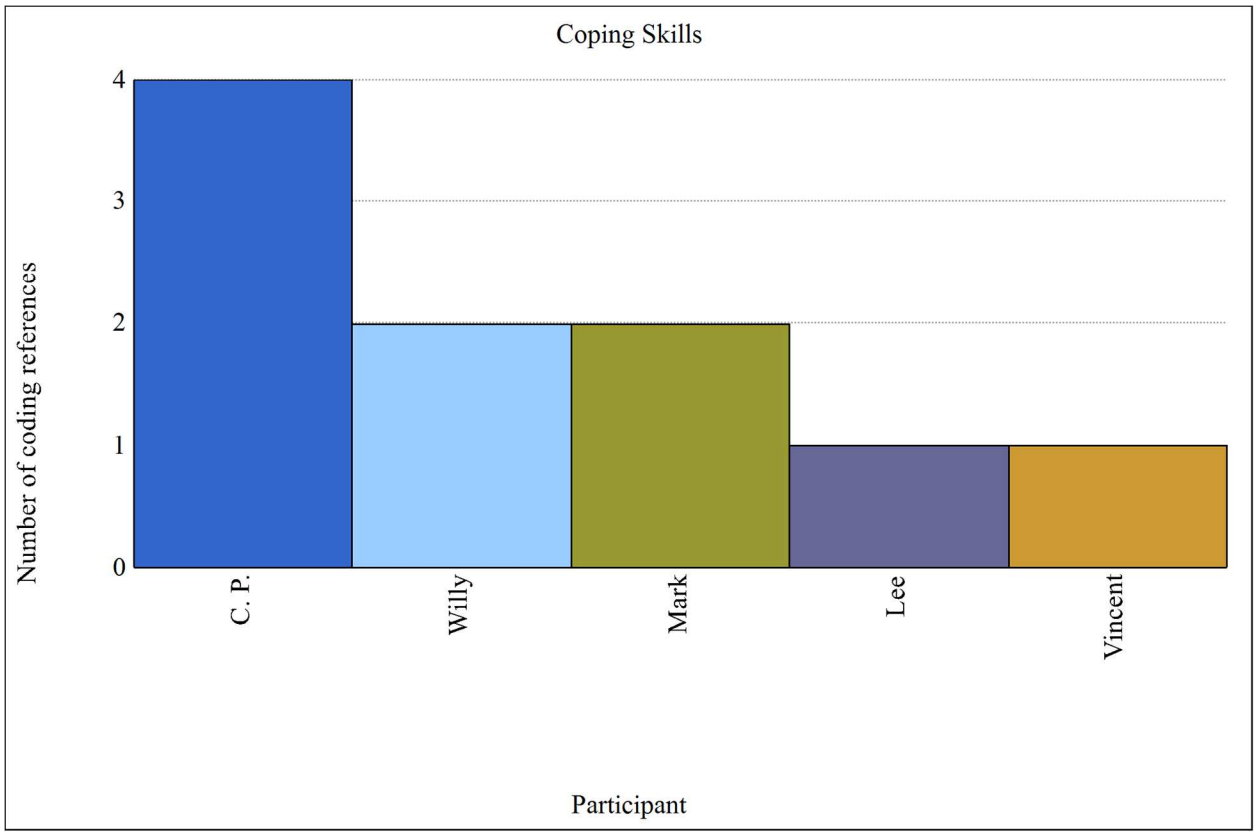


Figure 3 Coping skills

Lee understood how important self-care is to preventing or treating vicarious trauma, stating, “I really try now to do a lot of proactive self-care.” He added, “I have had situations where I've desperately needed to take a vacation, utilize my supervision as a means of self-care.” Lee demonstrated insight into how self-care increases his professional efficacy when he said, “I need to implement some self-care strategies if I'm going to be effective with the children that I serve. I have to take care of myself.”

C. P. stated, “I feel like I am pretty excellent at self-care,” noting that he has learned the value of self-care and cited his excellent support system of his supervisor, wife, brother, parents, and family.

Through experiencing vicarious trauma, Mark reported, “There are things that I'm doing naturally through my own self-care to help rebuild resiliency on a daily basis so that these things impact me less.” He added, “We want to say that self-care helps to mitigate, and it does but those are the things that you have to process there yourself, or it will continue to have more negative impacts on your life.”

As an EMDR certified counselor, Biff relayed how he has used self-care techniques to mitigate the symptoms of vicarious trauma, stating, “A lot of times when I was driving home I’d be like gripping the steering wheel and actually doing bi-lateral stimulation as I drove home.”

Vincent reported that his self-care is more self-assessment and dealing with the causes, while Willy reported that he uses self-care through “my sick sense of humor,” “…roll down the windows in the truck and turn up the radio on the way home,” “sitting in the backyard and listening to music,” and “visit with the family.” Willy truly reflected

the literature that self-care can mitigate the effects of vicarious trauma by stating, "That's the self-care that comes in to get through those kinds of things."

## Applying Constructivist Self-Development Theory to Creating Perceptions of Reality and Self

Additionally, researchers used CSDT to explain how individuals created perceptions of reality and self, using five components that included: (1) psychological needs; (2) cognitive schemas, memory and perception; (3) ego resources; (4) self-capacities; and (5) frame of reference (Helm, n.d.; Jankoski, 2010; Saakvitne et al., 1998; Trippany et al., 2004). I explored participants' experiences in creating perceptions of reality and self through the lens of CSDT. Using the CSDT lens, I identified several examples of participants being impacted by vicarious trauma in all five of these components.

**Psychological needs and cognitive schemas, memory, and perception.** In interpreting participants' experiences with the first and second components of CSDT, I looked for five needs that included control, trust, safety, intimacy, and esteem. These reflect the most basic psychological needs of individuals. These five components also guide how individuals process information that is related to those needs when they develop or add to their cognitive schemas about themselves and others (Pearlman & Saakvitne, 1995). I identified examples of distortions within each of the five needs from the interview of each participant. I then interpreted the phrase or experience related by each participant through the lens of CSDT based on these five components.

Control needs might lead to a counselor feeling helpless. According to Pearlman and Saakvitne (1995), "These beliefs lead to distress as we [counselors] question our ability to take charge of our lives, to direct our future, to express our feelings, to act freely in the world" (p. 292). Biff made the point that as counselors working with children, "We just don't have a real good handle to protect them before it happens unfortunately." He added that he finds it difficult to experience a loss of safety in his ability to protect these children, stating:

> How can I live in a world like this where this crap happens, and we do a shit job of protecting the children? We blame them, we don't believe them. We don't protect them. We just do a shitty job of protecting them.

Biff made the feeling of loss of control very visual, stating, "the failure to protect…it's like watching a station wagon full of kids on a train track, waiting to get hit by the train over, and over, and over again."

Male counselors who treat children who have experienced trauma might express trust needs as self-trust in his perceptions or beliefs, or trust in others to meet his physical, emotional, and psychological needs; or loss of trust in a population due to empathy with a client who experienced trauma at the hands of a person or people in this population. Within the theme of the "world is unsafe/people are bad," there were several examples of loss of trust. For example, Willy stated, "You start to get suspicious of people you see," and he wondered if people he sees disciplining children are really abusing them. He expressed a feeling that he is unable to intervene in every situation to protect every child in this situation and reported that he has "become very jaded." He

added, “I understand there's a lot of bad things that happen in this world. There's terrible things that happened to children,” and “There's a lot of people out here that their entire world revolves around what evil can they do to their child.” Lee also identified a loss of trust in others stating: “When you work in the field of trauma, you certainly become much more aware that trauma is unfortunately a very real and very frequent event in the lives of children.” Biff also expressed a loss of trust in others by asserting

> There’s just a whole lot of bad in the world. And that you can’t tell who’s bad. People who are really bad probably look better than the people who are good. Honestly. And really in terms of people harming children or harming others that people who do that shit find all sorts of ways to protect themselves and make the other people look like shit; pathologize them.

This is a very basic loss of trust in humanity, where there is no easy way to tell the good from the bad, prompting him to state, “It’s really not a world I want to live in.”

An example of a safety need might be increased concern, vulnerability, or fearfulness and that they have no safe way to protect themselves from real or imagined threats to their safety. None of the participants identified any loss of personal safety due to experiencing vicarious trauma. Perhaps not feeling concern about their safety could be related to the gender of the clients in this study.

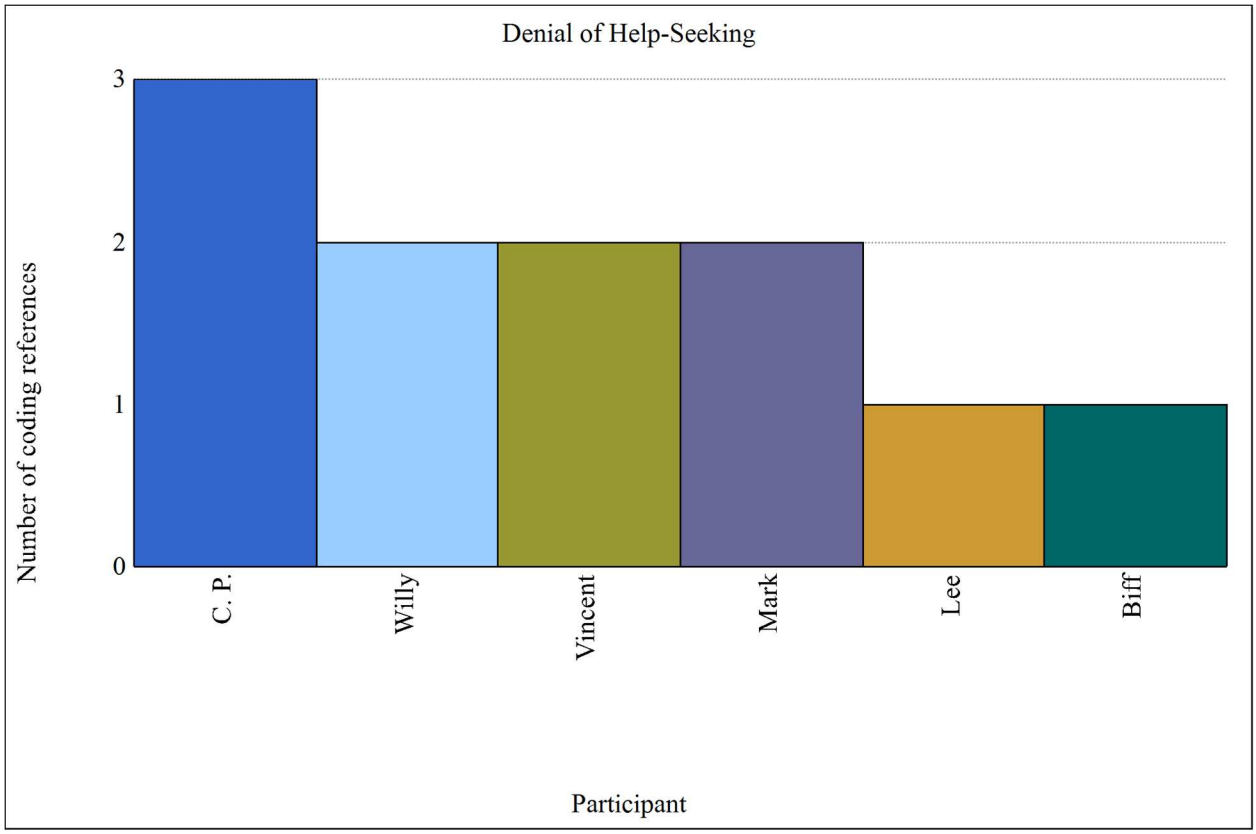


Figure 4 Denial of help-seeking

This might be at least partially explained by the ideas of why Mark hasn't sought help for symptoms of vicarious trauma:

> We do think that we are Captain America at times and, and we can handle those things. And as a male therapist we probably are more guilty of that, just simply because of that ego and macho-ism. You know, where we're capable of dealing and don't necessarily have to seek that supervision or consultation because of that.

Lee also expressed the reasons he, or other male counselors, don't seek help with symptoms of vicarious trauma that included, "In society, men, we're socialized. We're conditioned to be tough, to be strong. You confront this, and this can be very overwhelming. And in society in general, men are conditioned not to show emotions."

Pearlman and Saakvitne (1995) defined intimacy needs as "the need to feel connected to oneself and others" (p. 62). An example of outcomes from experiencing a lack of intimacy needs might include feelings of emptiness, difficulty or refusal to be alone, or becoming increasingly dependent on another or others. C. P. expressed this desire for and seeking intimacy saying, “I have an excellent support group. I have a really strong relationship with my wife. I have a really strong relationship with one of my brothers. I have a really strong relationship with my parents, and my family,” and he added that he seeks out “cuddle time” with his wife, which helps mitigate the impact of vicarious trauma. Lee identified “family members” and “friends,” as being supportive, which seems to be his way of fulfilling the need for intimacy. Mark also gave family as a way to help with the impact of vicarious trauma including his “community of Believers,” his wife, and he also reported, “[Y]ou go home and you hug your children tight.” Feeling connected to oneself and others might also include seeking supervision or peer consultation.

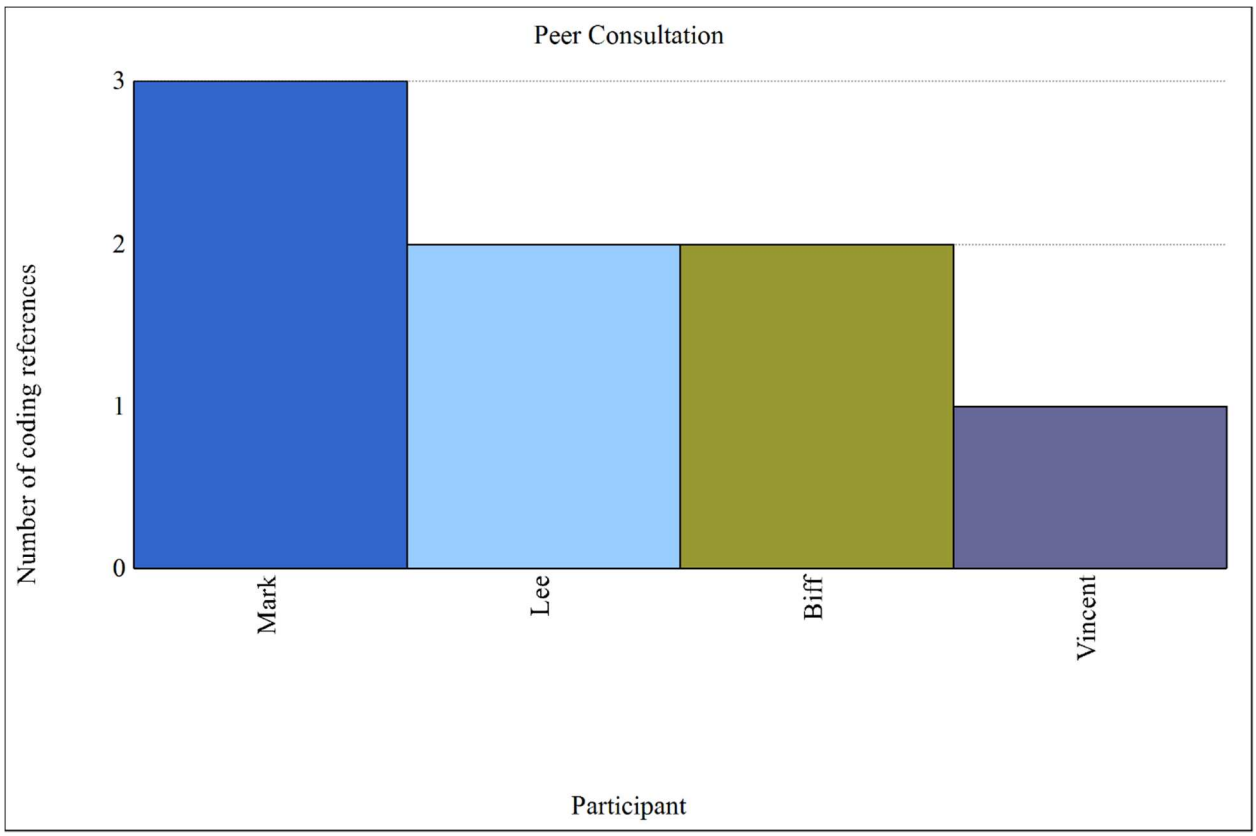


Figure 5 Peer consultation

Biff, Lee, Mark, and Vincent identified seeking peer consultation, with Mark calling them "informal relationships" out of his desire for "community" in order to "process through" difficult cases and calling that "very, very beneficial." Biff comments that through "community" he can "connect with somebody" and that it is a "valuable part of what we do." Vincent also discussed seeking "other clinicians that have been around here for a long time" as being helpful for "just talking," bringing a sense of intimacy within his professional role.

Pearlman and Saakvitne (1995) identified esteem needs as having value for self and others. Esteem needs can be disrupted in counselors if they experience trauma with results such as feeling ineffective or inadequate and questioning abilities to help clients,

and this can occur as counselors empathize with clients' trauma surrounding the cruelty of others or an unfair world. Biff values his ability to help children who have experienced trauma. He also values others in the field saying, "I've got several folks who are considered experts in their field that I'm lucky enough to know." Six participants expressed having value for others in the form of supportive supervisors, including C. P., Lee, Biff, Mark, Vincent, and Willy.

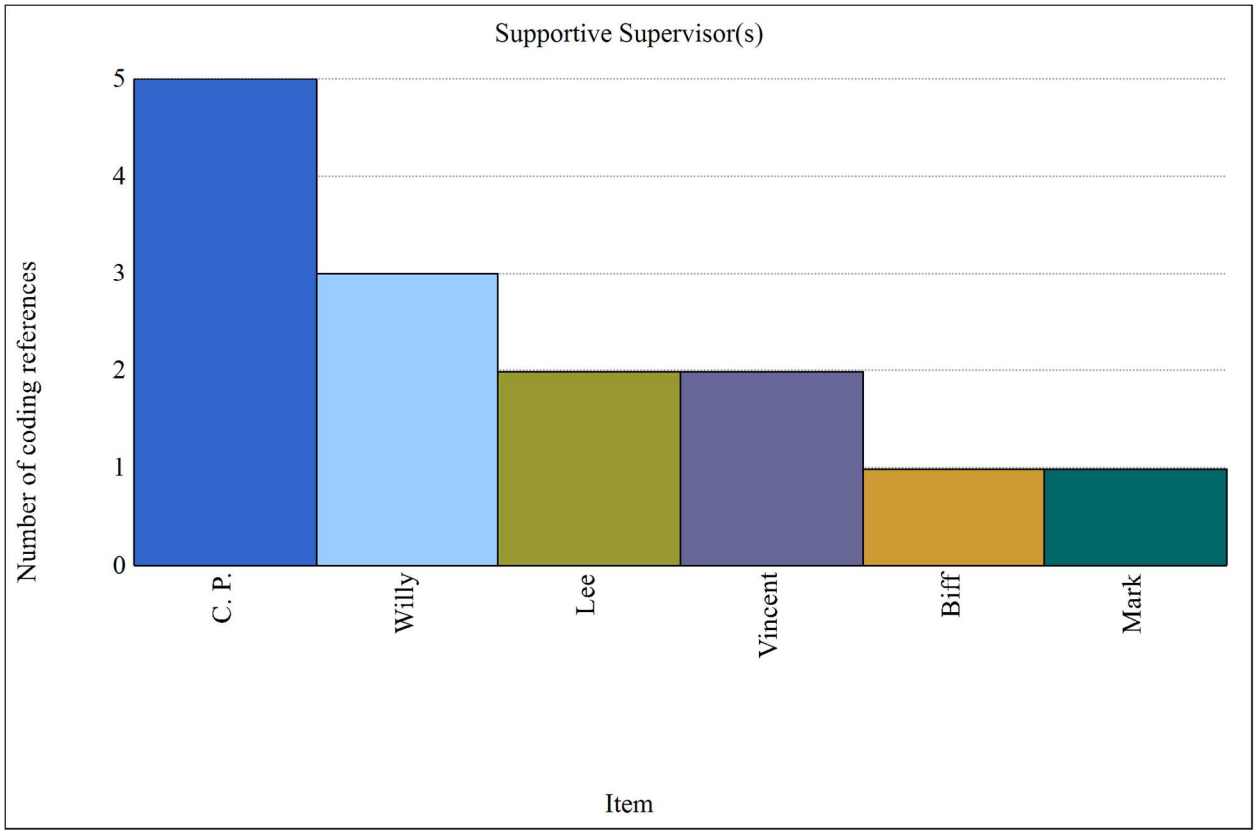


Figure 6 Supportive supervisor(s)

Willy relayed, "I have a wonderful group of Supervisors." C. P. described his supervisor as "great," "absolutely wonderful," "super empathetic," "really, really compassionate," "phenomenal," and "excellent." Vincent expressed appreciation for two supervisors, saying they are "real good" and that "it's been a pretty good experience."

He also expressed self-esteem stating that "I'm happy to do that" when referencing working with the worst trauma of his clients' trauma with them. Mark praised his previous supervisor, stating that even after supervision was not required "early on I would go back to my supervisor and talk with her. . . . even after receiving my full licensure." Lee expressed that he is "very fortunate" and has worked with his supervisor for "25 years" and that she is "very, very supportive." Biff expressed esteem not only in his supervisor experience, but in his clients and himself. He praised the "resilience," "bravery," and "innate capacities" of his child clients who have experienced trauma, stating that these children would "face down stuff that's happened that would freak out 20 Navy Seals or Special Operations" and pick "the worst thing you could imagine happening to human beings and they have the energy, the chi, the whatever to do that. That really says something that goes well beyond words." Biff's esteem for himself includes his appreciation to get to help children who have experienced trauma in a way that genuinely helps: "It's a very sacred space to me. It's a very beautiful space with me. I feel so lucky to get to do that." As a trainer of EMDR, Biff also asserted, "I just feel very fortunate to be able to not only treat trauma but again, put the tools out there where others can effectively treat it."

**Ego resources.** Pearlman and Saakvitne (1995) used ego resources to identify how individuals meet psychological needs as well as how they relate interpersonally to others (Pearlman & Saakvitne, 1995). Three ego resources include the ability to self-protect, conceive consequences, and set boundaries (Pearlman & Saakvitne, 1995). If a disruption in one or several of these resources occurs, counselors might have trouble

experiencing or expressing empathy with clients, overextension at work, or perfectionism within personal or professional roles. Only C. P. talked about experiencing a challenge of his ego resources where something in his personal life has been impacted by his clients' trauma, stating, "I've got the bad what if's, you know; if I had done that extra session last week… if I talked specifically about this thing." He also reported struggling to self-protect after hearing clients' trauma, "I've had lots of stuff in my own life that I have mulled, and mulled, and mulled, and mulled where stuff doesn't hit me that way but personal stuff will then stick, and I know that okay if you could've just come to counseling like three years ago this would have been such a … big deal if you had just handled it." Biff also reported a challenge in his ego resources as a feeling of helpless in self-protection, "It's really not a world I want to live in. You know it's not a world anybody would want to live in."

**Self-capacities.** Pearlman and Saakvitne (1995) defined self-capacities as "inner capabilities that allow the individual to maintain a consistent, coherent sense of identity, connection, and positive self-esteem" (p. 64). Counselors use self-capacities to maintain positive self-esteem and maintain positive relationships with others. If a counselor experiences disruption in self-capacities he may have trouble with interpersonal relationships, loss of self/identity, difficulty regulating or tolerating negative emotions, or feeling powerless to meet others' needs. As previously explored, all six participants gave examples of how self-capacities are impacted in their denial of help-seeking behaviors as an assumption of adequate self-capacity, coherent and consistent sense of identity, and positive self-esteem. C. P. summed it up stating, "I feel like I handle it pretty good on my

own," and continuing, "I don't think I've ever seen it as necessary." Willy also expressed feeling an adequate self-capacity stating that he has not sought help for symptoms feeling like he has not needed help yet, saying, "not necessarily at this point." Biff, Mark, Vincent, and Lee did not give affirmation of positive self-capacities, but they did say that they have not sought any other help outside of the community within peer consultation to maintain a sense of identity and connection with other counselors.

**Frame of reference.** McCann and Pearlman (1990) asserted that "a meaningful frame of reference for experience is a fundamental human need" (p. 141). Pearlman and Saakvient (1995) also identified an individual's frame of reference as the context or framework through which an individual understands and views the world and self; and that framework encompasses his identity, belief system, and worldview, which is the foundation for interpreting the world and self. Although personal as well as professional experiences play a part of each individuals' frame of reference, there were two primary frames of reference identified in my study. The first included the experience of participants who felt their past education and training was inadequate to working with their current population. The second frame of reference identified was each participant's eclectic therapeutic approach to working with children who have experienced trauma.

Five out of six participants identified that they have sought additional training to supplement inadequate education, training, and experiences to efficaciously work with children who have experienced trauma.

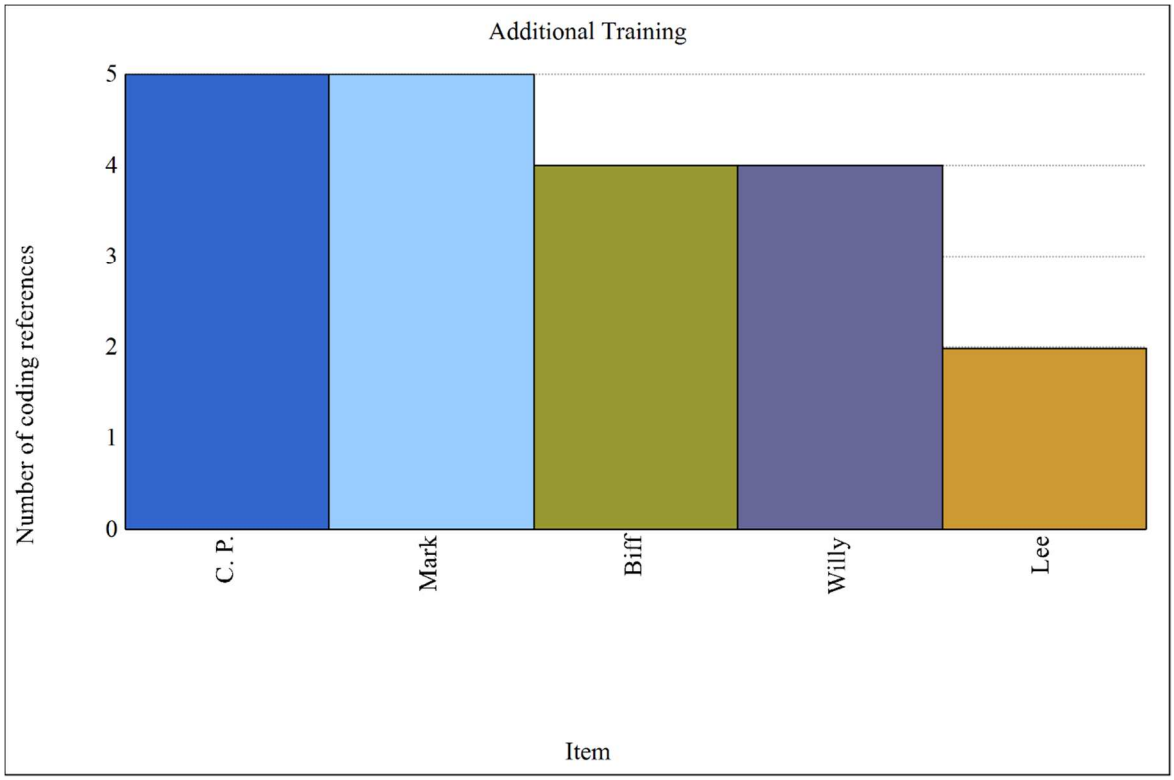


Figure 7 Additional training

C. P. summed up his need for additional training, “I mean there's all kind of trauma-related stuff that you'll go over in school and I probably could list you classes; but in my opinion, I think you learned very little in school that actually applies to doing counseling,” continuing, “But sure I had classes, but I don’t give much credence to those.” He added, “I wouldn't say that I learned anything in school that helped me to be able to empathize with a kid that was talking about being raped.” Biff sought out additional training saying, “I really want to do that because maybe if you intervene early you could prevent all the balling up, the harm, the negative events that kept cascading.” So, he said that he “got trained in EMDR and it’s like…night and day.” He also sought out an additional internship “post-masters because I wanted to learn how to work with

children, specifically. There wasn't an opportunity to do that before I graduated…before I completed all the requirements." Lee also felt that his graduate school classes were inadequate expressing:

> I would love to tell you that I had . . . some wonderful training in graduate school but, ironically, the first job that came open after graduate school was as a child therapist. I mean, I don't want to downplay my graduate training, but a lot of my training came really on the job.

Mark identified his need for addition training stating:

> I would love to say I came out of grad school with my exact theory and that it's exactly what I stick to on a day-by-day basis. Well, that's bull and I am constantly evolving the theory based on new research, based on new intervention methods, based on individual clients.

He continued his thoughts regarding seeking more training and education after his graduate education: "Everything outside of graduate school came through continuing education…just reading and using specific interventions." He continued that most came "as a direct result of needing a specific intervention to deal with a specific case." Based on his experience with his first client, when he felt overwhelmed, he reported, "So as I got into practice, it became more of an idea that I needed to get some extra education to help me with it." He stated, "I feel like it pushes me to try to become the better clinician, to work harder to be able to understand and work with those clients and gain more knowledge and more abilities to help them as best I can." He began seeking training, saying, "[T]hen I've also had my EMDR training and I'm working through my TF-CBT

training right now." Five of the six participants specified that they implement an eclectic approach to counseling.

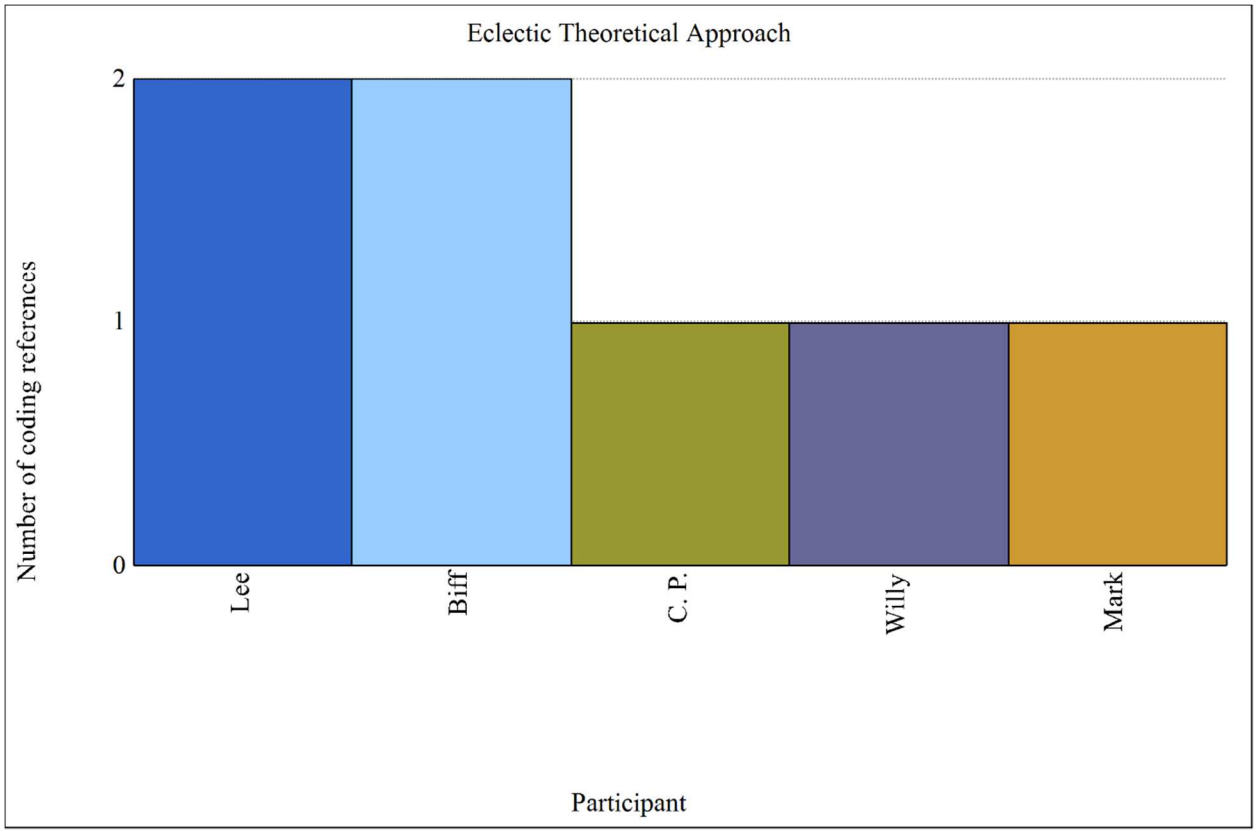


Figure 8 Eclectic theoretical approach

For example, both Biff and Mark implement additional training in play therapy into Rogerian and person-centered approaches. Lee did not specifically identify his approach other than his additional training in play therapy and implementing techniques that are "prescriptive in nature" and that he will "pull from various theories," stating, "Eclectic, yes." C. P. identified that he primarily uses a person-centered approach with "solutions-focused" as well. Mark said that he uses training in play therapy with "other elements" and "various techniques and interventions." Willy uses his new training in TF-CBT, with a person-centered approach.

Due to the complexity of the experiences of vicarious trauma within each participant, there were no way to identify one representative story of vicarious trauma. Participants' experiences led to themes that were shared by two to all six participants, but no two participants told the same story. As a result, while this study confirmed previous themes of vicarious trauma (Helm, n.d.; Janoski, 2010; Saakvitne et al., 1998; Trippany et al., 2004), the challenges of working with children who have experienced trauma remained difficult to specifically define in any other way but through examples of participants' reactions to their clients' trauma.

## Limitations of the Study

The design of the study contained the primary limitation of my study. This limitation was demonstrated in my decision to use phenomenological interviewing as the primary method of data collection, necessitating that I also interpret the data. I was able to somewhat mitigate potential bias using the CSDT as the lens through which I conducted interpretation. Wu et al. (2011) asserted that interpretation is heavily influenced by the rapport that the interviewer establishes with the interviewee. Because of this, it is not inconceivable that my identity as a woman and also a terminally licensed counselor with experience working with children who have experienced trauma might have influenced how participant information was gathered during the interpretation process and interpreted later during the data analyzation process. To mitigate this potential bias, I implemented triangulation through member-checking giving participants the opportunity to confirm, clarify, or correct the quotes, reflections, and interpretations I made regarding their interviews. In addition, in using phenomenological interviewing a

limitation could be the assumption that the self-reported stories and experiences of male counselors were truthful, and accurately portrayed their actual experiences (Chan, 2009). To diminish this potential limitation, I implemented a semi-structured interview approach and used clarification, reframing, and open-ended questions with the goal of eliciting comprehensive details or information.

Additionally, although I made attempts to seek participants from a diverse population of male counselors, all my participants were White. While I sought a diverse population and I made efforts to attract participants from various sources, such as on Social Media and through having a contact at the ArMHCA send an invitation on my behalf to all male counselors who are members, I still had a limited sample population. Based on this limitation, this study will not be transferable to any other race. Fortunately, the age range of participants was from mid-20s to late 60s, which improved the diversity in age of participants within my study. Findings in my study may have been influenced by the sample size of this study. This study contained six participants, which is an appropriate sample size for a qualitative study. Conceivably a sample size larger than six could have increased the diversity of the sample and may have provided more substantial themes surrounding the experiences of male counselors who primarily work with children who have experienced trauma. Generalizability was not the goal for this study, so this limitation is acceptable and expected for this type of study.

## Recommendations

The findings and results of this qualitative, phenomenological, hermeneutic study provided mental health professionals and counselor educators with an opportunity to hear

and understand the experiences that male counselors endure when working with children who have experienced trauma. Additionally, this study filled a gap in the literature surrounding the way in which male counselors perceived the impact of their clients' trauma. While this study confirmed scholarly research findings regarding how trauma progresses through the CSDT, it also raised questions that should be explored in future research. One example of this was my decision not to delineate between novice and terminally licensed counselors. As a result, the development of themes regarding issues specific to only novice or only counselors with several years of experience might not have been exhausted. Future research in the area of how men experience the trauma of their clients' trauma is needed to focus on potential differences between experiences of vicarious trauma from the findings in this study.

Since I recruited my sample primarily from Central Arkansas, the findings might not be generalizable to similar sample populations from geographically diverse areas of America; and could be significantly different from a sample population drawn from anywhere else in the world. Participants in my study were all White and except for Biff, employed as full-time counselors in a clinic setting. Using a sample with such defined traits could also limit the generalizability of my study. In future research, a broader sample population that includes several races from geographically diverse areas could increase generalizability. Additionally, racial diversity should be considered by recruiting from social media sites or professional organizations that focus more on racially diverse populations.

Using the results of my study, several quantitative studies could be formulated. A survey instrument could be created utilizing the themes I discovered in this study. The instrument could be given to a large sample of male counselors who counsel children who have experienced trauma to determine whether the themes are experienced in a large population. In an additional study, the results from male counselors and female counselors could be compared.

## Implications for Positive Social Change

As I stated in Chapter 1, the purpose of this study was to fill a significant gap in the literature related to the effect that child clients' trauma has on male counselors who work with them. At the time of this study, I could find no literature on the impact of male counselors working with children who have experienced trauma, so there is no rich, thick, descriptive experiences or stories from participants regarding this construct. This study appears to be the first focusing on this construct; and will inherently lead the way for future studies and it is my hope that it will create recognition of potential future studies. I also hope that the findings from this study will be the positive impetus of change that will begin to empower current and future male counselors to effectively understand and mitigate negative consequences of vicarious trauma from working with children who have experienced trauma.

As a recommendation for action and social change, results from this study indicated that male counselors may not be receiving adequate education or training to empower them to effectively work with children who have experienced trauma. Counselor educators should consider focusing targeted learning to provide education and

experiences that will present male counseling students with realistic expectations and applicable interventions to help them conceptualize what working with children who have experienced trauma might look like, sound like, and feel like. Counselor educators should also consider providing specific education, training, and support regarding the preventable and treatable, but natural experience of vicarious trauma that these men can expect to encounter in their future careers. Clinical counselors who might work with these men who are experiencing vicarious trauma, could use the results of this study to inform more efficacious treatment interventions focused on normalizing the experiences of vicarious trauma and helping to target the clinical intervention of the one or more areas of life previously identified.

## Conclusion

The purpose of this qualitative hermeneutic phenomenological study was to explore the lived experiences of licensed male counselors who primarily work with children who have experienced trauma. I conducted this study to fill a significant gap in the literature related to how male counselors experience hearing the trauma of their child clients. Understanding the experiences of these men and the meaning attached to their experiences was necessary in the development of evidence-based educational and clinical interventions for male counseling students and licensed counselors who work with children who have experienced trauma. I conducted this study by implementing a qualitative hermeneutic phenomenological methodology. I recruited six male counselors who primarily work with children who have experienced trauma and I used a semi-structured, qualitative interview process as data collection to invite participants to share

their stories of working with children who have experienced trauma, and how these experiences have impacted seven areas of their life, including (a) emotion, (b) cognition, (c) spirituality, (d) behavior, (e) personal relations, (f) soma, and (g) work performance (Figley, 2005).

I transcribed all interviews by hand and then entered and coded then using NVivo software. Rigorous data analysis of the data resulted in the development of the following themes: (a) eclectic theoretical approach; (b) majority of clients have experienced trauma; (c) increased empathy and growth; (d) negative impact(s) of vicarious trauma; (e) help-seeking behavior; (f) denial of help-seeking behavior; (g) additional training; (h) coping skills; (i) supportive supervisors; (j) peer consultation; (k) supervisor role; (l) world is unsafe/people are bad; and (m) increasing knowledge.

The purpose of this chapter was to explain this study's findings based upon the existing scholarly literature on interpreting experiences of vicarious trauma through the lens of CSDT as well as through themes identified during the data analysis. In addition, I analyzed and interpreted the findings based on existing literature regarding the lived experience of symptoms of vicarious trauma as well as the conceptual framework identified in Chapter 1. I addressed the limitations of this study as well as the recommendations for future research. Finally, I summarized the implications for positive social change based on the findings of this study.

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# Appendix A: Interview Protocol

My interviews with participants will begin with an introduction that will include a definition of trauma and vicarious trauma. This will lead to the central question followed by additional interview questions. If interview questions have already been answered, they will not be asked. I will ask additional open-ended questions for clarification or to explore emergent themes.

The following definitions of trauma and vicarious trauma will be given to participants.

*Trauma:* Trauma is an emotional response to an event like a natural disaster, accident, or rape and includes a clinical diagnosis that reflects traumatic experiences.

*Vicarious trauma:* Vicarious trauma is an emotional contagion, which is a natural, preventable, treatable, and predictable, undesired consequence of working with suffering people. It can potentially impact seven areas of life including emotion, cognition, spirituality, behavior, personal relations, soma, and work performance.

1. Opening Procedure
    a. Introduction
    b. Purpose of the Study
    c. Informed Consent
    d. Definition of Trauma and Vicarious Trauma
2. Central Question
    a. Given the definitions of trauma I just explained, what is your experience in working with children who have experienced trauma?

3. Additional Interview Questions

    a) How would you describe your counseling approach?

    b) How did you learn to work with children who have experienced trauma?

    c) How do you experience your clients' trauma?

    d) How do you seek supervision or consultation?

    e) What is your experience when you have sought supervision or consultation?

    f) Would you say that any part of your identity, worldview, or belief system has changed since you since you began counseling children who have experienced trauma?

    g) Based on the definition of vicarious trauma, would you say that you have experienced vicarious trauma?

    h) What does it mean to you to experience vicarious trauma?

    i) Have you ever sought any type of help for symptoms of vicarious trauma, and if so what was your experience?

    j) Are there any other experiences or information that you would like to share with me today?

4. Closing

    a. Do you have any further comments or questions?

    b. I will email you a summary of today's interview. Please feel free to respond with any clarification, comments, or questions.

Appendix B: Biff's Self-Portrait

# Appendix C: Institutional Review Board Approval

The Walden University Institutional Review Board approval number for this research was 02-22-18-0289719.