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Individual and Organizational Coping Resources of Counselors who Survived Vicarious Trauma: A Multiple Case Study

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Abstract

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by

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MS, Troy University, 2009

BS, Florida State University, 1999

Dissertation Submitted in Partial Fulfillment

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Abstract

Vicarious trauma poses a risk factor for clinicians. The purpose of this qualitative multiple case study is to examine the individual and organizational resources used by counselors who have self-reported vicarious trauma and have continue practicing their profession effectively. Two theories that comprised the framework of this study were: the social cognitive theory and the constructivist self-development theory. The sample consisted of 10 counselors who self-reported vicarious trauma. Data were collected using semi-structured interviews, observations, and then were analyzed using thematic analysis. NVivo software was utilized to come up with distinct similarities in each of the participants. These similarities were then further analyzed to reveal concrete coping strategies that helping professionals can utilize to prevent the effects of vicarious trauma. The top coping skills were discovered to be as follows: effective transition time, spiritual practices, psychological preparedness, wellness, and self-control. Furthermore, organizational skills were also examined to see the effects the organization had on vicarious trauma. The leading organizational coping skills that were acknowledged were: co-workers and supervisor involvement, self-care evenings, weekly wellness meetings, and consultation groups. This study will provide positive social change implications by enabling present and future mental health professionals to gain insight into the coping strategies used to manage vicarious trauma successfully.

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Chapter 1: Introduction to the Study

Introduction

The nature of the work that counselors perform in helping trauma patients has implications for their experiences as mental health professionals, whether positive or negative (Hernandez-Wolfe, Killian, Engstrom, & Gangsei, 2015). Counselors who are working with trauma patients are susceptible to vicarious trauma, which is the negative "transformation of the helper's inner experience, resulting from empathic engagement with clients' trauma material" (Saakvitne & Pearlman, 1996, p. 40). Vicarious trauma can affect the careers of counselors as a result of decreased level of competency, loss of passion in their work, or even removal from employment (Abendroth & Figley, 2013).

Individual and organizational resources are often important for counselors who are working with trauma patients to prevent vicarious trauma (Dagan, Itzhaky, & Ben-Porat, 2015; McFadden, Campbell, & Taylor, 2014). The focus of this study will be on examining the individual and organizational resources that counselors who have self-reported vicarious trauma used to cope with the experience and continue practicing their profession effectively. This study is significant because practicing clinicians can gain the valuable tools needed in overcoming vicarious trauma by learning from other clinicians who have successfully coped with this form of trauma.

In this chapter, I will introduce the study. The chapter will include the following sections: (a) background, (b) problem statement, (c) purpose of the study, (d) research questions, (e) theoretical framework, (f) nature of the study, (g) definitions, (h)

assumptions, (i) scope and delimitations, (j) limitations, and (k) significance. The chapter concludes with a summary of the key arguments of the study.

Background

Counselors who work with trauma patients are involved in various treatment approaches ranging from cognitive-behavioral therapy to eye movement desensitization and reprocessing (Cloitre, 2015). During this process of treating trauma patients, counselors are vulnerable to vicarious traumatization, burnout, or compassion fatigue (Hernandez-Wolfe et al., 2015). For instance, Versola-Russo (2006) suggested that mental health professionals are exposed to vicarious violence when they treat clients who are seeking treatment for trauma such as sexual assault.

Cieslak, Shoji, Douglas, Melville, and Luszczynska (2014) noted that vicarious trauma is a concept that is connected with similar terms such as countertransference and burnout. Burnout is often associated with overexposure to a person's daily work that leads to psychological distress (Maslach & Leiter, 2016), whereas countertransference occurs when the counselor has deep-seeded beliefs that may be unconsciously triggered by the trauma presented by the client at the time (Cavanagh, Wiese-Batista, Lachal, Baubet, & Moro, 2016). Vicarious trauma, on the other hand, pertains to the "painful and disruptive psychological effects of trauma-based work" (Barrington & Shakespeare-Finch, 2013, p. 90).

There have been numerous studies on the effects of vicarious trauma on counselors (Dagan et al., 2015; McFadden et al., 2014; Michalopoulos & Aparicio, 2012), but little was found on how helping professionals coped with this form of trauma.

Most studies on vicarious trauma focused on the resources that should be available to counselors to prevent vicarious trauma (Dagan et al., 2015; McFadden et al., 2014; Michalopoulos & Aparicio, 2012). There was a seeming lack of research on the coping strategies needed once vicarious traumatization becomes a problem for mental health professionals.

Individual resources of counselors can play a role in the prevention of vicarious trauma as a result of engaging with their clients who are highly traumatized (Dagan et al., 2015; Michalopoulos & Aparicio, 2012). Michalopoulos and Aparicio (2012) posited that the personal experiences of counselors have a direct relationship to their susceptibility for vicarious trauma when treating high-risk clients, such as those suffering from trauma. Dagan et al. (2015) found that individual resources such as tolerance for ambiguity and stress are significant factors that can explain the variance of vicarious traumatization among mental health workers.

In addition to individual resources of counselors, organizational resources can also play a role in minimizing the development of vicarious trauma among mental health professionals who work with trauma patients (Dagan et al., 2015; McFadden et al., 2014). The presence of organizational resources such as policies, positive working environment, and support from management can protect counselors from stress-related work, including the treatment of trauma patients (Sansbury, Graves, & Scott, 2015). Dagan et al. (2015) found that organizational factors such as the size of case load of trauma patients can explain the variance of vicarious traumatization among mental health workers.

Problem Statement

Clinicians are often faced with treating clients who have experienced severe trauma. Helping these troubled individuals with a wide variety of issues is a top priority for most helping professionals (James & Gilliland, 2013). Counselors' desire to help their clients can occasionally lead to stress and mental health difficulties as a result of the emphatic transformation of their inner experiences (Figley, 2002). This form of stress is called vicarious trauma and can be debilitating if left unnoticed or untreated (Barrington & Shakespeare-Finch, 2013). This form of trauma can occur quickly for counselors and typically occurs when treating trauma clients (Hernandez-Wolfe et al., 2015).

When clinicians are faced with counseling exceedingly difficult issues such as sexual assault, child abuse, and other traumas; they become at risk for experiencing vicarious trauma (James & Gilliland, 2013). Identifying the risks for trauma to counselors early is critical in order to prevent lasting and sometimes career-ending outcomes. Most studies on vicarious trauma focus on the importance of the resources needed to prevent vicarious trauma (Dagan et al., 2015; McFadden et al., 2014), but little research exists on the coping of counselors once vicarious traumatization is experienced. The research problem is that it is not known how individual and organizational resources help counselors cope, which is in keeping with Iqbal's (2015) conclusions. Without this information, counselor educators and supervisors will not be able to help in training counselors cope with negative experiences associated with vicarious trauma such as burnout, compassion fatigue, and decreased professional effectiveness (Hernandez-Wolfe et al., 2015; Maslach & Leiter, 2016).

Purpose of the Study

The purpose of this qualitative multiple case study is to examine the individual and organizational resources that counselors who have self-reported vicarious trauma used to cope with the experience in order to continue practicing in their profession effectively. The central phenomenon that was examined is the experiences of clinicians coping with vicarious trauma. The scope of the context of the multiple case study was on individual and organizational coping resources of counselors who have successfully coped with vicarious trauma, which will be operationalized based on their own self-assessment of overcoming the obstacles related to vicarious trauma. This study is significant because the results could help counselors become more aware of the individual and organizational resources in coping with vicarious trauma. Counselor educators and supervisors can also benefit from the findings by presenting new information relevant to the training of counselors on how to become more prepared when confronted with vicarious trauma.

Research Questions

To address the purpose of the study, the research questions of the study are the following:

RQ1: How do counselors who have self-reported vicarious trauma describe the individual resources that assist with effective coping?

RQ2: How do counselors who have self-reported vicarious trauma describe the organizational resources that assist with effective coping?

Theoretical Framework

Theories give research projects a road-map from which to navigate. This study focused on how counselors were able to cope with their experiences of vicarious trauma. Two theories that will comprise the framework of the study will be the social cognitive theory and the constructivist self-development theory. Both theories are rich in research and track a commonality that the study will use as the theoretical framework.

Bandura (1989) noted that the social cognitive theory's main focus is that people are neither autonomous in their social behaviors, nor are they influential to environmental influences. The social cognitive theory is based on the beliefs of individuals about their own action, based upon how they view the social norm at that moment. Many of the interactions individuals have with each other are influenced in some way by their subjective social interpretation of the event, regardless of their actual abilities.

Central to the social cognitive theory is the concept of self-efficacy, which concerns human cognition, thought, and action. Bandura's (1989) conception of self-efficacy states that the more effective a person believes himself or herself to be, the more effective he or she will actually be. Past researchers have used self-efficacy in terms of how it could contribute to developing successful interventions to deal with vicarious trauma experienced by counselors (Gundoz, 2012; Bozgeyikli, 2012; Berger & Gelkopf, 2011). With the phenomenon of vicarious trauma, self-efficacy can be used to understand how clinicians view themselves as capable of being able to cope with vicarious trauma.

The second theory in the framework is constructivist self-development theory. McCann and Pearlman (1990) hypothesized that the constructivist self-development

theory was developed and tested to understand the psychological responses to victimization. The constructivist self-development theory attempts to understand the multifaceted nature that manipulates personal behaviors when dealing with victimization by oneself or others. According to McCann and Pearlman (1990), the life experiences of individuals shape the present and the future. The authors continued to note that if counselors' life experiences are too closely aligned with the trauma presented by their clients, this experience puts helping professionals at greater risk for vicarious trauma.

Nature of the Study

The selected research approach for this study was a qualitative paradigm. This research approach provides the ability to capture the human story behind the topic that is being analyzed. Qualitative research is appropriate for the study because in-depth information is needed to address the research questions. Under the qualitative research approach, a case study approach will be best suited to gain rich and in-depth information from the participants using various data collection tools (Patton, 2002). The logic for the selection of case study research design is flexibility (Yin, 2013). The use of multiple sources of data collection tools such as interviews and observations will enhance the comprehensiveness of the study.

Case studies are utilized when a complex phenomenon needs to be examined naturally without manipulating the context (Baxter & Jack, 2008). According to Yin (2013), case studies are appropriate when the research questions involve "how" or "why" questions, manipulation of behaviors cannot be made, the context plays a significant role in understanding a specific phenomenon, and there is no clear boundary

between the phenomenon and context. A qualitative case study research design will give researcher the opportunity to converge various data sources to fully illuminate the nuances of a case (Baxter & Jack, 2008).

The sample consisted of 10 counselors from three different organizations who have successfully coped with vicarious trauma based on their own self-report. The rationale for the sample size of 10 participants is the need to reach data saturation, the point where no new information can be uncovered even if more participants are added in the sample (Francis et al., 2010). Even though data saturation is not the same for every study, 10 participants is usually sufficient for data saturation to occur (Francis et al., 2010).

For the collection of data, a designated person was responsible for conducting the individual semi-structured interviews, generating observation notes of organizational practices, and collecting document records. The semi-structured interviews were conducted individually and face-to-face in the office of the participants. Data collection for the observation involved observing the workplace of the counselors to gather information about the organizational resources that may be critical in the coping of the participants from vicarious trauma from their patients. The observation data did not include the counseling sessions, but the interaction of counselors with their coworkers within the organization. The collection of document records included reports, meeting notes, memos, leaflets, written policies, and help guides pertinent to addressing vicarious trauma within the organization. The designated person used thematic analysis to analyze all the data collected from the participants and the organization.

Definitions

The following key terms are defined in this section:

Individual resources: This term refers to individual factors that can play a role in the development of vicarious traumatization such as "personal history of maltreatment, training and preparation for child welfare, coping, secondary traumatic stress, compassion fatigue and compassion satisfaction" (McFadden et al., 2014, p. 7).

Organizational resources: This term refers to organizational factors that can play a role in the development of vicarious trauma such as "workload, social support and supervision, organizational culture and climate, organizational and professional commitment, and job satisfaction or dissatisfaction" (McFadden et al., 2014, p. 7).

Vicarious trauma: This term refers to the "painful and disruptive psychological effects of trauma-based work" (Barrington & Shakespeare-Finch, 2013, p. 90).

Assumptions

The first assumption is that the participants will be honest in their self-assessment that they have experienced vicarious trauma and that they were able to cope with the problem. An assumption was made that the responses of the participants in the interviews are honest and a true reflection of their past experiences. Encouraging honesty during interviews by developing a researcher-participant relationship that is based on trust and openness.

The second assumption is that the selection of case study research design was influenced by the interconnectedness between the research phenomenon and the context. The lack of clear boundaries between the phenomenon and context is one of the main

features of case study research design (Yin, 2013). The assumption is that the experiences of the individual counselors with regard to coping with vicarious trauma are interconnected with their organizational practices.

The third assumption is that the use of 10 participants in three different organizations is sufficient in reaching data saturation. Even though data saturation is not a fixed number, 10 participants is usually sufficient for data saturation to occur in qualitative studies (Francis et al., 2010). Data saturation is important in qualitative studies in order to determine the point where no new information can be uncovered even if more participants are added in the sample (Francis et al., 2010). If data saturation is not reached with the initial target, the sample size will be increased until data saturation is achieved.

The fourth assumption is that the use of semi-structured interviews, observation notes, and document records will be sufficient to gain insights about the individual and organizational resources that counselors who have self-reported vicarious trauma use to cope with the experience and continue practicing their profession effectively. The use of semi-structured interviews will be the main source of data. Supplemental data such as observation notes and document records will provide information about the organizational resources that may be critical in the coping of the participants from vicarious trauma from their patients.

Scope and Delimitations

The scope of the study was confined to counselors: (a) who have successfully coped with vicarious trauma (which will be defined as those who have self-reported based on their own assessment of having successfully coped with vicarious trauma), (b)

who are currently active in the profession as counselors of trauma patients, (c) who work in an organizational mental health clinical setting, and (e) who have at least two years of counseling experience. These delimitations are made because these participant characteristics are central to the phenomenon that will be examined, which is the experiences of counselors coping with vicarious trauma. Only semi-structured interviews, observation notes, and document records will be used for the collection and analysis of data.

Limitations

One limitation of the study is the transferability of the study, which is the extent to which the results presented can be considered outside the sample of the study (Golafshani, 2003). The results may not be transferred to all counselors who experienced vicarious trauma. The transferability of the results of the study are enhanced by generating a thick description of the context wherein the study was intended (Shenton, 2004). By generating a thick description of the context of the study, other researchers can be informed about the intent and scope of this study. Through this thick description, other researchers can evaluate the relevance and appropriateness of the results that will be presented in this study on their own research.

Another limitation of the study is that both vicarious trauma and recovery from such trauma will be self-reported. I relied on the assessment of the counselors regarding their own experience about vicarious trauma based on their scores on two questionnaires. This is a limitation because verification if all the participants had vicarious trauma and that they were able to successfully cope with the condition cannot be definitively made.

To ensure that all participants had experienced vicarious trauma in the past they were asked to self-assess themselves on their degree and severity of vicarious trauma and if they felt they have successfully managed this form of trauma. To ensure the high standards of the American Counseling Association Code of Ethics (2015) were followed, no counselors who were currently experiencing vicarious trauma were included in the study.

Significance

This research could yield significant results by focusing on counselors who have already successfully coped with vicarious trauma. The logic for the selection of the population is that only professionals who have successfully coped with vicarious trauma can provide useful and relevant insights about the necessary strategies needed to cope with vicarious trauma. This study is significant because the results can help counselors, educators, and supervisors gain a deeper understanding of how current clinicians are able to cope with vicarious trauma. This could provide treatment approaches to current counselors who are suffering from this form of trauma.

This study will also offer much needed education on a form of trauma that many clinicians are not aware. Counselors, like other helping professionals, enter this profession to assist people who may be struggling with life stressors. This study could significantly impact these helping professionals by highlighting the coping resources that helped in surviving vicarious trauma. Learning from clinicians who have successfully coped with this form of trauma will be significant in allowing other practicing clinicians to learn from these experiences.

Summary

As recommended by James and Gilliland (2013) to examine the issue of vicarious trauma with more depth, this study focused on vicarious trauma experienced by counselors as a result of treating trauma patients. When clinicians are faced with treating trauma patients, the experience puts clinicians at risk for vicarious trauma. The purpose of the qualitative multiple case study was to examine the individual and organizational resources that counselors who have self-reported vicarious trauma, used to cope with the experience, in order to continue practicing their profession effectively. This study is significant because learning from clinicians who have successfully coped with this form of trauma might allow other counselors to improve their own practice. Educators and supervisors may also benefit from the findings by presenting new information relevant to the training of counselors in order to become more prepared when confronted with vicarious trauma. The next chapter will include the presentation of the literature review.

Chapter 2: A Review of the Recent Literature

Introduction

The nature of the work that clinicians perform in helping trauma clients has both positive and negative implications for the professional and personal lives of mental health care professionals (Hernandez-Wolfe, Killian, Engstrom, & Gangsei, 2015). The characteristics that make counselors effective—such as self-efficacy— put them at risk and make them vulnerable to burnout (Saakvitne & Pearlman, 1996; Figley, 1995). This is because self-efficacy is the foundation upon which vicarious trauma can originate and develop. Threats of vicarious trauma are always present in counselor work, whether one is treating a combat veteran's experiences of post-traumatic stress disorder (PTSD), or a child welfare case worker is working with children who suffered extensive abuse in unhealthy environments (James & Gilliland, 2013). Understanding the traumatic experiences of clients is tremendously useful for the practice of counseling; however, it can also have an emotional and psychological toll on the professional and personal well-being of counselors (Hayden, Williams, Canto, & Finklea, 2015).

A 2004 study of 221 mental health providers showed that 70% of them had come into contact with moderate to profound trauma in their patients during treatment (Khadambi & Truscott, 2004). Over a third of identification of symptoms for the detection of vicarious trauma in clinicians, as well as identifying and developing effective organizational and individual strategies for its prevention, becomes imperative for the entire mental health profession.

For example, recent attention has been focused on various organizational characteristics that may contribute to the emergence of vicarious trauma. However, there are limited scholarly investigations exploring the role organizational policies and practices that can play in coping with vicarious trauma on organizational employees such as social workers and counselors that are at high risk. This is because the studies that have focused on organizational resources have done so mainly with reference to occupational burnout in general, but not the specific kinds of stresses and strains unique to the mental health profession such as vicarious trauma (Dagan et al., 2015; Cloitre, 2015; Hinderer, Vonrueden, Friedmann, Mcquillan, & Gilmore, 2014; Bride & Kintzle, 2011).

For example, in the literature, the terms compassion fatigue, secondary traumatic stress disorder, or vicarious trauma have been used in this context to distinguish the phenomenon from occupational burnout (Cieslak et al., 2014). More research on the central role that the work environment and organizational systems and structures play in the formation of both vicarious trauma and occupational burnout is needed. With this in mind, the purpose of this qualitative multiple case study is to identify and examine a variety of individual and organizational coping factors that mental health professionals with self-reported vicarious trauma have devised, and have used, in order to cope with the negative experience. The scope and context of this multiple case study analysis was on the individual and organizational coping factors devised by counselors who have successfully coped with vicarious trauma based on their own self-assessment. The major research gap to be addressed is the lack of scholarly studies and adequate knowledge base

concerning the individual and organizational factors that counselors have either developed to deal with their own vicarious trauma.

This study focused on the identification of the signs, symptoms, and serious impairments associated with vicarious trauma, as well as a host of understudied risk factors. In addition, this study is additionally to provide the foundations for the development of a comprehensive knowledge and database of successful coping skills for vicarious trauma. Organizations are at risk of losing good clinicians due to their unnecessary suffering with vicarious trauma and it maybe in the organization's best interest to invest in its successful treatment and prevention.

The following online databases and search engines were used in order to write this literature review: EBSCOHost, JSTOR, ScienceDirect, PsychArticles, ERIC, and PubMed. Search terms used included *trauma, burnout, vicarious trauma, secondary trauma, secondary trauma disorder, compassion fatigue, vicarious resilience, compassion satisfaction, self-efficacy, self-care, job satisfaction, managerial supervision, organizational culture* and *organizational commitment*. Using these keywords (both individually and in combinations), relevant studies were generated from database searches. Those that were deemed relevant to the study were included in the literature review. Most of the literature included was published between 2011 and 2015, to ensure that the latest findings and reports were included in the review. However, a few seminal sources in the theoretical framework were published before 2011.

This literature review will provide an expanded background to the research problem discussed in the earlier chapter. The first section identifies the literature search

strategy used to write the literature review. The second section focuses on social cognitive theory and includes the central concept of self-efficacy (Bandura, 1989), as well as the constructivist self-development theory (McCann & Pearlman, 1990), which was specifically worked out in the context of trauma theory and subsequent possible remedies for its successful treatment. The rationale and relevance for the choice of theories is also provided. The third section focuses on discussing concepts of trauma and occupational burnout. The fourth section focuses on conceptual clarifications surrounding the notion of vicarious trauma. This includes a discussion of the symptomatology and the consequences of vicarious trauma. The fifth section focuses on the coping factors dealing with vicarious trauma at the organizational level. There will be a discussion of organizational culture and commitment, the role of supervision, as well as having adequate access to the resources needed to combat vicarious trauma. The sixth section focuses on various individual and personal coping factors for dealing with vicarious trauma, including discussions of vicarious resilience, compassion satisfaction, social support, self-efficacy, self-care and relaxation and spiritual exercises. The chapter ends with the summary and conclusions of this literature review, including addressing the major theoretical gap in the literature, and explaining how this study dealt with this gap, while providing materials and knowledge that would work towards narrowing or closing it.

Theoretical Framework

The two models that provided the theoretical framework for this study are the self-efficacy and social cognitive theory (SCT) (Bandura, 1989), and constructivist self-

development theory (McCann & Pearlman, 1990). Bandura's (1989) work was the foundation of SCT. The concept of self-efficacy is a theoretical construct concern about human cognition, thought, and action, first articulated and then developed in the work of Albert Bandura (1989), in the context of theorizing from the social cognition theory (SCT) model. The scholarly literature on professional and personal self-efficacy, focuses on how it could contribute to successful interventions developed to deal with vicarious trauma experienced by counselors (Shoji, Cieslak, Smoktunowicz, Benight, & Luszczynska, 2015; Gundoz, 2012; Bozgeyikli, 2012; Berger & Gelkopf, 2011).

The constructivist self-development theory (CSDT) is a theoretical construct developed within the context of trauma theory and vicarious trauma, which combines object relations, self-psychology, and social cognition theories. CSDT is grounded in the constructivist view of trauma, which argues that a person's unique history forms, structures, and constructs his or her experience of traumatic events, including how they have adapted to their trauma (Pearlman & Saakvitne,1995; Figley, 1995; McCann &Pearlman,1992). An important concept in CSDT are cognitive schemas, which are cognitive framework that helps an individual organize or interpret information. Realities are constructed through experience, not simply given. CSDT provides a model to help theoreticians and practitioners come to a better and more thorough understanding of cases in which psychological defense mechanisms are constructed to help an afflicted individual deal with situations or events that fail to correlate with that individual's perceptions and conceptions of what is real. Such situations are often the result of vicarious trauma.

Within the framework of CSDT, the development of vicarious trauma in healthcare professionals is interpreted as an adaptive mechanism that helps them properly respond to their clients' retelling of their traumatic experiences (Cohen & Collens, 2013). CDST also provides a theoretical model for better understanding the host of changes and modifications that may occur to counselors' belief systems and cognitive schemas, as a result of their exposure to and personal experiences with vicarious trauma. Within the context of CDST, it is acknowledged that such changes and modifications to human emotional, mental and cognitive capacities are both pervasive as well as cumulative. This pervasiveness is due to do to the fact that vicarious trauma, substantially impact counselors or counselors in numerous ways and through different aspects of their professional and personal lives (Cohen & Collens, 2013). They are cumulative in that every time a counselor encounters a client that has been traumatized for any number of reasons, the modifications to the belief systems and cognitive schemas are reinforced, re-modified, and sometimes expanded (Pearlman & Saakvitne,1995). There are three different aspects of the self that traumatic experiences can exert a profound influence over or even modify. They include:

> Self-capacities, or the ability to tolerate strong affect and regulate self-esteem. Cognitive schemas, or beliefs and expectations about self and others in the areas of frame of reference (or identity and world view), safety, trust, esteem, intimacy, power, and independence; and intrusive trauma memories and related distressing affects. (McCann & Pearlman, 1992, p. 189)

Hence, counselors could experience interference or even modification of the basic schemas that constitute their self-structure while treating clients and patients that have lived through trauma. CSDT was developed to better understand the changes and modifications to the core self of counselors during such treatment (McCann & Pearlman, 1990).

Many terms have been given that attempt to describe or classify the kinds of experiences that counselors report when they are at risk for facing trauma simply by treating trauma patients—including burnout, compassion fatigue, secondary stress disorder, vicarious trauma, and others. Due to the variance of terms in the literature, terminological and conceptual clarification and analysis is necessary. The first terms to be analyzed are trauma itself, as well as the phenomenon known as occupational burnout.

Trauma and Occupational Burnout

> According to Pearlman and Saakvitne (1995), psychological trauma is defined as
>
> …a unique individual experience, of an event or enduring condition in which the individual's ability to integrate his/her emotional experience is overwhelmed, and/or the individual experiences (subjectively) a threat to life, bodily integrity, or sanity. (p. 60)

Some researchers defined occupational burnout based on the characteristics or symptoms. The attributes of occupational burnout include reduced levels of energy, feelings of low self-esteem, unhealthy sleep patterns and subsequent workplace irritability, and destructive avoidance coping mechanisms (Carello & Butler, 2015; Kim & Kao, 2011). According to other researchers, three characteristics of definitive

occupational burnout are: (1) emotional exhaustion, (2) diminished sense of professional achievement and commitment to the profession, and (3) depersonalization (Russell, 2016; Hamama, 2012a; Hamama, 2012b).

Demographic Characteristics and Occupational Burnout

Two of the more important demographic features associated with occupational burnout are age and gender (Hamama, 2012a). For example, a research investigation of 591 Israeli social workers suggested that social workers under the age of 30 experienced higher levels of burnout compared to their more senior counterparts. Moreover, Hamama (2012a) also discovered that female social workers reported more elevated levels of occupational burnout than did male social workers of the same or similar age. In addition, social workers who felt unsupported by their organization self-reported higher levels of burnout (Hamama, 2012b).

In a related study on age, gender, and the phenomenon of occupational burnout, Kim and Kao (2011) discovered that female social workers in California self-reported inferior physical health and heightened levels of workplace stress as compared to male social workers. Data from the study also suggest that younger social workers report more adverse physical health due to workplace stress than more senior social workers (Kim & Kao, 2011). Higher levels of adverse physical health and stress in younger workers may be due to the fact that they have yet to obtain ample opportunity to successfully incorporate and reconcile the traumatic experiences and reports of their clients into their own cognitive schemas and belief systems (Kim & Kao, 2011). Another factor is that they may not have had time to develop adequate coping mechanisms for responding to

the negative effects of vicarious trauma as compared to their older and more experienced counterparts (Carello & Butler, 2015; Kim & Kao, 2011). Carello and Butler (2015) stress how important it is for all counselors to be educated so that they can immediately recognize the onset of trauma-intensive therapy-related problems. More studies on burnout and its relevance to demographic features such as gender and age are needed.

Occupation burnout and vicarious trauma

Although occupational burnout is oftentimes mistaken for the notion of vicarious trauma, it is necessary to keep them conceptually distinct. Two major distinctions are that occupational burnout is a condition that will gradually affect an individual over time and can often be resolved or alleviated with some quality time away from the jobsite. Vicarious trauma, on the other hand, comes on more suddenly, and often requires clinical intervention in order to become free of it (Cieslak, Shoji, Douglas, Melville, & Luszczynska, 2014). On a related topic, Plouffe (2015) present data which suggest a substantial correlation between counselors experiencing burnout, and a significant likelihood that these same counselors would develop vicarious trauma. Burnout is correlated to vicarious trauma in this study. The researcher caution that the correlation may be at least partially the result of both constructs being analyzed and calculated within the same framework of compassion fatigue Plouffe (2015). Sansbury, Graves, and Scott (2015), on the other hand, identify the connections between occupational burnout and vicarious trauma when they argue that vicarious trauma often leads to occupational burnout, but not vice versa. Hence it seems that burnout eventually emerges as a result of vicarious trauma, and not that burnout causes vicarious trauma.

Vicarious Trauma

Vicarious trauma refers to harmful changes that happen in how an individual perceives themselves, others, and the words (Baird & Kracen, 2006). STS refers to psychological symptoms that mimic post-traumatic stress because of exposure to individuals suffering from trauma (Baird & Kracen, 2006). Pearlman and Saakvitne (1995) define vicarious traumatization as the "transformation in the inner experience of the therapist that comes about as a result of empathic engagement with clients' trauma material" (p. 31), while Michalopoulos and Aparicio (2012) define vicarious trauma as the "disruption in schemas and worldview often accompanied by symptoms similar to those of posttraumatic stress disorder (PTSD), which occur as a result of chronic secondary exposure to traumatic material (p. 646)".

To conclude this section on conceptual clarification, recognizing that in the literature a variety of different terms are used in reference to the potential risks to their psychological well-being that counselors face when constantly exposed to trauma experiences of their clients, Hinderer et al. (2014) felt it most appropriate to use a single term which is; vicarious trauma to capture the phenomenon. Likewise, while the terms (vicarious trauma, secondary traumatic stress, and compassion fatigue) are often used interchangeably in the literature, for the sake of simplicity and consistency of this study, the term vicarious trauma was used exclusively throughout this study, unless otherwise noted.

Measurement of Vicarious Trauma

The Vicarious Trauma Scale (VTS), created as part of a study related to constructivist self-development theory, was developed in order to measure the negative impacts vicarious trauma has on the shifting and modification of counselors' cognitive schemas (Aparicio & Michalopoulos, 2013). Due to its preliminary success, the authors recommended that VTS be used as a practical and effective tool for the proper screening of signs and symptoms of vicarious trauma in the work and lives of practicing counselors. Jenkins, Mitchell, Baird, Whitfield, and Sarah's (2011). The examination of 101 sexual assault and domestic violence counselors investigated the consequences when counselors who have experienced trauma treated clients who have experienced the same, or similar, types of trauma. Although present research conducted on the topic is not definitive, Jenkins et al. (2011) found that counselors who experienced trauma themselves, and who treat clients who experienced the same kind of trauma, self-reported more symptoms of vicarious trauma and hence were at higher risk of vicarious trauma than those counselors not treating trauma patients on a regular basis.

Ullman (2014) came to similar conclusions after analyzing the data collected from interviewing 12 clinicians who treated survivors of sexual assault on a regular basis. In a related study of sexual violence and rape among Nigerian University students, Ilesanmi, Olatundun and Asiazobor (2012), discovered that counselors working on a regular basis with a high percentage caseload of victims of sexual violence and abuse experienced more vicarious trauma and greater disruptions in their cognitive schema—their belief systems about themselves and others—than did counselors not assigned to clients who

were victims of sexual violence and abuse. This and other studies have suggested that, despite being educated on the topic of trauma and vicarious trauma, counselors can at times become unwittingly emotionally enraptured in their client's trauma and it is therefore, important to tailor remedies and solutions that are developed case by case, in order to assure that as many cases of vicarious trauma are identified and treated as soon as possible, before problems escalate (Cloitre, 2015; Hinderer et al., 2014).

Symptoms of Vicarious Trauma

Other researchers have also identified some physiological symptoms typical of vicarious trauma, including intrusive imagery, flashbacks, nightmares, and obsessive thoughts, that are also typical of PTSD (Hensel, Ruiz, Finney, & Dewa, 2015; David, 2011). Pointing out the correlations between PTSD and vicarious trauma is very helpful in our growing scientific knowledge of vicarious trauma because a substantial literature and a solid knowledge base on PTSD has already been developed, and this can be applied to the further study of vicarious trauma. For example, Pearlman and Saakvitne (1995) coined the term *vicarious traumatization* to help specifically explain the intrusive imagery often experienced by counselors, which develops as a result of the treatment of trauma patients. Intrusive imagery is imagery that imposes in an unwanted way into the mind, memory, and imagery system of counselors and can cause them pain and suffering when they try to deal with the raw experiences, images and other emotions related to the traumatic experiences of their clients (Pearlman & Saakvitne, 1995).

The key insight of much of this research devoted to conceptualizing the problem is that the emotional and psychological shock resulting from exposure to client trauma is

a conditioning experience, and in fact is thought to be transferred through the emotions of empathy and sympathy from client to counselor (Figley, 1995; Pearlman & Saakvitne, 1995). This is an important point because it helps us better understand the possible causal mechanisms underlying vicarious trauma. A more comprehensive and thorough understanding of the causal mechanisms could provide the knowledge needed to better identify and treat secondary stress disorder, or vicarious trauma. Hence, it is clear from a review of the literature that social workers, counselors, and other mental health care providers can be indirectly traumatized through the direct work he or she does with individuals who have experienced trauma (Williams, Helm, & Clemens, 2012*;* Houck , 2014; Choi, 2011).

For Williams et al. (2012), the major characteristics of vicarious trauma are: (1) substantially impacting the counselor's life in multiple ways; (2) a cumulative effect where continuous exposure to the trauma material presented to them by their patients increases their risk to vicarious trauma; and (3) the potential for permanent damage to the emotional and psychological makeup of clinicians, leading to actual modifications of their own perspectives and imagery, and sometimes even personality. Further research has established the presence of numerous possible harmful effects on counselors who are continuously exposed to their clients' traumatic problems and concerns (Houck, 2014; Hinderer et al., 2014; Whitfield & Kanter, 2014; Elwood et al, 2011). Houck (2014), for example, noted that oncology nurses are especially prone to developing symptoms of cumulative grief and compassion fatigue due to the death and dying element many are exposed to when treating terminally ill and end-of-life cancer patients.

In their study on the prevalence of secondary traumatic stress in mental health workers, Robinson-Keilig (2014) collected data from a sample of 320 licensed mental health providers who completed an online questionnaire. The hypothesis to be tested was that the more mental health counselors experienced greater levels of intrusion, avoidance, and arousal symptoms (typical of both PTSD and vicarious trauma), the more likely they would also experience disruptions in their interpersonal relationships. The results were mixed, but one finding of the study suggested that higher levels of symptoms experienced that were associated with secondary traumatic stress caused a lessened sense of social intimacy, disjointed communication patterns, a heightened sense of detachment, and mental health care providers eventually emotionally withdrawing from their colleagues and their clients (Bercier & Maynard, 2014). What is more, these conditions remained the same even after controlling for demographics such as gender, socio-economic status, and number of years of working as a counselor.

Hensel, Ruiz, Finney and Dewa (2015) pointed out the fact that in the most recent revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013), continuous exposure to trauma patients increased the risks of developing vicarious trauma in the counselors and counselors who treat them. Some of the signs and symptoms of vicarious trauma include changes in trust, beliefs about safety, and intrusive and unwanted thoughts (Hensel et al., 2015). Additional symptoms of vicarious trauma include (1) depression, (2) anxiety, (3) nightmares, and (4) hypervigilance. These often appear quickly, without warning, and continue to endure throughout the personal and professional lives of counselors,

potentially threatening the quality of mental health services provided (Elwood et al, 2011). Furthermore, symptoms of vicarious trauma are witnessed in counselors after they have been exposed to their clients' retelling of their own traumatic experiences, in which counselors subsequently can take on the characteristic symptoms experienced by the trauma survivors that the counselor is treating (Elwood et al., 2011). Just as constructivist self-development theory posits, researchers have recognized that vicarious trauma may even lead to disruptions and disturbances in one's belief system and thought patterns, what experts call cognitive schemas, that we all have and hold about ourselves, other people, as well as the world around us (McCann & Pearlman, 1992; Pearlman & Saakvitne,1995). In a seminal study, some researchers distinguish burnout from vicarious trauma simply by the fact that vicarious trauma developed out of, and is clinically based specifically on trauma theory, in particular constructivist self-development theory, whereas the analysis of burnout was not (McCann & Pearlman, 1992).

Nevertheless, despite the literature already discussed, research on the level of counselors' risks posed by vicarious trauma is inconsistent. For example, Elwood et al. (2011) suggested that, of the trauma counselors studied, the presence of clinically significant levels of symptoms of vicarious trauma experienced by trauma counselors is not as high as some researchers suggest. These levels are not clinically significant compared to the levels experienced by other medical health providers.

Other researchers have arrived at similar conclusions (Wood, 2011). Such inconsistencies point to why there is a substantial gap in the academic literature on vicarious trauma. There are also gaps on how counselors have either devised or learned

how to utilize organizational and individual coping factors to successfully deal with vicarious trauma in more productive, therapeutically, and clinically ways. Such gaps in the literature reiterate why the present study is needed, necessary, and timely.

Effects of Vicarious Trauma

One study examines how biased perceptions related to a caregiver's ability to help traumatized patents directly correlates with the level of secondary traumatic stress experienced by those very caregivers themselves (Shalvi, Shenkman, Handgraaf, & De Dreu, 2011). The hypothesis tested in this study of Israeli caregivers working with terror victims traumatized by war was whether mental health providers have a tendency to overestimate their ability to help with their client's traumatic experiences, subsequently ending up underestimating their own vulnerability to secondary traumatic stress disorder and vicarious trauma. The conclusion of the study was that Israeli caregivers did overestimate their abilities, therefore making them more vulnerable to vicarious trauma.

Jenkins, Mitchell, Baird, Whitfield, and Sarah's (2011) examination of 101 sexual assault and domestic violence counselors, on the other hand, investigates the consequences when counselors who have experienced trauma treat clients who have experienced the same, or similar, types of trauma. Jenkins et al. (2011) found that counselors who have experienced trauma themselves, either in their own lives or as a result of treating trauma patients themselves, and who treat clients who experienced the same kind of trauma, self-reported more symptoms of vicarious trauma. Hence, they were at a higher risk for vicarious trauma than counselors who did not treat trauma clients on a regular basis. In fact, other researchers have come to the same or similar conclusions. For

example, Hayden, Williams, Canto, and Finklea (2015) also suggest that vicarious trauma does pose a higher risk to those counselors who work with clients dealing with trauma issues, as compared to their counterparts who do not treat client trauma on a regular basis. Therefore, it is imperative that the health care organizations in which counselor's work become much more aware of the possibilities and vicissitudes of vicarious trauma, and therefore align themselves to be in a better position to develop policies and procedures that are able to effectively treat it. Only in this way can researchers continuously and consistently build a substantial and empirically grounded body of literature on the topic. More research is needed on the susceptibility of professional counselors and counselors to vicarious trauma to informed counselors in the field about this possible problem (Hunsaker, Chen, Maughan, & Heaston, 2015). The purpose of this study is of course to directly address such concerns, adding to and expanding the scholarly work being done on the problem at hand, while at the same time working to construct and classify an empirically grounded and established body of knowledge on a variety of organizational and personal coping factors for dealing with vicarious trauma, from which future researchers can borrow and further build on.

When it comes to determining the interfering and potentially dangerous and harmful impact that vicarious trauma could have on the counselor-client relationship, it was first necessary to thoroughly examine the range of symptoms of vicarious trauma, and the harmful and unproductive consequences that are the result when the symptoms are not fully recognized, and vicarious trauma unfortunately becomes part of the reality of counselors. Which, in turn, can possibly impact not only their professional practices,

but have negative effects on the personal and psychological characteristics of the counselors themselves, such as distortions of emotional frameworks and cognitive schemas. Once the symptoms and the consequences of vicarious trauma were identified and analyzed, the next goal was to gain conceptual clarity amongst the various terminologies used to describe the phenomenon of counselors becoming traumatized while treating traumatized patients and clients. While there were numerous concepts used in the literature to capture the problems, including minor differences among the terms, most experts agree that all of the terms used, including secondary stress, secondary stress disorder, compassion fatigue, vicarious traumatization, and vicarious trauma, can best be summarized and simplified if only one term is used. This is why, for the purposes of this study, the term vicarious trauma has been used throughout, unless specifically noted otherwise**.**

Once conceptual clarification was preliminarily achieved, and the signs, symptoms, and consequences of vicarious trauma are properly identified and discussed, the next step is to identify and articulate the role organizations can play, both in exacerbating the problem among its counselor employees, as well as in providing assistance with organizational policies and practices that can be put in place to help counselors avoid the disorder in the first place. However, if by chance counselors become afflicted with vicarious trauma, it is important to determine how organizations could and should deal with the problem once it has become manifest in the counselors working within the organization. In fact, one finding of Zeidner et al.'s (2013) study was that it was the organizational culture which was judged to be in the prime position to provide

the right conditions so that emotional intelligence, ability-based management, and positive adaptive mechanisms, all mitigating factors against vicarious trauma, could have the time and space to mature and develop. In other words, the conclusion of the study demonstrates that the development and maintenance of a strong and viable organizational culture can provide the right preconditions so that positive adaptive mechanisms for fighting such things as vicarious trauma have time to be cultivated and time to flourish. On the other hand, numerous other researchers argued convincingly that, just as the right organizational culture and climate are beneficial when it comes to being exposed to vicarious trauma, likewise, the wrong organizational culture and climate are detrimental, and consequently do not and cannot provide the right workplace environment conditions for counselors and others in order for them to be shielded from such occupational hazards as vicarious trauma. There are organizational factors that often play a causative role in workers falling prey to such things as trauma, occupational burnout, compassion fatigue, secondary stress disorder, or vicarious trauma, and therefore these must be identified and fully analyzed.

Organizational Coping Resources

Organizational culture can be defined as "the shared norms, beliefs, and behavioral expectations that drive behavior and communicate what is valued in organizations" (Choi, 2011, p. 227). It is management and the organizational culture that they set in motion that generally sets expectations about counseling work, in fact, Choi (2011) argued in his conclusion that the presence or absence of organizational support could have a direct influence on counselors' susceptibility to occupational burnout and

vicarious trauma. This seems to be true in organizations that must deal with patient-centered trauma, whether working in rape crisis centers, battered women's shelters, working with veterans returning from war, or victims of child sexual abuse. In fact, a substantial body of literature has developed over the decades drawing attention to a variety of organizational and workplace factors, such as nature of the work or work atmosphere, that can have negative impacts on counselors working within such organizations, especially the susceptibility of counselors within organizations to contact vicarious trauma (Howard, 2015; McFadden, Campbell, & Taylor, 2014; Dean, 2014; Shier & Graham, 2013; Joubert, Hocking, & Hampson, 2013; Harr, 2013).

There are policies and procedures that an organization that hires counselors, and others who treat traumatized victims as part of their regular caseload can implement, in order to intervene when their counselors are faced with vicarious trauma (Dagan et al., 2015; Bride & Kintzle, 2011). Dagan et al. (2015) conducted a study that involved a random sample of 217 social workers who were employed by an Israeli social service department catering to families confronted with crisis and trauma. One of the major findings of the study was that a particular organizational factor, which was the number of cases of a social worker, played a role and was a predictor of secondary traumatization in counselors. That is, the larger the caseload, the more prone counselors became to vicarious trauma. Researchers suggest more training, support and care from the organization, resulted in less burnout (Hamama, 2012a; Shier & Graham, 2013; McFadden et al., 2014).

An overview study of organizational factors specifically designed to investigate what structures may contribute to burnout and possible vicarious trauma identified specific organizational features, including workload, social support and supervision, organizational culture and climate, organizational and professional commitment, and job satisfaction or dissatisfaction (McFadden et al., 2014). For example, as concerns a counselor's general workload, it is clear that it is the organization, its culture, and its management structure that are in a prime position to make sure that trauma cases are properly distributed among the counselors who are in a position to be equipped with the skills necessary to deal with traumatized patients (Shier & Graham, 2013; Cox & Steiner, 2013; Harr, 2013). This is important, especially given the fact that one of the prime instigators of vicarious trauma in counselors is the excessively large caseload work that they were assigned.

A qualitative study of social workers conducted by Shier and Graham (2013) set out to gain more knowledge on the organizational factors that contribute to social workers' subjective well-being, or overall happiness. Starting with self-reported low levels of job and professional satisfaction disclosed by the 19 social workers interviewed, the data was used to determine factors in their lives and employment that could account for the low levels of subjective well-being of the social workers. One factor that appeared more often was the organizational context of the workplace and how that affected social worker job satisfaction and happiness in their professional lives. Additionally, while further investigating a range of organizational factors—including intra-organizational dynamics, interpersonal workplace relationships, decision-making processes,

management dynamics, workload and workplace expectations, access to resources and infrastructure support—it was intra-organizational relationships which appeared at the top of the list of the social workers surveyed (Shier & Graham, 2013). Such findings are especially relevant and have practical applications for the study of organizational policies and practices and how they can influence social workers in negative ways. In fact, professional burnout and/or vicarious trauma affect not only individuals but have a direct impact on organizational policies and practices. For example, organizations often see increased levels of counselor and social worker intentions to quit their jobs as a result of vicarious trauma, which could cost the organization sizeable amounts of time and money (McFadden et al., 2014).

One simple but effective way a counselor's organizational culture could provide assistance for counselor vicarious trauma, both once developed, but also as a preventive measure, is for supervisors to encourage counselors and social workers to verbally communicate to their superiors their experiences and reactions to clients who are suffering the debilitating effects of trauma (Cox & Steiner, 2013; Harr, 2013). For Harr (2013), one way for organizations and management to create a supportive work environment is for managers to continuously affirm the good work their counselors and social workers are doing and encourage further successful counseling and therapeutic work. A simple strategy is to provide opportunities for, and promote, more humor in the workplace (Harr, 2013).

Other organizational factors that can mitigate the negative impact of burnout and vicarious trauma are regular informational debriefings, and managers and senior workers

that promote an open-door policy where newer counselors feel comfortable seeking guidance from their superiors and older and wiser colleagues (Joubert et al., 2013). Counselors should be provided with the opportunity to discuss with their superiors their trauma so that they could better process reports of trauma by their clients and not internalize the client's traumatic experiences. McFadden et al. (2014), in their literature review of sixty-five articles study, which focused on child protection social workers, were led to similar conclusions after the analysis of the data was conducted**.**

Excessive caseload was identified as an aggravating factor when it came to counselors falling prey to the possible debilitating effects of vicarious trauma (Ullman, 2014: Joubert et al., 2013), especially if a particular counselor's or social worker's caseload consisted of clients who have come seeking help due to their experiencing a great deal of trauma. In other words, counselors and social workers that are exposed through treatment to a high number of clients that have traumatic histories themselves are at a higher risk for developing the symptoms of vicarious trauma (Ullman, 2014). Although not conclusive, these studies show that the more counselors treat traumatized patients, the more they are at risk of developing vicarious trauma. As a matter of fact, organizations that encourage their counselors and social workers to seek out additional resources when symptoms of vicarious trauma are first detected seem to be more successful in providing assistance to their workers that may experience the symptoms of vicarious trauma (Nelson, 2015; Cox & Steiner, 2013). Nelson (2015) even went so far as to call vicarious trauma an occupational hazard in the counseling and social work

professions and argued that organizational culture itself could very well be part of the cause of vicarious trauma in counselors.

A further suggestion for organizations is that they develop and promote more on-the-job training specifically geared towards burnout or vicarious trauma (Howard, 2015; Kulkarni, Bell, Hartman, & Herman-Smith, 2013). This includes the periodic administration of programs that are able to measure the risk of vicarious trauma (Kulkarni & Bell, 2012). Howard (2015) reiterated the point by arguing that the organizations social workers and counselors work for should be aware of not only occupational burnout, but vicarious trauma as well, and that they should provide training to their employees on how to recognize the symptoms of vicarious trauma and how to deal with it when experienced by the counselors themselves.

According to Sanchez-Moreno, de La Fuente Rolda, Gallardo-Peralta & Barron Lopez de Roda (2014), organizational variables could not be linked with creating or exacerbating the preconditions for burnout or vicarious trauma associated with distress. The researchers recommended that further and more detailed longitudinal and qualitative research should be conducted in order to further investigate the nature of the relationship between organizations, the counselors that work for them, and the potential for vicarious trauma. Due to discrepancies in the literature, such as those pointed out by Sanchz-Moreno et al. (2014), more research is needed in order to further investigate policies and practices at the organizational level which could act as countermeasures in order to lessen the possible signs and symptoms of vicarious trauma in those that work for the organization.

Role of Supervision

Proper supervision is essential to any productively functioning organization. As far as vicarious trauma and its possible organizational factors are concerned, the benefits of excellent supervision are at least two-fold. First, qualified and caring supervisors should be able to notice the first signs of vicarious trauma, putting them in a prime position to do something about it (Cox & Steiner, 2013). In fact, Cox and Steiner (2013) emphasized how crucial it is for organizations to hire managers and supervisors who are trained to pick out the signs and symptoms of occupational burnout and vicarious trauma and can furthermore help counselors develop practical coping strategies and skills. Other researchers expressed similar concern (Berger & Quiros, 2014; Furlonger & Taylor 2013).

Second, good supervision should be able to create and maintain a work environment where counselors or other workers feel supported and are provided the opportunity to learn and develop so that they may provide superior services to their clients (Joubert et al., 2013). Likewise**,** supervisors are in a position to provide educational opportunities and proper training that could inform their workers about the dangers of vicarious trauma, how to recognize the signs and symptoms of the disorder, and how to cope with it when actually experiencing compassion fatigue or vicarious trauma (Oleson, 2014; Dombo & Grey, 2013; Harr. 2013; Michalopoulos & Aparicio, 2012). For example, Oleson (2014) stressed the important role that supervisory debriefing of counselors' cases could play in helping prevent vicarious trauma. Sitting down with one's manager to discuss one's caseload provides the opportunity for the supervisor to

detect any possible situations that may lead to compassion fatigue or vicarious trauma. For example, a multiple case study of 16 oncology social workers revealed that one of the most treasured aspects of good supervision was the feeling of support and guidance the social workers felt while working for the organization (Dean, 2014; Joubert et al., 2013). According to Dean (2014), the more the counselors studied received satisfactory supervision and concerned managers, the better they felt able to deal with and even mastering work-related problems. On the other hand, social workers who felt that their supervisors showed little to no support, the more stress they felt in the workplace (Harr, 2013).

Contrary to the research just discussed, however, a study of 154 social workers whose clients included survivors of sexual violence uncovered little to no connection between the quality of supervision and vicarious trauma (Choi, 2011). This discrepancy in the literature might be because they are social workers. They receive support from their environment that makes them less vulnerable to vicarious trauma. In sum, the physical and cultural environment of an organization, and its supervisory managers, can either put a stop to, or predispose counselors to, vicarious trauma. Therefore, more research is needed in order to come to a better understanding of how supervisors working for the organization, could very well create the preconditions for vicarious trauma or burnout. In addition, more scholarly work should be carried out in order to find out, first-hand, how counselors who have already experienced vicarious trauma made a successful recovery, in the presence of superior managerial supervision, and hence were able to continue their work as counselors.

Access to resources. Access to resources refers to counselors' access to all of the materials, knowledge, time, capital, and support needed in order provide optimal services to their clients (Choi, 2011). For example, it is up to the organization to make available a safe, comfortable, and supportive environment so that counselors are in a better position to handle trauma patient cases. In addition, the more resources that counselors have access to, the more they are in a position to fulfill the organization's purposes and goals (Choi, 2011). Adequate access to resources includes being provided proper workplace conditions (Dagan, Itzhaky, & Ben-Porat, 2015; Thompson et al., 2014**;** Smith, 2015). For example, a relatively simple tactic that supervisors and management could and should put into operation is supplying a break room for counselors where they can take refuge and be in a better position to openly discuss their trauma patients, as well as being able to work on their self-care needs (Dagan et al., 2015; Thompson et al., 2014**;** Smith, 2015). The simple resource of providing access to a comfortable and welcoming break room, perhaps decorated by the counselors themselves, correlates directly with counselors' and others' increased job satisfaction levels. That is, creating a space for social relations to develop is a major factor in creating job satisfaction among counselors and others. Likewise, the more counselors feel a sense of personal fulfillment and satisfaction with their job, the less apt they are to becoming prey to insidious vicarious trauma (Dagan et al., 2015; Thompson et al., 2014**;** Smith, 2015). In this context, organizations should provide ample opportunities for discussion among colleagues so that they are able to exchange best practices, etc. Counselors should also be provided adequate resources for further research and continuing education (Elwood et al., 2011).

Organizations and management should provide clear workplace expectations, so that roles and responsibilities are properly delineated to the right personnel (Shier & Graham, 2013). Furthermore, organizations need to provide the best working conditions available, including being assigned the proper number of clients and not being overwhelmed with a caseload they cannot handle (Smith, 2015; Dagan et al., 2015). Moreover, organizations should also provide adequate vacation time, pay, raises and promotions, and other financial incentives to keep their counselors motivated and in order to maintain adequate levels of job satisfaction among counselors. All of this has the additional benefit in that it should result in improved patient care (Elwood et al., 2011).

The presence of a well-rounded staff, including those counselors who specialize in a particular area, whether it be anxiety and depression, sexual trauma and assault, eating disorders, or behavior therapy, could ensure that clients are receiving the exact counseling they need by well-trained counselors. Likewise, by increasing the availability of treatment options, especially when dealing with trauma, case workers are less likely to be overburdened with case after case of patients and clients dealing with traumatic experiences and that need psychological counseling in order to learn how to cope with it (Dagan, et al., 2015; Shier & Graham, 2013).

Ray, Wong, White, and Heaslip (2013) focused their quantitative research on the costs to an organization whose staff are experiencing vicarious trauma. The Professional Quality of Life Revision IV (ProQOL), the Areas of Work Life Survey, Maslach Burnout Inventory-General Survey and a Demographic Data sheet were completed by 169 frontline mental health providers. Higher levels of compassion satisfaction and lower

levels of compassion fatigue were predictive of lower burnout levels among the frontline mental health providers. Financial and other costs accrued by organizations as a result of vicarious trauma include heightened levels of physical illness, resulting in more prevalent use of sick time, increases in counselors' intentions to quit their job, lowered morale, and lessened productivity. Moreover, as Ray et al. (2013) pointed out, being burdened with a stress-related condition such as vicarious trauma affects not only individual health care workers, but it also has an impact on fellow co-workers, as well as clients, who, when not receiving the proper care that they deserve, will be more apt to complain about inferior mental health services received.

The various kinds and varieties of organizations that counselors work for can exert substantial influence over their employees in numerous ways, including organizational policies and practices, the role of supervisors and supervisory structures and strategies, and a counselor's access to adequate resources. All of these structures and roles need to be in place so that counselors can provide superior care to their clients and patients, while at the same time playing a role in advancing the goals of the organizations they work for. In order to build a comprehensive and through knowledge base on vicarious trauma and its impact on counselors, it was necessary to identify and discuss the various relevant organizational factors that could contribute to our understanding of the problem posed by this study.

Nevertheless, it is equally crucial to develop a firm understanding of all the various kinds of individual and personal coping factors that counselors should be aware of, and should avail themselves of, if the risk of vicarious trauma threatens their abilities

to carry out their professional duties and responsibilities as counselors. In fact, because of the importance of understanding both organizational as well as personal and individual coping mechanisms to confront nefarious vicarious trauma, this literature review has uncovered numerous researchers who discuss both individual and organizational factors (Dagan et al., 2015; Silveira & Boyer, 2015; Mason, Leslie, Clark, Lyons, & Walke, 2014; Harr, 2013; Bozgeyikli, 2012).

There are, in fact, tactics and strategies that counselors as individuals could take advantage of in the event that they experience symptoms of vicarious trauma. For example, Thompson, Amatea, and Thompson (2014) examined the gender, years of experience, and self-reported working conditions of 213 mental health counselors in order to determine individualized coping strategies for dealing with compassion fatigue and burnout. The findings suggested that those counselors who focused on mindfulness and compassion satisfaction as coping strategies, and developed positive working relations, were less likely to report having experienced compassion fatigue, vicarious trauma, or burnout.

Another study, conducted by Zeidner, et al. (2013), was designed to investigate the role that personal and professional factors played in helping to develop compassion satisfaction among health-care professionals (n= 89 mental and 93 medical). Variables that were tested included emotional intelligence and ability-based management. These were proven to be inversely associated with compassion fatigue. In other words, the more those mental health professionals acquired and efficiently utilized emotional intelligence and ability-based management, the less they experienced compassion fatigue.

Another finding of the study was that individual adaptive coping mechanisms were found to be inversely related to compassion fatigue, suggesting, again that the more apt counselors and mental health professional were at devising and implementing positive adaptive coping strategies, the less they developed or were burdened with, compassion fatigue.

Individual and Personal Coping Resources

Vicarious resilience. Hernandez-Wolfe, Killian, Engstrom, and Gangsei (2015) conducted a study of programs instituted across the United States that deal with traumatized victims of torture, in order to investigate the extent to which vicarious trauma and vicarious resilience could coexist in counselors and counselors. *Vicarious resilience* occurs when counselors can possibly be transformed by the resilience that their clients show when dealing with their own trauma due to being victims of extreme trauma such as torture. In other words, counselors, absorbed how resilient clients are when dealing with their own traumatic experiences, actually, themselves can develop vicarious resilience, just the opposite of vicarious trauma (Burnett & Wahl, 2015). Due to vicarious resilience, they were able to handle the sometimes extreme and painful trauma that their patients were subjected to and lived through. As Hernandez-Wolfe et al. (2015), concluded, when discussing the possibility of counselor vicarious resilience, that working in the arena of patient and client trauma counselors as well as counselors do become immersed in their clients' stories of experiencing extreme trauma, just like what happens in vicarious trauma, especially with those studied that were victims of publicly motivated violence or survivors of torture. However, when the client showed substantial resilience to their own

trauma, the counselors and counselors in turn developed a vicarious resilience to the suffering in patients who experienced extreme torture trauma.

Silveira and Boyer (2015) used a qualitative instrumental multiple-case study design and thematic analysis of the data to investigate whether counselors who treated child and youth victims of interpersonal trauma, and who witnessed the brave resilience some of the children showed in dealing with their own personal traumas, would themselves be impacted in positive rather than negative ways. Their hypothesis was confirmed. In other words, in this situation at least, the counselors experienced vicarious resilience. A majority of counselors who participated in the study reported experiencing increasing optimism and a sense of hope as they became inspired by the inner strength of their young clients. Similar findings were reported by Lambert and Lawson (2013) in their study of how counselors became encouraged by the resilience showed by the victims of two of the most devastating hurricanes to hit the United States, Hurricane Katrina and Hurricane Rita. Likewise, Pulido (2012) also had similar findings. In Pulido's exploratory qualitative case study of 26 mental health clinicians, results indicated that the presence of vicarious resilience was also reported in a study investigating counselors' responses to victims of the September 11th terrorist attacks in New York City (Pulido, 2012).

In a related study on the physical health of settlement workers caring for refugees and asylum seekers in South Australia, Puvimanasinghe, Denson, Augoustinos, and Somasundaram (2015) pointed to the strength, growth, and empowerment they encountered (vicarious resilience) in counselors' and social workers attending to the

South Australian refugees who experienced trauma in one form or another. A qualitative method, including data-based thematic analysis, was used to assemble and examine 26 in-depth open-ended interviews, the results of which have important implications for developing more effective treatments, by way of vicarious resilience, including mental health treatments of refugees (Puvimanasinghe et al., 2015). These results include the strength, growth, and empowerment experienced by trauma workers due to their work.

To summarize, cases of vicarious resilience highlight the fact that a true empathetic connection to clients that have been severely traumatized, can affect counselors either in a positive or negative way. Feelings of empathy towards one's clients seem to be an inescapable aspect of what it means to be a counselor or mental health care provider. Nevertheless, the stressful, and potentially harmful, impact of client trauma could result in an individually inspiring experience for counselors and counselors, provided counselors and counselors are supported by their work environment, which could very well make the difference between experiencing vicarious trauma instead of vicarious resilience (Puvimanasinghe et al., 2015). This is an important point because it underscores, again, the role that organizations in which counselors and counselors work can play, in either creating conditions that lead to vicarious trauma, or in leading counselors away from its potentially debilitating effects on their practices as well as their person (Silveira & Boyer, 2015; Puvimanasinghe et al., 2015; Lambert & Lawson, 2013).

Compassion satisfaction. Compassion can be defined as the "deep awareness of the suffering of another individual, coupled with the wish to relieve it" (Baverstock & Finlay, 2015, p. 1). Compassion satisfaction is a way of conceptualizing a certain kind of

job satisfaction that counselors experience when they derive pleasure from knowing the fact that their unique skills as mental health workers are successful in helping others work through their problems and succeed in their lives (Mason et al., 2014). A study involving 491 direct care registered nurses working in a 700-bed health care and teaching facility in the southwestern United States showed that organizational factors such as experienced job satisfaction were accurate predictors of compassion satisfaction. That is, the more supported by their organization the registered nurses perceived, the greater their capacity for compassion satisfaction (Kelly, Runge, & Spencer, 2015).

In a related study, Hunsaker et al. (2015) set out to examine certain demographic and work-related factors that had an impact on either the prevalence or absence of compassion fatigue and compassion satisfaction in the nursing profession nationwide across the U. S. While age was a prevalent factor in the development of compassion fatigue, with younger nurses feeling its effects more than their senior counterparts, overall the results showed more or less normal levels of compassion fatigue, while on the other hand the presence and experience of compassion satisfaction was higher than average. Lee et al. (2015) had similar findings. Lee et al. investigated the relationships between state and trait anxiety, burnout, compassion satisfaction, selected demographics, and compassion fatigue risk in practicing genetic counselors. Genetic counselors (n= 402) completed the State-Trait Anxiety Inventory, and the Professional Quality of Life scale. Four significant predictors of compassion fatigue were found: higher levels of trait anxiety, burnout, and compassion satisfaction, and ethnicity other than Caucasian

The purpose of Slocum-Gori, Hemsworth, Chan, Carson, and Kazanjian's (2013) study was to gain more knowledge than is presently known about the complex set of relationships that exist between compassion satisfaction, compassion fatigue and occupational burnout, especially in hospice and palliative care workers. The researchers also wanted to know how prevalent and successful specific mediating factors were, including professional status and affiliation, and principal institution of employment that, if present, could play a role in the development of compassion satisfaction rather than compassion fatigue. In order to test their hypotheses, a national survey of 630 health care workers, of all stripes and levels working in hospitals, community-based as well as homecare, was conducted. The results suggested a significant negative correlation between compassion satisfaction and compassion fatigue. In other words, the higher the levels of compassion satisfaction, the lower the levels of compassion fatigue, and vice versa. These results provide valuable information for organizations that are looking for ways to increase compassion satisfaction among their counselors, while reducing their counselors' potential risks of falling prey to the negative impacts of compassion fatigue.

Counselors and other mental health professionals who work with death and dying patients are often exposed to psychological challenges, emotional distress, as well as other serious issues when they have to deal with possible end-of-life situations (Sansó, Galiana, Oliver, Pascual, & Sinclair, 2015). It would, therefore, be helpful if researchers and practitioners could identify any successful coping strategies that could improve counselors' palliative care and subsequently increase patients' quality of end-of-life in death and dying contexts. To further investigate these issues, Sansó et al. (2015)

conducted a cross-sectional study of 387 Spanish palliative care providers who received, completed, and returned surveys by email in order to test the hypothesis that successfully being able to cope with the reality of dying and the awareness of death would relate positively to compassion satisfaction and negatively to compassion fatigue (Sansó et al., 2015). The results were not definitive, but one of the conclusions suggested that compassion satisfaction could predict counselors' overall competence in coping with death and dying. Organizations should therefore produce policies and practices that encourage more compassion satisfaction among the individual counselors who work for such organizations as a way of combating vicarious trauma. Again, we see how organizational and individual factors, working in tandem, together are able to prevent such debilitating conditions like vicarious trauma.

Self-efficacy. As part of their study of 90 baby-care nurses working in war torn parts of Israel, Berger and Gelkopf (2011) divided the nurses into two groups by randomly selecting 42 nurses who would receive an intervention, the test group, and 38 nurses that became the control group, and who did not receive the intervention. The intervention included providing the nurses with training in the use of screening tools that could be used to identify the possibility of vicarious trauma by increasing their professional self-efficacy. The intervention also included providing the nurses with stress management techniques in order to equip them to be sensitive to stress and be in a better position to deal with it. At the end of 12, 6-hour sessions of intervention, the two groups were then assessed according to four parameters: professional self-efficacy, measure of secondary traumatization, presence of hope, and sense of self mastery through self-

efficacy. The results showed that the test group had superior professional self-efficacy measurement scores, as well as reporting diminished levels of secondary traumatization. Therefore, Berger and Gelkopf (2011) concluded that it is essential for medical personnel working with traumatized children and their families to receive the correct training in order to enhance their professional self-efficacy and therefore decrease their vulnerability to secondary traumatization.

Another study examined the complex set of factors that relate to both burnout and self-efficacy in 194 school counselors, well-trained to recognize workplace stress, who were administered and who completed the Maslach Burnout Inventory, The School Counselor Self-Efficacy Scale, and the Personal Information Sheet. The study's findings showed that high levels of professional self-efficacy in the school counselors could predict both depersonalization as well as personal accomplishment dimensions as calculated by the Self-Efficacy Scale and Information Sheet (Gundoz, 2012). This means that comprehensive training programs lead to higher self-efficacy, while at the same time reducing depersonalization and increasing feelings of personal accomplishment.

In a related study conducted by Bozgeyikli (2012), a random sample of 142 school psychological counselors were surveyed in order to examine the relationship between levels of compassion fatigue and the counselors' corresponding perceptions and beliefs about their own self-efficacy, in reference to a variety of multidirectional roles and skills. Methods used to collect the research data included the use of personal information forms, life quality questionnaires for workers, and school counselor competency expectation scales. To properly analyze the data, Pearson product-moment

correlation coefficient matching, and direct multiple regression analyses were used. The results demonstrated a negative connection between the counselors' perceptions of self-efficacy and compassion fatigue, as regards the multidirectional goals identified, suggesting that the greater the self-efficacy reported by the counselors, the less they were susceptible to compassion fatigue. Likewise, when tested for psychological skills needed to perform at optimal work levels, the study showed that compassion fatigue was reduced as a result of positive self-efficacy as it related to the particular goals and skills tested (Bozgeyikli, 2012).

Likewise, results from a further study and meta-analysis of 57 original studies found in the literature review conducted by Shoji, Cieslak, Smoktunowicz, Rogala, and Benight (2015) pointed to similar conclusions. The purpose of the study was to analyze the strength of probable connections between self-efficacy and burnout, and how such connections could be moderated by occupation type, years of work experience, age, and ethnic background. The results showed that the professional self-efficacy strategies used by social workers and counselors were an effective mitigating factor against occupational burnout in the workplace. Given the promising findings of the literature reviewed so far on the relationships between self-efficacy and vicarious trauma, more studies need to be conducted.

Self-care. Self-care is about choosing behaviors that balance the consequences of emotional and physical stressors (Walker et al., 2015). According to a 2011 Fact Sheet on Vicarious Trauma published by the American Counseling Association, the dangers associated with counselors who are at risk for vicarious trauma include developing a low

self-image from guilty feelings of not being able to do enough for the patient(s). This could have the potential of leading counselors to come to question their actual clinical abilities and/or their very personal identity as well as overall world view. The potential for these unproductive and threatening situations to occur is real, and this points to the need for counselors to focus on their self-care as a way to combat vicarious trauma (Cox & Steiner, 2013). In fact, self-care has been called "an ethical imperative for professional helpers" (Cox & Steiner, 2013, p. 52). Simple activities related to self-care include healthy eating habits, proper exercise, getting proper rest, not becoming overwhelmed at work, engaging in recreational activities, or pursuing spiritual practices (Cox & Steiner, 2013). All of these self-care practices can go a long way in offsetting or preventing the potentially debilitating effects of vicarious trauma (Cox & Steiner, 2013; Harr, 2013; Tosone, Nuttman-Schwartz, & Stephens, 2012; McGarrigle & Walsh, 2011).

Tosone et al. (2012) referred to traumatogenic environments when discussing preconditioning factors that have the potential to exert an influence on counselors such that they may show signs of certain developmental symptoms related to vicarious trauma. In their investigation, however, case studies were provided by clinicians in Manhattan, New York and Sderot, Israel that described the transformative changes those counselors may experience when their care of the self actually led to heightened levels of compassion satisfaction and subsequent reduced potential for vicarious trauma (Tosone et al., 2012). The results of the study suggested that what was most important was the ability of counselors to be able to properly articulate their own trauma narrative in the context of their awareness and attentiveness to self-care (Tosone et al., 2012). Tosone et

al. (2012) also reiterated the point that organizations are often in a position to provide the necessary education, supervision, and support needed in order to combat the effects of vicarious trauma. In other words, when organizations were able make available the adequate resources such as those individual coping factors discussed, their counselors were less vulnerable to the clutches of vicarious trauma. This study points out the intertwined relationships between individual coping mechanisms and organizational factors that either promoted or prohibited individual self-care strategies, suggesting that individual and organizational coping factors should be studied together in research projects designed to better understand the relationship between vicarious trauma and such coping factors.

Mindfulness, an age-old notion rooted in Eastern philosophy and Buddhism, can best be described as a "heightened and deliberate awareness of both the internal and external experiences taking place in the present moment" (Baer, Lykins, & Peters, 2012, p. 233). Some of the important aspects of mindfulness include keen self-observation of one's own sensations, perceptions, thoughts, and emotions, being able to verbally articulate these experiences and express their impacts and practicing total non-judgment and non-reaction to such experiences in a detached and calm mood (Baer et al., 2012). Mindfulness has been empirically investigated and, in some cases, validated as a technique or personal philosophy that counselors should be aware of and should be able to implement in their professional as well as personal lives, in order to combat the onset of possible compassion fatigue, vicarious trauma, or occupational burnout (Raab, 2014; McGarrigle & Walsh, 2011). For example, Raab (2014) began her study with the

assumption that mental health care professionals are, on the whole, particularly susceptible to experiencing stress overload and vicarious trauma, simply due to the oftentimes emotionally exhausting environment in which they work. The purpose of the study was therefore to investigate any correlations that may exist between practicing mindfulness and vicarious trauma, or compassion fatigue, especially considering how feelings of compassion fatigue and conditions of vicarious trauma may result in inferior delivery of health care. As Raab (2014) pointed out, however, it is not possible to show compassion to others if we have not first shown compassion to ourselves, what is called self-compassion, which includes being kind to one's self, feeling connected to a common humanity, as well as practicing techniques of mindfulness. The conclusion the researchers drew was that counselors derived a two-fold benefit from applying mindfulness techniques. For one, the more counselors learned to seek out and experience self-compassion, the more they could express compassion for others, including their clients and patients. On the other hand, the more counselors desired and experienced self-compassion, the less vulnerable they became to the vicissitudes of vicarious trauma (Raab, 2014; Lee, Laurenson, & Whitfield, 2012).

In a related study on mindfulness which focused on certain self-care practices such as sleep hygiene, mindfulness and mediation, regulation of the emotions, and solid social and familial support, the results of an extensive survey of 488 psychology graduate students demonstrated that such self-care practices were all strong mitigating factors that reduced stress and the potential beginning signs of vicarious trauma (Myers, Sweeney, Popick, Wesley, & Bordfeld, 2012). Given the results of their study, the researchers

recommended that graduate students in counseling and psychology should become exposed to and educated about self-care practices in order to better deal with the stresses related to clinical training (Cho & Jung, 2014; Myers et al., 2012; Clements & Minnick, 2012).

The study devised by Cho and Jung (2014) was designed to analyze the effects that self-care had on compassion fatigue in a sample of 171 oncology nurses. Among the significant results was the finding that self-care had negative correlations with compassion fatigue, meaning that self-care was again shown to be a mitigating factor against compassion fatigue. It is therefore necessary to increase and make available strategies for enhancing personal self-care factors in order to combat compassion fatigue and vicarious trauma (Cho & Jung, 2014).

According to Salloum, Kondrat, Johnco, and Olson (2015), child welfare workers are especially vulnerable to experiencing vicarious trauma and possible total burnout, due to the fact that they are routinely exposed to any number of menacing traumatic situations while working with children and their families. Granted that self-care is often recommended as a protective or even restorative remedy for vicarious trauma, Salloum et al. (2015) argued that not enough studies have been conducted to empirically test the benefits of self-care that could combat possible compassion fatigue and vicarious trauma, and they therefore urged that further research is needed in order to investigate the matter further.

Social Support. Social support refers to the physical and emotional support individuals receive in the work environment through their interactions with peers,

coworkers, and supervisors (Sanchez-Moreno et al., 2014). Some of the characteristics of social support in workplace environments included the art of careful listening and attentiveness on behalf of supervisors and management, provisions for emotional and professional assistance when needed, a common company purpose and set of goals that can motivate the staff to perform at optimal levels, and mental and professional challenges that are designed to keep workers actively engaged (Sanchez-Moreno et al., 2014). These are all issues that a caring organization could and should provide, just like Michalopoulos and Aparicio (2012) showed in their survey study of 160 social workers in the state of Maryland. The profile of the majority of the sample consisted of Caucasian women with graduate degrees. After analyzing the data, the researchers concluded that it turned out to be better social support systems that the social workers consistently referred to when discussing their own susceptibility to, and experiences of, vicarious trauma (Michalopoulos & Aparicio, 2012).

Organizations are in a position to create the conditions for, and promote, social interaction among counselors and their work colleagues. Yearly company get-togethers, staff retreats, company Christmas parties, etc. all work towards building positive teamwork among staff members. If provided the necessary support from their peers, counselors are in a better position to be able to openly discuss their trauma patients, seeking possible clarification from their fellow workers, in order to correct any distortions that may arise, which could of course threaten their practices as well as their psyche. The results of the hierarchical regression analysis confirmed the central role that

informal social support can play in the alleviation of burnout and vicarious trauma in counselors and social workers (Sanchez-Moreno et al., 2014).

One important factor that emerged from the data analysis of a qualitative study involving six school counselors that were interviewed was the importance counselors placed on qualified managerial oversight of the clinical work that they do with clients (Parker & Henfield, 2012). It seems like the more counselors were able to freely discuss cases of patient trauma with their supervisors, and gain needed guidance and support from them, the less likely they were to fall prey to such occupational hazards as vicarious trauma. Nevertheless, while informal social support sources have been identified as factors that are likely to decrease vicarious trauma, as well as the subsequent psychological distresses which are the result, the extant literature has not thoroughly or sufficiently pursued the topic of informal social support systems and their relation to vicarious trauma and occupational burnout (Sanchez-Moreno et al., 2014).

Dombo and Gray (2013) argued that due to the potential menacing presence of occupational burnout and vicarious trauma, clinical social workers could be at risk to their health and mental well-being along a variety of spiritual dimensions, including putting into question the meaningfulness of their counseling work, a sense of hopelessness, feelings of loss of purpose, as well as unhealthy internalization of their clients' traumatic experiences. The researchers argued that various spiritual practices have been shown to reduce the signs and symptoms of burnout and vicarious trauma, while at the same time creating space for the development of personal and professional growth (Hervezi, 2015; Gregory, 2015; Lee & Miller, 2013; McGarrigle & Walsh, 2011).

For example, Hervezi (2015) discussed how meditation exercises practiced by nurses could reduce the effects of work stress, compassion fatigue, and vicarious trauma. Taking advantage of ProQOL Version 5, a tool designed to measure the levels of compassion satisfaction, burnout, and secondary traumatic stress, Gregory (2015) carried out a study designed to determine whether yoga and mindfulness, two self-care spiritual strategies, had a positive impact on burnout, secondary traumatic stress, and vicarious trauma. The study included 11 social workers. Six were assigned to the control group and five to the experiment group. Members of the experiment group were instructed on meditation practices and completed a series of meditation sessions. The findings suggested that active participation in a yoga meditation and mindfulness program may increase the potential for compassion satisfaction, while at the same time inhibiting the development of vicarious trauma (Gregory, 2015). Additional studies confirmed these findings (Lee & Miller, 2013; Koehler, 2012; McGarrigle & Walsh, 2011; Injeyan, Shuman, Shugar, Chitayat, & Atenafu, 2011).

Injeyan et al. (2011) pointed out that certain counselors who experienced higher levels of occupational burnout and corresponding lower levels of compassion satisfaction often turned to spiritual or religious practices in order to deal with, and effectively manage, the emotional stresses and psychological strains associated with compassion fatigue. Even simple hobbies such as knitting have been shown to be effective in alleviating excessive stresses in counseling work, which could lead to vicarious trauma (Anderson & Gustavson, 2016). These repetitive tasks are useful because it helps individuals to have “increased awareness of feelings and improved ability to focus on the

future rather than dwell on the past" (Esaki et al., 2013). Although the results of the various studies conducted suggesting that spiritual practices can have a mediating effect on vicarious trauma, some researchers also recommended that more studies need to be conducted on this important, but understudied topic in the literature, due to gaps in the scholarly analysis of the relationships between spiritual practices and vicarious trauma (Gregory 2015; Koehler, 2012).

Summary and Conclusions

Vicarious trauma is a potentially devastating occupational hazard that has the potential to debilitate counselors who are not aware of its signs and symptoms or do not have an understanding of the various coping mechanisms that can assist them when they are confronted or exposed to serious trauma in patients. Without that knowledge base, they seem much less protected from vicarious trauma being triggered in counselors treating trauma patients. The various types of organizations that counselors and other mental health care providers who are susceptible to vicarious trauma work for, are in a position to provide policies and practices that can educate counselors about the disorder as well as provide backing and assistance for those counselors who fall prey to this very threatening organizational and occupational hazard. A variety of organizational coping mechanisms have been identified and discussed in this literature review, including organizational culture, the role of supervisors, and access to needed resources.

While the conclusion of Choi's (2011) study suggested that lack of organizational support directly correlates with counselors' susceptibility to occupational burnout and vicarious trauma, Dagan et al.'s (2015) study determined that a particular organizational

factor, that of assigning the number of cases to individual counselors, directly influenced counselors' susceptibility to vicarious trauma. In a related study, McFadden et al. (2014) also drew attention to the connection between excessive workload and the subsequent prevalence for vicarious trauma. Likewise, Hamama's (2012a) research strongly suggested that the more training, support and care that counselors received from the organizations that they work for, the less likely they were to develop occupational burnout. While investigating a range of organizational resources and their possible connections to vicarious trauma and occupational burnout—including organizational dynamics, relationships between fellow workers, management oversight, workplace expectations, and access to resources—the results of the study conducted by Shier and Graham (2013) showed that intra-organizational relationships appeared at the top of the list of the social workers surveyed. Cox and Steiner (2013) pointed out at least two benefits derivable from proper managerial supervision that, if put in place, could mitigate the possible emergence of vicarious trauma among counselors. Cox and Steiner (2013) further stressed the need for organizations to hire managers and supervisors who are trained to pick out the signs and symptoms of occupational burnout and vicarious trauma in their workers. That way, they would be in a better position to spot the signs and symptoms of the disorder, or at least be in a better position to help working counselors that may have nevertheless fallen prey to vicarious trauma or occupational burnout. Numerous gaps in scientific knowledge still exist because not enough work is being done to uncover the organizational causes and conditions of vicarious trauma. There are also not enough studies conducted on possible organizational coping resources. The present

study is designed to add to the scientific knowledge base concerning the organizational causes and conditions of vicarious trauma. However, not only the organizational causes and possible remedies for vicarious trauma need to be further studied. Individual and personal coping resources developed by counselors who have experienced vicarious trauma also need to be further investigated.

In fact, in addition to organizational coping mechanisms, a range of personal and individual coping mechanisms have also been identified and discussed that can provide counselors with the knowledge and resources they need in order to successfully and efficiently combat vicarious trauma in the workplace, including: vicarious resilience, compassion satisfaction, self-efficacy, self-care, social support, and relaxation and spiritual exercises. So, for example, as the study of Silveira and Boyer (2015) demonstrated, counselors treating children, who were victims of personal trauma but nevertheless displayed a substantial resilience to their trauma, themselves developed a kind of vicarious resilience as a result of their appreciation of the children's own personal resilience to potentially damaging violent trauma. Lambert and Lawson (2013) reported similar cases where counselors became inspired by the resilience of the victims they treated and developed vicarious resilience, who were subject to Hurricane Katrina and Hurricane Rita, two of most devastating hurricanes to hit the U.S. Gulf Coast in decades. Vicarious resilience was also reported in a study investigating counselors' responses to their treatment of victims that experienced trauma associated with the September 11th terrorist attacks (Pulido, 2012). It was also noted how important social support systems

were in providing the proper work environment that facilitated the emergence of counselors' vicarious resilience (Hernandez-Wolfe et al. (2015).

In their study on self-efficacy, Berger and Gelkopf (2011) showed that when nurses received the proper training on how to deal with possible vicarious trauma, their levels of professional self-efficacy became elevated which, in turn, made them less susceptible to such mental disorders like vicarious trauma. In a related study of school counselors conducted by Bozgeyikli (2012), the results demonstrated a negative connection between the counselors' perceptions of self-efficacy and compassion fatigue, suggesting that the greater the self-efficacy reported by the counselors, the less they were susceptible to compassion fatigue. A further literature review and meta-analysis of numerous studies discovered in the literature arrived at a similar conclusion; namely, that self-efficacy was a possible predictor of compassion fatigue, and furthermore that the greater the self-efficacy of counselors, the less likely they were to develop compassion fatigue and vicarious trauma (Shoji et al., (2015).

Cox and Steiner (2013) showed how simple activities related to self-care practices such as healthy eating habits, proper exercise, getting proper rest, not becoming overwhelmed at work, engaging in recreational activities, or pursuing spiritual practices could offset or prevent the potentially debilitating effects of vicarious trauma. In their study involving numerous case studies of counselors and clinicians who were susceptible to vicarious trauma due to their regular caseload of trauma patients, Tosone et al. (2012) reported transformative changes in counselors whose care of the self-resulted in more instances of compassion satisfaction, as compared to counselors who did not implement

any self-care practices. Likewise, the studies on mindfulness conducted by numerous other researchers led to the common conclusion that being aware of mindfulness, and adopting self-care strategies that increase mindfulness, were also potential anecdotes to the ravages of vicarious trauma (Raab, 2014; McGarrigle & Walsh, 2011).

The fact is, the opposite of occupational burnout is fulfilled job satisfaction, where the individual enjoys their work and gains positive feelings and thoughts of empowerment and a sense of accomplishment from it and is therefore actively engaged in their physical and social surroundings. Achieving and maintaining job satisfaction depends on both organizational and individual coping mechanisms. Following the precepts uncovered in this literature review, and therefore at least being made aware of the variety and scope of the different organizational and personal and individual coping resources, should put counselors on the path to greater overall job satisfaction, while at the same time providing lessons on individual and organizational coping resources that, if followed, could lessen the potential for excesses of stress to accrue and accrue, and preventing their eruption into some form of vicious vicarious trauma.

The gap in the literature is the lack of studies concerned with the identification and analysis of organizational and personal coping mechanisms that should be available to counselors so that they become educated about vicarious trauma, and who would then be in a better position to identify its signs and symptoms in their own practices, as well as in the practices of their fellow counselor colleagues. Specifically, there is still a lack of adequate empirical research conducted on how counselors who become afflicted with vicarious trauma are able to successfully deal with it so that they can remain effective as

counselors, while at the same time being able to provide superior therapeutic and clinical services to their clients and patients. The studies canvassed and analyzed in this literature review have uncovered a host of productive individual and organizational coping resources that can contribute to the scholarly literature on the topic and can work towards closing the various theoretical gaps that were identified.

Given the problem and the identified gap in the literature, a qualitative case study research program will be able to address the lack of understanding regarding the nature of vicarious trauma, and the potentially toxic and debilitating affect it can have on both the professional as well as personal lives of counselors. Furthermore, both organizational and individual resources that can be used to either inhibit or properly manage vicarious trauma were identified and thoroughly discussed and analyzed.

Chapter 3: Research Method

Introduction

The purpose of this qualitative multiple case study was to examine the individual and organizational resources that counselors who have self-reported vicarious trauma used to cope with the experience in order to continue practicing their profession effectively. This chapter will include a detailed discussion of the methodological plan for the multiple case study. This chapter will include the following sections: (a) research design and rationale, (b) role of the researcher, (c) methodology, and (d) issues of trustworthiness. The chapter concludes with a summary of the key methodological issues, procedures, and concepts to be used in conducting the study.

Research Design and Rationale

The research questions that were used for this study are as follows: (a) What individual resources do counselors who have self-reported vicarious trauma use to cope with the experience in order to continue practicing their profession effectively, and (b) What organizational resources do counselors who have self-reported vicarious trauma use to cope with the experience in order to continue practicing their profession effectively? The central issue examined was the successful coping of counselors who experienced vicarious trauma. Successful coping will be defined as having self-reported to have successfully coped with vicarious trauma based on their own assessments. To determine that the participants have successfully coped with vicarious trauma, the Coping Strategies Inventory (Bober, Regehr, & Zhou, 2006) was administered.

A qualitative research approach was used to examine the individual and organizational resources that counselors who have self-reported vicarious trauma used to cope with the experience in order to continue practicing their profession effectively. Qualitative research is often characterized by detail-orientedness, subjectivity, comprehensiveness, and the use of small sample size (Corbin & Strauss, 2014). Qualitative research is beneficial in capturing the essence of a complex phenomenon through detailed narratives (Patton, 2002). The findings can be used to inform future studies about the topic (Silverman, 2013).

Qualitative research is exploratory in nature, which is appropriate for the study because in-depth information is needed in order to address the lack of literature available on the research topic. The level of detail and comprehensiveness needed can be acquired using qualitative methods such as semi-structured interviews (Patton, 2002). Quantitative research is not appropriate because of lack of alignment with the purpose of the study. Quantitative research is more appropriate in studies that require measuring concepts and the use of statistical tools to conclude how two or more variables are related to each other (Neuman, 2005).

A multiple case study research design was used to address the purpose and the research questions of the study. The lack of clear boundaries between the phenomenon and context is one of the main features of case study research design (Yin, 2013). The experiences of the individual counselors with regard to coping with vicarious trauma are interconnected with their organizational practices. Exploring the individual and organizational resources that counselors use to cope with vicarious trauma cannot be

accomplished in a controlled environment where variables are manipulated. In case studies, researchers do not manipulate variables but examine a phenomenon within a naturalistic context (Yin, 2013).

Case studies also involve the comprehensive examination of a complex phenomenon using multiple sources of data (Yin, 2013). The use of multiple sources of data allow researchers to triangulate the findings and generate a more comprehensive description of explanation of a phenomenon. The scope of the context of the multiple case study was on individual and organizational coping resources of counselors who have successfully coped with vicarious trauma based on their own self-assessment. The units of analysis will be at the individual and organizational level. The sources of data will be based on semi-structured interviews, observation notes, and document records.

The logic for the selection of case study research design was flexibility and comprehensiveness (Yin, 2013). The use of multiple sources of data collection tools enhanced the comprehensiveness needed to answer the research questions of the study. Another reason for selecting the case study design was the lack of clear boundaries between the phenomenon and context of the research problem, which is a key feature of the selected research design (Yin, 2013).

Other qualitative research designs such as phenomenology and grounded theory were not selected because of their misalignment with the purpose of examining the individual and organizational resources that counselors who have self-reported vicarious trauma used to cope with the experience in order to continue practicing their profession effectively. Phenomenology is not appropriate because the scope of the study is larger

than just focusing on the perspectives of individuals but also on organizational resources. Phenomenology is the in-depth exploration of the lived experience of individuals (Moustakas, 1994). Grounded theory is not appropriate because the study is not concerned with generating theories, which is the main output expected from a grounded theory study (Corbin & Strauss, 2014).

Role of the Researcher

In qualitative studies, the researcher plays the most significant role in terms of the collection and analysis of data (Walker, Read, & Priest, 2013). As the primary researcher, I was responsible for conducting the individual semi-structured interviews, generating observation notes of the three organizations, and collecting document records. Through reflexivity, which is the recognition and deliberate identification of the biases of the researcher (Shenton, 2004), the trustworthiness of the study was strengthened. The personal views of the researcher on vicarious trauma were: (a) clinicians can learn from the vicarious trauma experiences of other clinicians, (b) coping with vicarious trauma can occur at personal and organizational level, and (c) professional training helps clinicians address and cope with vicarious trauma. This researcher articulated these personal biases in an effort to account for trustworthiness and credibility across the study.

Methodology

Participant Selection Logic

The population for the study were counselors who experienced vicarious trauma. The logic for the selection of the population is that only professionals who have successfully coped with vicarious trauma can provide useful and relevant insights about

the necessary strategies needed to cope with vicarious trauma from their clients. From that population, the sample consisted of 10 counselors who had successfully coped with vicarious trauma based on their own self-report. Vicarious trauma had to occur within the last two years of their professional career. To ensure that all participants had experienced vicarious trauma in the past two years, the participants were asked to self-report their experiences with vicarious trauma and if they felt they have successfully managed it.

Purposive sampling strategy was used to recruit 10 counselors who had successfully coped with vicarious trauma based on their own self-report. Purposive sampling is a non-probability technique wherein participants are recruited based on fulfilling key eligibility criteria that are central to the research questions (Suri, 2011). The selection criteria to be eligible for the sample include the following: (a) counselors who have experienced vicarious trauma based on their own self-report, (b) counselors who are currently active in the profession as counselors of trauma patients, (c) counselors who work in an organizational clinical setting, and (d) counselors who have at least two years of working experience. To ensure all participants met inclusion criteria for this study, I reviewed each criterion with participants at the beginning of the interview and had them confirm they me requirements for participation.

The rationale for the sample size of 10 participants was determined by data saturation and the literature on case study. Based on the assumptions of data saturation and the literature on case study research designs, the sample size of 10 participants across three different organizations was deemed appropriate for the study. Based on the review conducted by Guetterman (2015) of 10 peer-reviewed journal articles that utilized the

multiple case study research design, the mean sample size was 188 individuals in three different organizations. Even though data saturation is not fixed for every study, 10 participants is usually sufficient in reaching data saturation based on previous studies (Francis, et al., 2010). Data saturation is reached when data become repetitive and no new information can be gained (O'Reilly & Parker, 2013). The relationship between sample size and data saturation is important in qualitative studies because data saturation gives rationale for the decisions made regarding sample size (Francis et al., 2010). In this study, data saturation was met with 10 participants.

Participants were identified, contacted, and recruited by visiting several clinics that employ several counselors within the organization. The target number of organizations was three, but more organizations would have been included if the sample size of 10 counselors was not reached during recruitment. Inquiries were made with the appropriate administrators or representatives within the organization about the possibility of inviting employed counselors to be part of the study. Once organization leaders provided me with lists of their organization's counselors, I contacted potential participants via email communication. This email included an invitation to participate in the study and listed all inclusion criteria. With organizations that I was familiar with, direct contact with the participants was made.

The approval of the Internal Review Board (IRB) of the Walden University was granted after a thorough review of all necessary forms, and ethical considerations were explored for the study that was completed. No actions during the study required additional contact or guidance by the IRB.

Data Sources

The researcher is considered the main instrument in qualitative studies (Walker et al., 2013), responsible for conducting the individual semi-structured interviews, generating observation notes, and collecting document records. To enhance effectiveness during the data collection, guides and templates for the semi-structured interviews were used and observations were conducted. To complete the semi-structured interviews (see Appendix A), an interview guide containing all key questions that needed to be asked during the researcher-participant interaction was used. The semi-structured interview guide contained a list of open-ended questions intended to elicit information needed to gain insights about the individual and organizational resources that counselors who have self-reported vicarious trauma used to cope with the experience and continue practicing their profession effectively. The follow-up questions used the language of participants so that more relevant information could be collected during the interview.

For the organizational observation (see Appendix B), a sheet of document was used that will serve as a guide during the observation. The observation data involved the following issues or resources: (a) collaboration/communication with coworkers, (b) availability of resources, (c) policies/practices, and (d) organizational climate. The observation did not involve watching clients or sitting in during a therapeutic session. The observation did involve observing the workplace of the counselors to gather information about the organizational resources that may be critical in the participants' coping of vicarious trauma. The observation sheet served as a guide of all the key processes that needed to be observed in order to answer the research questions.

Another source of data for the case study were organizational documents. These documents were analyzed during the interview process. Due to the sensitive nature of clients that the organizations serve, physical records were not provided. Organizational policies and procedures, meeting notes and guides were examined during the site visit. To ensure that these documents were available, inquiries were made regarding their availability during recruitment.

Procedures for Recruitment, Participation, and Data Collection

An inquiry was made with the appropriate administrators or representatives within the organization about the possibility of inviting employed counselors to be part of the study. After permission was secured in person from the appropriate authority, counselors within the organization were invited to participate in the study. A verbal questionnaire was used to ensure that potential participants had experienced vicarious trauma and had successfully recovered from the said trauma in the past. Due to the sensitive nature of this study and the overarching ethical restrictions I adhered to, no counselors who were currently experiencing vicarious trauma were included in the study.

After potential participants were identified, the informed consent forms were presented. The informed consent forms included a basic outline of the purpose of the study and the expected nature of the participation. This form was given to the selected participants prior to each of the interviews. During the distribution of the informed consent forms, issues pertaining to confidentiality, withdrawal, and voluntary participation were explained. When the targeted individuals agreed with all the terms of the study, the participants were asked to sign the informed consent forms to recognize

voluntary participation. The discussion and signing of the informed consent forms took approximately 30 minutes, but more time was allotted if participants had more questions about the study.

The primary data source were individual semi-structured interviews. For the semi-structured interviews, a face to face appointment for each participant was scheduled. The interviews took approximately 45 minutes to one hour and were conducted in a mutually agreed upon location of each participating counselor with permission from participant and the site. If an alternate place was preferred, a different location was set for the interview. The interview sessions were digitally recorded so that the entire responses of the participants for each question could be captured accurately. After the interviews were completed, the participants were informed to expect an email within five weeks from the interview for the process of member checking, the process of utilizing the help of the participants to enhance the credibility of the findings (Morse et al., 2008). The participants were informed to expect an email containing a copy of the completed study upon completion and approval from the Walden University Board.

Data Analysis Plan

For the two research questions of the study, thematic analysis was used to analyze the interview transcripts, observation notes, and document records collected from the participants. Thematic analysis is the most commonly used qualitative analysis strategy to code and categorize data into themes (Guest, 2012). To conduct the thematic analysis of data, several key tasks central to the development of themes and relevant to the purpose

and research questions was performed. The researcher was responsible for the transcription of the interviews to minimize exposure of the data to third party individuals.

The first phase of thematic analysis is familiarization with the data (Braun & Clarke, 2006). The first step in the familiarization of data was to transcribe the interviews and to prepare observation notes and the document records. To enhance the organization and storage of data, a qualitative software called Nvivo was used. All the data was loaded to the software in preparation for the analysis. The key features of Nvivo software such as creating projects, generating nodes based on specific portions of text, hyperlinks, and access to illustrations such as graphs and figures (Wong, 2008) was helpful in the coding of data.

After all the data was loaded in the Nvivo software, familiarization with the data commenced by reading and rereading all the transcripts and observation notes (Braun & Clarke, 2006). The goal of the process of familiarization through reading and rereading is to acquire a general idea of the patterns from the data. A preliminary set of codes as a starting point for the more formal stages of the analysis were identified.

The second phase of thematic analysis was the initial coding of data (Braun & Clarke, 2006). The coding process was conducted by documenting how codes are determined based on the process of data reduction. Data are reduced into codes when labels are generated in order to achieve a more efficient process of categorization and thematizing. The initial generation of codes were accomplished by assigning names or labels to specific chunks of information from the interview transcripts and observation notes.

The third phase of thematic analysis was the determination of themes (Braun & Clarke, 2006). Themes were searched by analyzing all the codes that were generated for patterns. Several interrelated codes were combined into broader categories in order to get a better sense of the patterns from the data. These categories were instrumental in the determination and search for possible themes.

The fourth phase of thematic analysis was the review and verification of themes (Braun & Clarke, 2006). Themes were reviewed and verified by linking the themes with the data. The first level of the finalization of themes is to determine their coherence, which was accomplished by reworking the themes until a clear pattern is apparent. The second level of the finalization of themes is to determine the accuracy of themes, which was accomplished by reading and rereading to confirm that the themes are supported by the raw data.

The fifth phase of the analysis was the naming and definition of themes (Braun & Clarke, 2006). The themes were named by identifying the essence of what is being captured in the data using a few key words. These themes were defined by explaining their essence using a few sentences that capture what the data are all about. At this phase of the analysis, the goal was to capture what was interesting in the themes that are central to the research questions.

The final phase of thematic analysis was the production of integrative report based on the final themes that were developed (Braun & Clarke, 2006). To generate the final report, a narrative was written that incorporates all the key themes central to answering the research questions. The goal of the report was to generate a narrative that

was convincing of the merits of the data analysis (Braun & Clarke, 2006). Examples and direct quotes from the participants were included in the narrative to strengthen the validity of the themes.

Discrepant cases were addressed by providing the complete coding results for each thematic category. Even though themes only reflected the codes that are reflective of the general sample, the discrepant cases provided more holistic information about the scope of the data. The inclusion of discrepant cases enriched the understanding of the research phenomenon.

Issues of Trustworthiness

Reliability and validity are measures that do not readily translate in qualitative studies (Morse, Barrett, Mayan, Olson, & Spiers, 2008). Rigor and trustworthiness are often used to ensure that qualitative research is scientifically acceptable (Golafshani, 2003). Issues of trustworthiness in the study were addressed using credibility, transferability, dependability, and confirmability (Morse et al., 2008; Thomas & Magilvy, 2011).

Credibility pertains to the internal validity of the study, which depends on the efforts of the researcher to perform certain procedures or checks (Golafshani, 2003). The credibility of the results of the study will be enhanced through member checking, the process of utilizing the help of the participants during the analysis phase (Morse et al., 2008). After the initial results of the analysis were completed, the participants were asked to review the preliminary findings. Each participant will be emailed a summary of the findings once the study has been approved.

Transferability refers to the external validity of the study, or the extent to which the results presented can be considered outside the sample of the study (Golafshani, 2003). Case studies are not generally transferable to other cases because of the unique interaction between a specific phenomenon and its context (Yin, 2013). However, the results of a case study may be transferable to other cases that have significant similarities in terms of the context. The transferability of the results of the study will be enhanced by generating a thick description of the context wherein the study was intended (Shenton, 2004). By generating a thick description of the context of the study, other researchers can be informed about the intent and scope of this study. Through this thick description, other researchers can evaluate the relevance and appropriateness of the results that will be presented in this study on their own research.

Dependability pertains to the extent to which the study can be considered reliable (Morse et al., 2003). Just like other qualitative research designs, case study researchers make an effort to make the results as consistent as possible when conducted again by another researcher (Yin, 2013). The dependability of the study will be enhanced by using audit trails (Shenton, 2004). Through detailed audit trails, the source of every decision made from the beginning until the completion of the study can be traced (Shenton, 2004). Audit trails involved generating written records of what was performed at every stage of the study, from the data collection until the presentation of findings.

Confirmability pertains to the level or extent of objectivity of the study (Golafshani, 2003). The confirmability of the study was enhanced through the process of reflexivity, which is the recognition and deliberate identification of the biases of the

researcher (Shenton, 2004). By articulating personal biases about vicarious trauma of counselors, others will be informed about the views of the researcher regarding the research topic. Other researchers can evaluate if personal biases affect the results of the study.

Ethical Procedures

The need to secure agreement to gain access to the participants within the selected organization was addressed by talking with the appropriate administrators or representatives. The administrators of each organization from which the participants were selected were assured that no members of the study would be used that actively demonstrated a trauma engagement. The possibility of inviting employed counselors to be part of the study by discussing the purpose and the nature of the research was addressed by coordinating with the company's representative. Once approval was secured, the representative was asked to sign an agreement form indicating voluntary participation in the study.

The approval of the Internal Review Board (IRB) of the Walden University was sought by submitting all the necessary forms needed to assess the ethical validity of the study. The IRB approval number for this study is 02-12-18-0324154. The interview and observation only started after the approval was secured.

Regarding ethical concerns related to recruitment materials and processes, this issue was addressed by upholding voluntary participation. Informed consent forms were used to debrief all participants about the requirements to be part of the study and the

necessary procedures that were used to protect their identities and privacy. All materials that was collected from the participants are considered confidential data.

After participants were identified, the informed consent forms were presented to give participants an overview of the study. If the targeted individuals agreed with all the terms of the study, the participants were asked to sign the informed consent forms to recognize voluntary participation. The discussion and signing of the informed consent forms took approximately 30 minutes, but more time was provided if participants had more questions about the study.

The treatment of data collected from the participants was protected by maintaining confidentiality for a period of up to five years. The data storage procedures involved keeping all paper files in a locked cabinet and all electronic data in a secured and password protected laptop. For the dissemination of data, the real names of the participants were not included when presenting the results. The presentation of findings only reflected the assigned code names given to each participant. After the five-year period all materials will be destroyed using Health Insurance Portability and Accountability Act of 1996 (HIPAA) guidelines.

The researcher had sole access to the data collected from the participants, which were stored on a personal computer and maintained in a locked cabinet. These documents included files such as informed consent forms and audio recordings. Members of the research team, did not have access to the real names of the participants, including the personal information from the informed consent forms. Five years after the approval and publication of the dissertation in the university library, all the files will be destroyed in

the personal archive. The permanent deletion of data will entail removing files on the researcher's personal computer and destroying paper documents through shredding.

Summary

The purpose of the qualitative multiple case study was to examine the individual and organizational resources that counselors who have self-reported vicarious trauma used to cope with the experience in order to continue practicing their profession effectively. Qualitative research was appropriate for the study because in-depth information was needed to address the research questions. The logic for the selection of case study research design was flexibility (Yin, 2013). The use of multiple sources of data collection tools such as interviews, observations noted, and document records enhanced the comprehensiveness of the study.

The next chapter contains the results of the data analysis. The presentation of the results involved describing the setting of the study, demographics of the participants, data collection and data analysis procedures, evidence of trustworthiness, and the presentation of findings. The findings reflect the key themes of the study supported by thematic analysis.

Chapter 4: Results

Introduction

The purpose of this qualitative multiple case study was to examine the individual and organizational resources that counselors who have self-reported vicarious trauma used to cope with the experience to continue practicing their profession effectively. The unit of analysis in this study was the successful coping of counselors who experienced vicarious trauma. The research questions of the study are as follows: (a) What individual resources do counselors who have self-reported vicarious trauma use to cope with the experience to continue practicing their profession effectively, and (b) What organizational resources do counselors who have self-reported vicarious trauma use to cope with the experience to continue practicing their profession effectively? This chapter is a presentation of the results of the study, which includes the description of the setting of the study, demographics of the participants involved, actual data collection procedures, data analysis, and the evidence of the studies trustworthiness. The chapter concludes with a summary of the findings in relation to the research questions of this study.

Setting

The units of analysis are the resources at the organization and individual levels that counselors who have self-reported vicarious trauma used to cope with the experience to continue practicing their profession effectively. In this multiple case study, I began with a description of three organizations serving clients with mental health issues. I analyzed these three organizations in the context of their contributions to the coping experiences of counselors who reported experiencing vicarious trauma. All data was

processed through NVivo for themes. I visited the three sites to observe the organizational culture, policies and practices, collaboration, climate, and available resources supporting the coping processes of the counselors with vicarious trauma. This section presents the detailed report of these observations.

Organization 1

Organization 1 was a hospital specializing in behavioral health care services. Represented by a director of staffing, this organization implemented a policy covering shifts of a counselor who had to leave work due to personal crisis such as vicarious trauma. The director of staffing claimed that collaboration and communication between co-workers made shift trades feasible in their team. The director described the team as "supportive" to the needs of each other.

I noticed several therapy books; however, there were few training materials about trauma and coping. The director noted that the organization provides psychotherapy training to employees such as Eye Movement Desensitization and Reprocessing (EMDR). These professional development programs are well-communicated to their employees. The organization's policy and procedure book also included published guidelines that support employees' health.

Organization 2

Organization 2 was a community mental health facility in southeastern United States which specializes in children's mental health. Represented by the clinical supervisor, the organization implemented collaboration meetings and group texting to support the personal and professional needs of their staff. In addition to daily "1 o'clock"

group meetings, the supervisor mentioned monthly, and quarterly meetings aimed at building group camaraderie and supporting professional knowledge. It is notable though that these organizational activities had external funding that assures the sustainability of these activities.

On a personal level, I noticed the caring personality of the supervisor who appeared to have the best interest of his staff. He was very frustrated about the decisions that were made from top management which he felt he had no control over. Other staff was very open about leadership in this organization and felt that the direct supervisor was doing everything he could do to support them.

In terms of the available resources that support the needs of the counselors, therapeutic books were available in addition to the annual training and support staff hired to assist the caseloads of the clinicians. Some of the counselors had made efforts to bring their own informational materials for the play therapy room to share. The supervisor commended this accomplishment by saying, “the play therapy room has a bunch of stuff.” I noticed these materials during the site observation. I saw training books ranging from Cognitive-behavioral therapy (CBT) to Dialectical Behavior Therapy (DBT). I also noted the availability of DSM 5 manual for psychological diagnosis and several other treatment planning books.

The supervisor described the biases of corporate management in the financial accomplishments versus the quality delivery of service saying, “It feels like corporate is only concerned about the money”. These financial accomplishments are among the organizational stressors that the supervisor had to deal with. The employees, on the other

hand, had no knowledge about these priorities including policies that affect them. In one instance, I was able to ask if they have copies of these policies. One employee acknowledged that she had saved those on the computer but was uncertain about its location.

I investigated the organizational climate further and learned from the supervisor that employees experienced job insecurities because of the continuous employment layoffs. While the supervisor shared the negative aspect of the organizational leadership, the staff who I had interviewed gave favorable view of the organization and how well they worked together. This impression is observable in all the interviews with the participants who stated that the teamwork they felt from their coworkers is a key factor in dealing with vicarious trauma.

Organization 3

Organization 3 is a mental health facility within the government justice system. I noticed that the system of communication was working well between and among the employees and supervisor. The employees observed communication protocol in which escalated issues are forwarded to all staff purposely to inform them of the situations of each client. Electronic communication appeared to be the most prevalent way that leadership communicated with their staff. I thought that this form of communication could lead to misinterpretation by other staff members. Copies of policies and procedures are available and important reminders are posted in conspicuous places.

I noticed during site observation that the supervisor had a large collection of brochures, leaflets, handouts and also a DSM 5 was available for psychiatric diagnostic

purposes. Several participants mentioned available online mental health self-help resources that the state provided but the assessor was not able to view these resources due to login restrictions at the facility. In addition, the offices were neat and clean. The staff room where they would have morning meetings had posters and generic slogans on the wall promoting open communication and positive thoughts for the day.

The supervisor demonstrated a pleasing and warm personality. She implemented an open-door policy in which employees are encouraged to discuss personal and professional issues with her. While I observed the office environment, the supervisor was called upon several times and in a calming voice, she responded and maintained the positive mood at work. The positive environment is evident among the staff who responded to interview questions calmly and confidently. These staff appeared to respond without fear of negative repercussions from management. With hostile clients at the facility, the employees appeared comfortable and satisfied with their jobs and roles they played in the organization.

Demographics

All the participants in this study were counselors who had overcome self-reported vicarious trauma. Both men and women were selected with a wide age range to ensure reliability in the study. Most of the participants had a client base that included both children and adults. All participants in the study are professionally active in the field of counseling and are survivors of vicarious trauma as reflected in the self-reported verbal assessment.

Data Collection

I recruited a purposive sample of 10 counselors who have successfully coped with vicarious trauma based on their own self-report vicarious trauma assessment. The counselors are employed fulltime across three mental health facilities in southeastern United States. In the selection of the participants, vicarious trauma had to occur within the last two years of their professional career.

I recognized the influence of organizational environment to the development of vicarious trauma of participating counselors. I completed onsite observations of these three organizations to determine the contribution of these factors to the psychological wellness of these counselors with past experience of vicarious trauma. I conducted informal interviews with the employees and documentation review to determine the organizational culture, policies and practices, collaboration, climate, and available resources influencing vicarious trauma to counselors working with clients with varying traumatic experiences.

I further conducted 45-60-minute semi-structured interviews of the 10 counselors who passed the recruitment phase. These participants responded the guide questions focusing on: (a) coping with vicarious trauma, (b) personal resources that contributed the coping with vicarious trauma, (c) organizational resources influencing coping with vicarious trauma, (d) different examples of personal and organizational resources helping the coping processes of the counselors. I digitally recorded the interviews and transcribed for member checking and data analysis. I completed the data collection procedures with no unusual circumstances.

Data Analysis

I utilized thematic analysis in analyzing the interview transcripts, observation notes, and document records collected from the participants to generate answers to two research questions of the study. I utilized the NVivo 12 qualitative software in organizing, sorting, and analyzing the data. All textual data such as the observation notes, member-checked interview transcripts, and document records were imported, sorted according to file classifications, and saved in NVivo.

The NVivo software analysis for this study was comprised of the three organization observation notes and 10 interview transcripts which included all notes, records. I classified the data to generate parent and child nodes (or themes). Eight parent nodes were generated using the thematic topics asked of study participants. The parent nodes were thematically categorized as follows:

1. Coping with vicarious trauma
2. Contribution of personal resources in terms of behaviors and practices
3. Contribution of personal resources in terms of way of thinking
4. Contribution of personal resources in terms of personal relationship
5. Examples of personal resource in coping
6. Organizational resource aiding trauma
7. Examples of organizational resource in coping
8. Other resources required necessary to disengage in vicarious trauma

I reviewed and sorted the individual transcripts to generate each parent-child node describing the theme of the study using the parent node. The child nodes constituted the invariant constituents or the invariant horizontalization of the participants' experiences.

Results

The results of my study were both interesting and informative. All the participants that were interviewed were very open with their information and eager to add to the improvement of the field of counseling. The organizations observed on the other appeared to be overly focused on their financial wellbeing versus the quality of product provided. Understandably, the balance between making a profit and continued success versus ensuring employees are well compensated has always been difficult for a business. Below, I have detailed the results of my study in order to answer the main question of my study; how do individuals with self-reported vicarious trauma effectively manage this form of trauma and how does the organization they may be a part of play a role in this process.

I categorized the parent nodes as the thematic categories of the study using the thematic analysis. The labels are as follows: (a) coping with vicarious trauma, (b) contribution of personal resources in terms of behaviors and practices, (c) contribution of personal resources in terms of way of thinking, (d) contribution of personal resources in terms of personal relationship, (e) examples of personal resource in coping, (f) organizational resource aiding trauma, (g) examples of organizational resource in coping, and (h) other resources required necessary to disengage in vicarious trauma. These categories are equally important in showing the patterns of responses in the context of resources at the organization and individual levels.

Coping with vicarious trauma

All participants shared the processes concerning their coping with vicarious trauma. I generated 9 child nodes that describe the coping experiences of the participants in the review of the transcripts. I limited the discussion to child nodes that were shared by at least two or 20% of the participants for purposes of discussion.

Effective transition times. Five participants in this study described "transition times" as shift of work routine to activities that are fun and enjoyable. Participant #9 described this as "having good transition times for me is like a transition out of my role." Participant #9 further mentioned "going to the gym for like an hour immediately after work" is an effective activity to transition out of her work. Participant #9 also described transition time as an "extreme" activity that could take her time without her knowing. She said: "These are activities that could take my time almost to the point that when I get home at like 7 o'clock at night… it's like ok good night it is time for bed."

Participant #1 described effective transition times in two ways: (a) easy, and (b) intense. Participant #1 said: "depending on how intense it is, sometimes it is easier just to do little things even if it's just going home." An intense activity for Participant #1 is spending few days with the dog to process and work out the feelings of trauma. Participant #1 shared: "spending time with my dogs which could take few days to process everything and to work through the feelings that I have got from the clients." Participant #10 described an effective role transition as turning her attention to family and doing his homemade relaxation techniques. Participant #10 justified this by saying:

> I have my own methods of looking or dealing with my clients… I check how sexual abuse survivors cope while ensuring to keep myself well, so I have to keep a very stern foundation in where I stand so I have to determine boundaries.

Participant #4 described this transition time as "good work life balance." Participant #4 further described these activities as something that "separates work from other aspects of my life." Meantime, Participant #8 used the term "distraction" to describe the activity that could help her vent the stressors out. Participant #8 listed these activities as:

> …whenever I am feeling really stressed out about the different traumas that I am hearing, I do something to distract myself like plan events or something with friends and try to get things out of my head. I actually do a lot of art to release some of that negative feeling. I also do a lot of traveling to physically get out of some space and then just a lot of sleep.

Spiritual practices as coping strategy. Four of the participants clearly described the words "relaxation" and "enjoyable" activities as avenues that help vent out work-related stress. Participant #4 described these activities as part of "the self-care regiment that one wants to implement." Participant #5 mentioned the interest in "praying… spend time with animals and bike rides" while Participant #3 mentioned "writing." Participant #8 described the benefit of relaxation as: "the more rested I am, the more able I am to handle that stuff in the past."

Psychological preparedness. Three of the participants uniquely mentioned the need to accept that trauma is normal, and that as counselors their job is to help these

victims cope with the experience. For instance, Participant #7 shared a realization: "vicarious trauma is normal." Participant #10 described this psychological preparation as a "strong foundation" that could surround her in times of feeling the trauma. Participant #5, on the other hand, described psychological preparation as "emotional process or mental process" that had to be done to effectively carry the work as a therapist.

Wellness. Two of the participants mentioned the term "wellness" though they have different wellness priorities. For instance, Participant #6 used the term "social wellness… our spiral wellness" to describe social relationship and physical wellness like "eating healthier foods…getting better sleep…walks and hiking." Participant #3, on the other hand, mentioned "exercise" as a way of getting physically-fit to cope with trauma.

Self-control. Two of the participants directly mentioned the terms "control" and "shutting-down" to describe the practice they engage in when they experience or lead to experience vicarious trauma. Participant #7 described this as:

> Looking at what I can control, I see things that are just out of our control and just knowing my limit and this is my line… on the other side of this line is things I can't control. This is like not being able to control when a client chose to disengage and knowing where my circle of control is as well.

Participant #5 described this practice as "to shut it down and leave it here." Participant #5 further explained that it is more of a ritual to combat work-related trauma.

Other practices. Four child nodes emerged from four participants who mentioned practices related to the child nodes mentioned by other participants. For instance, "spending time with family," "connecting with nature," "being active in my

church," and "utilize resources outside of work to cope" were mentioned by Participants #3, #6 and #2 respectively.

I offered a summary of the coping processes shared by the participants in Table 1. I discussed the child nodes that were shared by at least two or 20% of the participants. These coping processes may not be significantly apparent in the transcripts of the participants but are essential in the presentation of the results.

Table 1

Coping with vicarious trauma

Invariant Constituents	# of Occurrence	% of Occurrence
Coping with vicarious trauma		
Effective transition times	5	50%
Spiritual practices	4	40%
Psychological preparedness	3	30%
Wellness	2	20%
Self-control	2	20%
Spent time with the family	1	10%
Connecting with nature	1	10%
Spiritual connection	1	10%
Utilization of resources outside work	1	10%

Contribution of personal resources in terms of behaviors and practices

The participants in the study were asked about the personal resources that contributed to their behaviors and practices in coping with vicarious trauma. The codes "Spiritual practices" and "Physical wellness" re-emerged in the transcripts of three participants in the study. For a detailed discussion, only invariant constituents with at least two occurrences will be presented.

Spiritual practices. The participants who mentioned about the relaxation and fun activities had various interest and view about fun activities. For instance, Participant #10 is a pet and nature lover who finds "walking in nature" and "walking with dogs" as resources that enabled her to cope with vicarious trauma. Participant #10 justified, "animals can really help us forget a lot of the things that are going on." In addition to nature and with the pet, Participant #10 finds her family especially the grandchildren as a way of "letting go" the negative emotions.

For Participant #4, spending time in enjoyable activities contributes to being mentally well. Participant #4 considered the "ability to separate from work, helped in coping with vicarious trauma." Participant #4 further described that mental wellness is achieved with physical wellness. Participant #4 described these activities as: "I try to contribute one day on a weekend, or you know like a few hours of the weekend, to doing something that I really want to do."

Participant #5 shared similar thoughts, "it is just doing the things that bring me joy." These activities include: "shopping, walking on the beach, praying, being with my animal, going to church… time with friends and maintaining, scheduling time off." Participant #5 explained that while "building a practice and maintaining work are good, it is equally important to step away and have some personal boundaries."

Physical wellness. The term "exercise" was consistently mentioned in the transcript of the participants. I however, consolidated this term to mean the physical activities engaged by participants in coping with vicarious trauma. Participant #3 described exercise as "helpful…as it was an outlet for energy. Whether I am angry or sad,

these strong emotions were good outlet for me." Participant #6 compared doing a physical exercise before and after work. Participant #6 shared that "after work, I could channel the frustration and stress. I like taking it out on the elliptical and they can't tell if I'm crying or sweating. So, those sorts of behavior." Participant #6 was mindful in sharing that venting out the strong emotions in physical activities will make the "kids safe at home" from possible vicarious traumatic behaviors. Participant #6 said:

> When I am there, I am channeling the stress into that particular activity, so I can pour out to other people… and not letting my mind wounding off. So, I know I said the right thing during the session, and I can focus on that so I can be there for the people that I serve.

Participant #1 similarly identified doing physical exercises as activities that contributed to her behavior and practices at work. Participant #1 shared: "I do a lot of fitness activities, running weightlifting, yoga, anything that gets me into using my body to get my mind out of that head space."

Engaging with the support structure. While the participants mentioned the importance of support structure throughout the study, only two of the participants directly mentioned the contribution of family, colleague, and friends to their behavior and practices. Participant #2 described her family as "big support system to me." Participant #2 further explained, "My mom is one of my best friends, so I definitely have to talk with her if I need somebody. I utilize her a lot and also my partner and my kids can be a relief, sometimes."

Participant #8 identified the colleagues who shared similar professional

challenges as her support system. Participant #8 boldly mentioned her needs to have someone who can provide professional "feedback and words of affirmation." Participant #8 explained:

> I kind of surround myself with other therapists who have gone through similar stuff so we can talk and spitball ideas. I have a faith [spiritual] background too so having that kind of helps me dissociate a little bit and helps me give it over to something bigger, so I don't feel like I am carrying all of it by myself, which is a huge part of moving forward.

Participant #8 further identified the activities like art and other forms of expression that will not require conversation. Participant #8 said: "exploring different art and having a form of expression that doesn't rely on others and talking about it [trauma] has been very beneficial."

Table 2 presents the summary of the collated responses of the participants concerning the contribution of personal resources in terms of their behaviors and practices. I presented a detailed discussion of the invariant constituents with at least two occurrences. The most experiences offered were in the context of spiritual practices, physical wellness, and engagement with the support structure.

Table 2

Contribution of personal resources in terms of behaviors and practices

Invariant Constituents	# of Occurrence	% of Occurrence
Spiritual practices	3	30%
Physical wellness	3	40%
Engaging with the support structure	2	20%
Positive emotion	1	10%

Spiritual connection	1	10%
Adjust expectations	1	10%
Connecting with nature	1	10%
Spiritual connection	1	10%
Utilization of resources outside work	1	10%

Contribution of personal resources in terms of way of thinking

The participants mentioned two resources, (a) positive emotions, and (b) self-control as resources. Many of these participants or 70% however identified self-control as a personal resource that aided coping from the experienced vicarious trauma. I only presented the invariant constituents with at least a 20% response for purposes of the discussion.

Self-control. Seven participants identified that knowing their limitations as clinicians contributes to their ability to cope with work-related trauma. Participant #6 described this limitation as "out of my control as a clinician and as a human and as a supervisor." Participant #6 explained the importance of control by saying: "what do I have control over with this day's stress, with this time, with this moment, otherwise the burnout will be huge for the things we will stress over." Participant #6 further explained that self- control is knowing your level of stress tolerance and how much one could take. Participant #7 described this experience as "circle of control." Participant #7 explained that control is a way of reducing "black and white thinking." Participant #7 further stated that there is a need "to let go of these labels and need to think on more of a gradient and accept that it is what it is." Participant #7 stressed the value of self-control in the psychological wellness of the clinicians. Participant #7 said: "this is really sad that this has happened and not label things as much and also give them value on them

themselves." Participant #9 described self-control as setting limitations concerning professional involvement with clients. Participant #9 used the phrases "stop trying to fix it" in describing the development of vicarious trauma among clinicians who persisted to manage clients' traumatic experiences Participant #9 described how self-control helped him managing possible vicarious trauma.

Participant #10 described self-control in a situation where she had to have a strong foundation that could not be pulled away by the negative emotions. Participant #10 visualized herself and client in a pit where she stands outside "throwing a rope…and if I get too close or compromise things that keep me safe, then I am going to be pulled in and I cannot help anybody out of the pit." Participant #10 kept reminding herself of her role and where his limitations should be. Participant #10 said: "I must keep myself strong, it's going to be self-talk, reminding myself where I am, what my current foundation is, and the things that I have to rely on to keep me well."

Participant #2 used the term "detach" to describe the limitations she imposed in working with clients. Participant #2 shared: "I had to learn to kind of detach in a way." Participant #2 narrated that being too involved with clients contributes to vicarious trauma. She shared:

> When I first started doing this, I was very enmeshed with my clients and felt that I was there all the time for them. I had to reteach myself and set boundaries. It made them better at dealing with their trauma because they were able to solve their own problems instead of relying on me to solve them.

Similarly, Participant #4 described self-control as a separation of self with work. Participant #4 said that while it is important to show empathy and showing the clients the clinicians' positive outlook about what they have been through, Participant #4 said: "I cannot bare the pain for them."

Participant #8 described self-control as a mechanism in adjusting the expectations of the outcome. Participant #8 said "I am not taking on more than I can handle." Participant #8 has a noteworthy self-reminder:

> You can only do so much in the day. I am trying not to get overwhelmed and thinking too far ahead. I stayed focus with the client in front of me and not worry about the client that are coming in 15 minutes, or in an hour. I try to focus on what I can do in this hour and that is it.

Positive emotions. While most of the participants mentioned the importance of having positive emotions in dealing with victims of trauma, only two of the participants directly related positive emotions as personal resources contributing their way of thinking in coping vicarious trauma. Participant #3 used the term "feeling" to describe the emotional response required to manage vicarious trauma. Participant #3 described the scenario: "I usually took those feelings and put them into something positive. Example of this case was when I was dealing with a child abuse case that really affected me. I used those emotions to motivate me to spend time with my kids or things like that."

Participant #1 mentioned that being emotionally mindful is helpful in processing traumatic experiences. Participant #1 expressed this in a statement: "Understanding what I am feeling and the other thing I find helpful in changing thought processes." Participant

#1 shared that "mindfulness techniques and acceptance-based therapy" were helpful in coping with vicarious traumatic experiences.

Contribution of personal resources in terms of personal relationship

Seven of the participants mentioned that family and friends are helpful in disengaging themselves with work. In this section, the discussion only covered this invariant constituent where it shows that almost all participants found their families and friends as important to their personal lives. A few participants shared the concepts of "engagement with like-minded people" and "spending more time"; however, these participants directed these experiences with their friends and family.

Families and friends' direct priorities outside work. Seven out of 10 participants mentioned family and friends as personal resources who could help depart their attention to negative emotions felt from their clients. Participant #3 identified the "immediate family, my wife and kids" as resources enmeshing her out from the experienced trauma. Participant #3 explained: "they just kept me busy because that was just part of life. We just stay really busy, so we didn't have a lot of time to dwell outside of work."

Participant #6 identified the support of friends outside work as beneficial in managing the job despite the danger of vicarious trauma. Participant #6 appreciates being surrounded by "people who do not do counseling, but also having people who understand what you do, but not talking about work stuff." Participant #6 further shared:

> It's nice to have those friends that you can just talk about healthy kids, there are awesome kids who haven't experienced trauma, and talk about great memories

> from childhood. And then it's good to have your supportive friends who understand what you are going through and do the same work. These people know that you simply want to not talk about work stuff.

Participant #1 also shared the same information and identified a friend who had been helping him in alleviating the "negative impact from client." Participant 1 shared: "being able to talk to colleagues is helpful in understanding negative feelings that you can pick up from negative clients."

Participant #10 considered her "husband and my partner" as personal relationship resource contributing her wellness about work. Participant #10 explained that her husband gave her a good balance between work and family life. With the presence of the husband, Participant #10 was able to keep her professional boundaries with clients and survived vicarious trauma. She considered talking with her husband about their children as an effective activity in coping her work-related stress.

Participant #2 also identified his "wife" as an effective personal resource in his coping. Her wife assisted her learning the process of detaching personal lives with his profession. Participant #2 shared: "My wife is a good resource because she has a good way of leaving work in the workplace. She helped me learn that process of being able to know that I was still doing a good even without taking it home."

Participant #8 identified the parents and friends as effective personal relationship resources aiding the process of coping with vicarious trauma. In the case of Participant #8, her parents exposed her early in caring for the people who she considered "difficult population." Participant #8 shared: "My family is a resource; my parents have always

worked with difficult populations so I kind of saw how they handled it all growing up and I was kind of able to adopt some of their practices." Participant #8 also shared that the "group of friends" who are also counselors and her supervisor were supportive in organizing trauma coping activities.

Ideas with like-minded people. While a good conversation with individual who knew and supported their profession emerged throughout the transcripts, only four of the participants directly mentioned that like-minded people or those individuals sharing the same knowledge, experience, and practices are personal resources contributing the coping from possible vicarious trauma encounters.

Participant #4 stressed the importance of being surrounded with people who understand her work and the possibilities of experiencing vicarious trauma. Participant #4 shared that her husband provided her the emotional support and psychological stability during her most difficult times. Participant #3 described this like-minded people as "co-workers" who she had "close relationship" with. Participant #3 mentioned two reasons for considering these individuals a personal resource: (a) "who has been through the same types of things" and (b) someone who "I could bounce ideas off."

Participant #7 shared a similar idea with Participant #3 who considered her colleagues as appropriate individual to share her work-related stress. Participant #7 noted that "being able to identify my safe people" is crucial in managing daily encounters with trauma. Participant #7 said: "Sometime my boyfriend is not always my safe person to talk about work because he doesn't know what this is like."

Participant #5 identified her college friends who are also counselors. Participant

#5 used the term "experienced similar things" to describe the level of comfort she gets when disclosing the emotional burden, she felt with the clients. Participant #5 said: "I have had wonderful college friends who helped me so much. They experienced similar things that I have, and they were able to cope with them.

Table 3 shows the summary of the participants' responses in terms of the contribution of personal resources to personal relationship. I focused in discussing the importance of friends and families in disassociating themselves from the experienced trauma and improving their personal relationship. While a few participants shared the concepts of "engagement with like-minded people" and "spending more time"; however, these participants directed these experiences with their friends and family.

Table 3

Contribution of personal resources in terms of personal relationship

Invariant Constituents	# of Occurrence	% of Occurrence
Families and friends direct priorities outside work	7	70%
Ideas with like-minded people	1	10%
Spending more time	1	10%

Examples of personal resource in coping

While I already sought the personal resource aiding coping in vicarious trauma, I further asked the participants specific examples of these resources. The intention was to cross check the information these participants shared in the process. In this instance, the participants were more comfortable in determining which personal resource is the most relevant in their experience.

Close relationship balances the effects of vicarious trauma. Seven out of 10 participants in this study identified the resources that aided their coping with vicarious trauma. These resources are not limited to person but include the environment that is considered personal to the participants. For instance, Participant #7 identified "(a) book in my desk" which she finds the content to be more supportive and align with her thoughts. Although there were no test data available to determine the personality of Participant #7, this Participant #7 opted to read books than seeking support or distractions from her social connections. Participant #7 said: "What I have been doing instead of that is having a book in my desk so I would read that book in-between sessions. I would get support from the content in that book."

Participant #9 supported the claim that coping mechanisms for work-related trauma vary and are based from the individual's personality. An introvert may withdraw from stressful situations while an extrovert may seek the presence of family and friends to cope with the trauma. Although Participant #9 did not describe his personality, he considered having a close relationship with someone who she or he can unload the emotional burden is helpful in coping with vicarious trauma. Participant #9 described the way he processed the trauma: "I am an internal processor, but I have a co-worker supporting my external processing needs if needed after my sessions with a client." Participant #9 shared that he also established self-limitations in engaging with co-worker traumatic events. Participant #9 explained:

> It becomes a little bit of a conflict or hard feelings when we are becoming aware of each other. The way we are functioning now made us more respectful with

> each other. We are taking it less personal when someone needs to come and talk to someone; but I can't be that person so she will have to go to someone else who likes to be there for that. We are kind of learning our limitations and boundaries up front before we have to establish them and not step on each other toes. Those have been helpful.

Participant #6 is more transparent in describing the friend who became her confidante in the process of unloading the emphatic engagement she had with clients. Participant #6 described the friend as "very logical and rational and who is very helpful because I am very emotional." Participant #6 described a situation when and where the help should start in unloading a vicarious trauma acquired with the client. Participant #6 shared:

> She is really helpful in knowing that I sometimes just need space to process feelings, but then she is very solution focused. That's her go-to thing and that is really helpful for me because I don't like to stay stuck in yucky feelings, but I have to at least acknowledge them. Her being a resource is so awesome.

Participant #2 processes the information internally, which made the conversation with the counselor difficult. However, Participant #2 mentioned that building a close relationship with someone who understands the profession and the traumatic material that may develop is essential in coping. Participant #2 said: "I was having a hard time functioning emotionally outside of myself. The counselor guides me in understanding myself, so I could be there for my clients and not let it affect my personal life."

Participant #4 identified her co-workers, family, and friends outside work as personal resources helping her with the traumatic engagement coping process. Participant #4 described the values she is getting with friends and family. Participant #4 explained: "understanding that people do see what a toll this type of job can take on someone and just providing them with support and encouragement." Participant #4 stressed: "I have been so lucky to have so many friends and family members who really just encourage and support me at every turn so that has definitely made it easier."

Participant #5 developed a close personal relationship with her mentor. Participant #5 shared: "I had a wonderful mentor and she was at my first private practice… She specialized in trauma as well and I would go to her for case staffing's. I would go to her in every difficult case I encountered." Participant #5 mentioned that having a close relationship with her mentor made me even more comfortable in sharing her thoughts and emotions. Participant #5 described the relationship as "great."

Participant #8 mentioned that having "somebody that is a little further removed" from the traumatic engagement with a client is effective in coping with the emotional burden. Participant #8 shared that engagement with traumatic experience can sometimes affect his judgment and practice. Participant #8 said: "I think that has been really helpful surrounding myself with people who think differently."

Table 4 shows the summary of the participants' responses in terms of specific examples of personal resources. A consolidation of these responses cross validated the responses of the participants that were not evident enough to support my claim. In this

instance, I found that close personal relationship with families and friends aided in coping with their vicarious trauma.

Table 4

Examples of personal resource in coping

Invariant Constituents	# of Occurrence	% of Occurrence
Close relationship balances effects of vicarious trauma	7	70%
Keeping boundaries	1	10%
Spending more time	1	10%

Organizational resource aiding trauma

In terms of the contribution of organizational resources to the healing of vicarious trauma among clinicians, I asked participants to identify the organizational resources that aided the healing of vicarious trauma. I focused discussing the invariants constituent where co-workers and supervisors were most valued by the participants. Other resources that the participants identified were outcomes of the close relationship the participants had with their co-workers and supervisors. I contextualized this constituent according to how the participants had experienced it.

Co-workers and supervisors. Nine out of 10 participants directly identified their coworkers and supervisors as the main organizational resource available for emotional detachment sessions. Participant #3 said that it was not the organization that set-up this type of sessions, but the co-workers who are able to develop close relationship and find the need for colleagues' interactions. Participant #3 said:

> …there was some that was put on by the organization, but it was just us who organize these activities … anytime we would spend time together in an informal sort of way to discuss what was going on or how we felt about it was very helpful.

Participant #6 described this co-worker relationship as "close knit team." Participant #7 described her team as "dynamic." Participant #7 stressed the importance of the time that her co-worker gave her. Participant #7 said: "I know that the rest of the team has my back if I need to just vent and let go of something I have been hearing. I having been able to let go so felt safe to do that and it has been really helpful."

Participant #8 described his team as "excellent". Participant #8 emphasized that without the team, the organization is completely not conducive for clinicians who is unable to help themselves disengage with traumatic experiences of clients. Participant #8 shared: "the administration and the requirements that come from above is not supportive and is not conducive to coping with vicarious trauma." With the invisible support they got from the organization, Participant #8 stressed "the supportive supervisors are a huge asset." Participant #8 further explained:

> I have worked in other places where the supervisors are not supportive and not as available and so them just having the availability to sit down and ask those questions and be more personal makes a huge difference in this field. And focusing on and understanding the importance of taking care of each other. Here, we have a great group of people who really do support each other. We got each other's back and being intentional about trying to take care of each other.

Through the leadership of their supervisor, Participant #8 shared that they were able to do "self-care meetings every Friday." Participant #8 described this meeting as: "it is an activity that you can leave all of the difficult stuff there rather than having to take it home with us over the weekend… that has been really helpful." Participant #2 also shared the same sentiment and stated that the supervisor is the only leader who provides the avenues for venting out their negative emotions. Participant #2 said: "my work isn't the best in everything. They don't give us an out."

Participant #1 also appreciated the help she received from the team and her supervisors. Participant #1 shared: "I think being able to talk to colleagues, supervisors is helpful in understanding negative feelings that you can pick up from negative clients." Participant #10 corroborated this idea by emphasizing that while the organization "don't have as much support as I would like," there were coworkers who have been fulfilling her emotional "healing." These people were described as her college mates "who have the same passion as I do for healing." Participant #10 further explained the importance of these coworkers: "I can't do that in any home setting or personal space, so the school would be my best organizational help."

Participant #4 identified the importance of having an involved supervisor and understanding coworkers. Participant #4 said: "I think that having a supervisor who is involved and understands the nature of my work is helpful in coping with vicarious trauma." Participant #4 also described how the peers who shared professional difficulties were helpful in coping with vicarious trauma. Participant #4 said: "I also think that

having peers in the office that are also dealing with hard things has been helpful in working through things that are affecting me with my clients."

Table 5 shows the summary of the participants' responses concerning the contribution of organizational resources to their effective coping of vicarious trauma. I focused discussing the invariants constituent where co-workers and supervisors were most valued by the participants. Other resources that the participants identified were outcomes of the close relationship the participants had with their co-workers and supervisors.

Table 5

Organizational resource aiding trauma

Invariant Constituents	# of Occurrence	% of Occurrence
Co-workers and supervisors	9	90%
Self-care evening	1	10%
Weekly wellness meeting	1	10%
Consultation group	1	10%

Examples of organizational resource in coping

While I already sought the organizational resource aiding coping in vicarious trauma, I further asked the participants specific examples of these resources. The intention was to cross check the information these participants shared in the process. In this instance, the participants were more comfortable in determining which organizational resource is the most relevant in their experience. While the participants articulated three invariant constituents, the most significant of these resources are the organized events

and leadership within the organization. These resources are discussed in detail in this section.

Organizational events. Six out of 10 participants identified the activities held inside the workplaces as a helpful resource in helping clinicians with their experienced emphatic engagement from clients. Participant #7 described these activities as "self-care orientated events." Participant #7 stressed that these are organized by the team who recognized the emotional burden and its effect to the wellbeing of the clinicians. Participant #7 identified how these activities contributed to their lives: "This allows us to express our emotional highs and lows and how we are doing intellectually and professionally."

Participant #9 identified few activities that were helpful: "We have tried to have debriefing meetings; we have tried to have a wellness model." Participant #9 also mentioned the efforts the organization had in ensuring all dimensions required for individual's wellness are supported through various activities. Participant #9 mentioned "spiritual wellness" and "intellectual wellness."

Participant #1 did not articulate specific activity but mentioned that she valued knowing the supervisor and college peers' input on managing vicarious trauma. Participant #1 mentioned that support and understanding from these individuals are values that impact an individual. Participant #10 mentioned that the organization conducted "monthly meetings" where there are "fun times to laugh and joke." Participant #10 kept a personal reminder: "laughing in this field is very important." Participant #10 described these moments as: "Being able to laugh and joke and have fun regardless of the

sensitive nature… Clinicians getting together and reminding that we can laugh." Participant #10 further described these activities as something that promotes "full asset of the relationship." Participant #10 explained the psychological need of clinicians: "we need to be humans. Not just trauma treating machines." Participant #10 shared that these are the professional needs the organization should support. Participant #10 further explained:

> I don't think one specific person responsible for looking out for us would work because we all have such a different nature. We tend to find the people in our groups and colleagues who have similar views. One therapist will not work for us. We need opportunities to be heard, someone who respects our views.

Participant #5 identified the "consultation group… continuing education, seminars, different modalities of therapy" as activities that the organization supported for the clinicians. Participant #5 shared that the organization upgraded the skillsets and management processes for counselors in handling vicarious trauma. Participant #5 detailed this development:

> BOD therapy [local technique] is a new program where the client would only have to be activate and is not required to speak. The benefit of this kind of therapy was that therapist does not have to hear the trauma with the client. The client would just have to activate the feeling, so you don't have to hear anything from them. The more different ways of therapy, supportive consultation, and the encouragement to acquire more skills, the less likely you are to be drawn in and have that secondary traumatization.

Participant #8 who shared that there is less support received from the organization claimed that "Friday meetings" are significantly important for clinicians. Participant #8 said: "I have seen staff meetings, but nothing really dedicated to that kind of self-care discussed during Friday meetings…we often asked colleagues 'how can we support you with this goal or with this struggle. I think that is really important having the space to be able to ask questions."

Leadership. The role of supervisor is essential in the successful trauma disengagement of participants with their clients. It is noted that while an organization may offer limited support for their clinicians in terms of vicarious trauma, the leadership of one's supervisor is critical in leading the team in organizing and implementing activities that values the emphatic care for each member. Participant #6 described the supervisor as "supportive." Participant #6 identified "getting good training" as the priority of the supervisor. Participant #6 said: "we know that he is helpful is getting good training, so we are supported in getting good trainings, especially evidence-based practices and models."

Participant #2 mentioned that a good supervisor is someone that supports clinician's attendance to activities that allow them to disengage with the traumatic experiences of their clients. Participant #2 shared: "I had one supervisor that said. "hey, you need a break and take a day. Go to the beach and don't think about the job. Nothing is going to happen when you're gone." Likewise, Participant #4 shared that the supervisor encouraged self-care activities to vent out traumatic engagement. Participant #4 said: "That's really been beneficial. Having that mentor type who can provide the

advice and guidance that is needed to effectively cope with vicarious trauma."

Table 6 shows the summary of the organizational resources aiding the clinicians coping with vicarious trauma. The participants articulated three invariant constituents. However, the most significant of these resources are the organized events and leadership within the organization. A participant shared though that stakeholders, which include external funding organization, is relevant in funding important yet unfunded programs for vicarious trauma.

Table 6

Examples of organizational resource in coping

Invariant Constituents	# of Occurrence	% of Occurrence
Organizational events	6	60%
Leadership	3	30%
Availability of stakeholders	1	10%

Other resources required to disengage in vicarious trauma

I consolidated other concerns brought about by vicarious trauma that the interview did not cover in this theme. This section presents four invariant constituents identified in the transcript. However, I will only present the experience shared by at least two participants.

Finding own support. Three of the participants directly mentioned the importance of internally processing their own vicarious trauma. Participant #7 shared that: "doing your own work and seeing your own therapist are really big." Participant #7 justified that "everyone has their stuff in this field." Participant #7 further stated that "everyone has baggage and having gone through the work of dealing with those things is

the best that I could do." This thought is also shared by Participant #5 who identified "self-care and surrounding yourself with really good practitioners" are ways to self-support his vicarious trauma. Participant #8 also shared that everyone had different ways of coping and the coping processes evolve that some strategy may not work all the time. Participant #8 said to "reserve some [empathy and compassionate] for later." Table 7 shows the summary of other required resources perceived to be important in disengaging with vicarious trauma.

Table 7

Other resources necessary to disengage in vicarious trauma

Invariant Constituents	# of Occurrence	% of Occurrence
Finding own support	3	30%
No available therapist	1	10%
Attending support programs	1	10%
Good research	1	10%

I presented the results of the thematic analysis performed for the 10 participants involved in the study in this section. These results answered the emerging patterns of individual and organizational resources that counselors who have self-reported vicarious trauma use to cope with the experience to continue practicing their profession effectively. It was also in this section that I presented how and specific processes and instances that these resources have been used at the individual and organizational levels. The emerging patterns of personal resources crucial in coping the vicarious trauma includes: (a) physical wellness, (b) engaging in relax and fun activities, (c) self-control, (d) talking with family and friends outside work, and (e) talking with like-minded people. In terms

of the organization resources, the emerging patterns include: (a) supportive coworkers, (b) attendance to organization events, and (c) middle management leadership or supervisor. These results will be further discussed in Chapter 5.

Summary

The purpose of this qualitative multiple case study is to examine the individual and organizational resources that counselors who have self-reported vicarious trauma used to cope with the experience to continue practicing their profession effectively. The research questions of the study are as follow: (a) What individual resources do counselors who have self-reported vicarious trauma use to cope with the experience in order to continue practicing their profession effectively, and (b) What organizational resources do counselors who have self-reported vicarious trauma use to cope with the experience in order to continue practicing their profession effectively? These questions were answered following the thematic categories discussed in the results section. A summarized pattern emerging in the study includes: (a) physical wellness, (b) engaging in relax and fun activities, (c) self-control, (d) talking with family and friends outside work, and (e) talking with like-minded people for personal resources. In terms of the organization resources, the emerging patterns include: (a) supportive coworkers, (b) attendance to organization events, and (c) middle management leadership or supervisor. The findings will be further discussed in the subsequent Chapter.

Chapter 5: Discussion, Conclusions, and Recommendations

Clinicians are often faced with treating clients who have experienced severe trauma. The top priority of professionals is to help these troubled individuals with a wide variety of issues (James & Gilliland, 2013). The desire of these counselors to help their clients can occasionally lead to stress and mental health difficulties because of the emphatic transformation of their inner experiences (Figley, 2002). This type of stress is called vicarious trauma (Barrington & Shakespeare-Finch, 2013). Vicarious trauma can occur quickly for counselors and typically occurs when treating trauma clients (Hernandez-Wolfe et al., 2015).

Clinicians are at risk for experiencing vicarious trauma (James & Gilliland, 2013). Most of the studies about vicarious trauma explored the importance of the resources needed to prevent vicarious trauma (Dagan et al., 2015; McFadden et al., 2014). There is little research about how counselors could cope once vicarious traumatization is experienced (Dagan et al., 2015; McFadden et al., 2014). It is not known how individual and organizational resources help counselors cope (Iqbal, 2015). Without this information, counselor educators and supervisors will not be able to help in training counselors to cope with negative experiences associated with vicarious trauma such as burnout, compassion fatigue, and decreased professional effectiveness (Hernandez-Wolfe et al., 2015; Maslach & Leiter, 2016).

The purpose of this qualitative multiple case study was to examine the individual and organizational resources that counselors who have self-reported vicarious trauma used to cope with the experience to continue practicing in their profession effectively.

The results could help counselors become more aware of the individual and organizational resources in coping with vicarious trauma. Counselor educators and supervisors could also benefit from the findings by presenting new information relevant to the training of counselors on how to become more prepared when confronted with vicarious trauma.

A qualitative multiple case study was appropriate because it was important to gain rich in-depth information from participants using various data collection tools. The study recruited a purposive sample of 10 counselors who had successfully coped with vicarious trauma based on their own self-report. I ensured that all participants had experienced vicarious trauma through self-reporting during the recruitment phase. I further conducted 45-60-minute semi-structured interviews of the 10 counselors. All textual data such as the observation notes, member-checked interview transcripts, and document records were imported, sorted according to file classifications, and saved in NVivo.

There were two thematic categories that resulted from the data analysis. One thematic category for individual resources and one thematic category for organizational resources. The themes for the individual resources include: (a) physical wellness, (b) engaging in relax and fun activities, (c) self-control, (d) talking with family and friends outside work, and (e) talking with like-minded people for personal resources. The themes for the organizational resources include: (a) supportive coworkers, (b) attendance to organization events, and (c) middle management leadership or supervisor.

I discussed the results of the study in this chapter, including a link between the results, studies in the existing literature, and the theoretical framework. The limitations

and recommendations will also be presented. The implications of the results of the study will also be included. The chapter will end with a conclusion.

Interpretation of the Findings

I interpreted the results of the study considering the current literature and the theories used in this study. I used the research questions to guide me in the investigation concerning the individual and organizational resources that counselors who have self-reported vicarious trauma used to cope with the experience to continue practicing in their profession effectively.

RQ1: How do counselors who have self-reported vicarious trauma describe the individual resources that assist with effective coping?

According to the results, the individual resources of the counselors to assist with effective coping include (a) physical wellness, (b) engaging in relax and fun activities, (c) self-control, (d) talking with family and friends outside work, and (e) talking with like-minded people for personal resources. The findings of physical wellness and engaging in relax and fun activities, were consistent with my hypothesis.

Physical wellness. In the literature, previous researchers focused on self-care as an individual resource for effective coping. According to Walker et al. (2015), self-care is about choosing behaviors that balance the consequences of emotional and physical stressors. Cox and Steiner (2013) also emphasized that self-care is ethically imperative for professionals. Cox and Steiner suggested several activities such as eating habits, proper exercise, getting proper rest, and not becoming overwhelmed at work that are related to the result of the study of physical wellness. These self-care practices will

enhance the physical wellness of the counselors that could offset or prevent potentially debilitating effects of vicarious trauma (Cho & Jung, 2014; Cox & Steiner, 2013; Harr, 2013; Salloum, Kondrat, Johnco, & Olson, 2015; McGarrigle & Walsh, 2011; Tosone, Nuttman-Schwartz, & Stephens, 2012). Myers, Sweeney, Popick, Wesley, and Bordfeld (2012) also noted the positive impact of taking care of oneself to mitigate factors that reduced stress and the potential beginning signs of vicarious trauma.

Engaging in relax and fun activities. The finding, engaging in relaxing and fun activities as an individual resource of counselors to cope with vicarious trauma, is consistent with the current literature. Cox and Steiner (2013) suggested counselors engage in recreational activities to prevent and cope with vicarious trauma.

Some scholars also recommended the use of mindfulness to relax (Baer, Lykins, & Peters, 2012; Raab, 2014; McGarrigle & Walsh, 2011). Researchers empirically investigated and validated that mindfulness is a technique or personal philosophy that counselors should be aware of and should be able to implement in their professional as well as personal lives, to combat the onset of possible compassion fatigue, vicarious trauma, or occupational burnout (Raab, 2014; McGarrigle & Walsh, 2011). Raab (2014) concluded that through mindfulness, counselors experienced more self-compassion which makes them less vulnerable to the vicissitudes of vicarious trauma (Lee, Laurenson, & Whitfield, 2012). Moreover, various spiritual practices have been shown to reduce the signs and symptoms of burnout and vicarious trauma, while at the same time creating space for the development of personal and professional growth (Hervezi, 2015; Gregory, 2015; Lee & Miller, 2013; McGarrigle & Walsh, 2011). Hervezi (2015) discussed how

meditation exercises practiced by nurses could reduce the effects of work stress, compassion fatigue, and vicarious trauma. Active participation in a yoga meditation and mindfulness program may increase the potential for compassion satisfaction, while at the same time inhibiting the development of vicarious trauma (Gregory, 2015).

New Contribution. The findings that individual resources such as self-control, talking with family and friends outside work, and talking with like-minded people were used by counselors to effectively cope with vicarious trauma are new contributions to the extant literature about vicarious trauma. These three specific resources provide new information about how counselors can cope effectively with vicarious trauma.

Theory. The results of the study are consistent with the social cognitive theory (SCT) (Bandura, 1989) and constructivist self-development theory (McCann & Pearlman, 1990). According to SCT, many of the interaction's individuals have with each other are influenced in some way by their subjective social interpretation of the event, regardless of their actual abilities. This is also related to self-efficacy. Self-efficacy can be used to understand how clinicians view themselves as capable of being able to cope with vicarious trauma. If counselors view themselves as having these individual resources, then their self-efficacy to cope and successfully overcome vicarious trauma will increase.

According to the constructivist self-development theory (McCann & Pearlman, 1990), life experiences of individuals shape the present and the future. The counselors' present status is that they encounter different patients all the time that puts them at higher risk of vicarious trauma. The theory also asserts that realities are constructed through

experience, not simply given. If counselors have these individual resources, they can better manage their experiences with their patients.

RQ2: How do counselors who have self-reported vicarious trauma describe the organizational resources that assist with effective coping?

According to the results, the organizational resources of the counselors to assist with effective coping include (a) supportive coworkers, (b) attendance to organization events, and (c) middle management leadership or supervisor. These findings were consistent with the results of previous researchers.

Supportive coworkers. Supportive coworkers served as an organizational resource that helped counselors cope with vicarious trauma. This theme is consistent with the current literature. Sanchez-Moreno et al. (2014) indicated interactions with peers, coworkers, and supervisors could serve as physical and emotional support for individuals. Sanchez-Moreno et al. also stated that organizations can create and promote social interaction among counselors and their work colleagues.

Attendance to organization events. The finding that attendance to organization events can serve as an organizational resource for counselors is also consistent with the current literature. Sanchez-Moreno et al. (2014) suggested that yearly company get-togethers, staff retreats, company Christmas parties, etc. may serve as a resource for counselors to cope and successfully overcome vicarious trauma. Positive teamwork and relationships among staff members are encouraged to have necessary support from their peers (Sanchez-Moreno et al., 2014). Through this positive relationship with their peers, counselors are in a better position to be able to openly discuss their trauma patients,

seeking possible clarification from their fellow workers to correct any distortions that may arise, which could of course threaten their practices as well as their psyche. This support has a role in the alleviation of burnout and vicarious trauma in counselors and social workers (Sanchez-Moreno et al., 2014).

Middle management leadership or supervisor. The result that middle management leadership or supervisor helped counselors cope with, and successfully overcome vicarious trauma is consistent with the current literature. Supervisors encourage counselors and social workers to verbally communicate to their superiors their experiences and reactions to clients who are suffering the debilitating effects of trauma (Cox & Steiner, 2013; Harr, 2013). Through this open communication, supervisors can help counselors. Counselors should be able to seek guidance from their superiors and older and wiser colleagues (Joubert et al., 2013). McFadden et al. (2014) also supported that counselors should be provided with the opportunity to discuss with their superiors their trauma so that they could better process reports of trauma by their clients and not internalize the client's traumatic experiences.

Harr (2013) also recommended that managers should create a supportive work environment to continuously affirm the good work their counselors and social workers are doing and encourage further successful counseling and therapeutic work. A simple strategy is to provide opportunities for, and promote, more humor in the workplace (Harr, 2013). Supervisors and middle management leadership should also conduct regular informational debriefings to mitigate the negative impact of burnout and vicarious trauma (Joubert et al., 2013).

Theory. The results are aligned with both theoretical frameworks. Bandura's (1989) SCT highlights self-efficacy. Given these organizational resources, counselors could improve self-efficacy to further cope with vicarious trauma. The constructivist self-development theory (CSDT) provides a lens to understanding vicarious trauma. A person's unique history forms, structures, and constructs his or her experience of traumatic events, including how they have adapted to their trauma, which is important in understanding vicarious trauma of the individual (Pearlman & Saakvitne,1995; Figley, 1995; McCann &Pearlman,1992). These organizational resources might help counselors adapt to their trauma.

Limitations of the Study

There are several limitations to the current study. The transferability of the results is one of the limitations. The counselors in this study met eligibility criteria: (a) counselors who have experienced vicarious trauma based on their own self-report, (b) counselors who are currently active in the profession as counselors of trauma patients, (c) counselors who work in an organizational clinical setting, and (d) counselors who have at least two years of working experience. The results may be transferrable to counselors who meet the same criteria and the same intent and scope of the current study.

Another limitation was the self-reported vicarious trauma. The counselors answered two questionnaires which determined whether they had vicarious trauma and that they were able to successfully cope with the condition. I have not doubted the self-report conditions and have relied on the honest answers of my participants; however, this

further limits my analysis in terms of qualifying the extent of vicarious trauma the participants have had to experience while managing to simultaneously work effectively.

My personal biases are also a limitation of the study. I served as the main instrument in the current study. I recruited, filtered, and interviewed the participants. I am also the person who transcribed and interpreted the data. My biases could influence the interviews and the interpretation of the data collected. I used guides and templates for the semi-structured interviews and observation to minimize my personal biases.

Recommendations

According to Sanchez-Moreno, de La Fuente Rolda, Gallardo-Peralta and Barron Lopez de Roda (2014), there is a need for more research about policies and practices at the organizational level which could act as countermeasures to lessen the possible signs and symptoms of vicarious trauma in those that work for the organization. I have provided initial data about the role of individual and organizational resources that can aid counselors in effectively coping with and overcoming vicarious trauma, but additional research is warranted

The results of the study provided a foundation about individual and organizational resources and how to use them to successfully cope with vicarious trauma. Future researchers may develop a valid instrument based on insights gained from this study. A valid instrument could be more effective in making sure that counselors have the individual and organizational resources needed to successfully cope with vicarious trauma.

Implications for Positive Social Change

The results of this study could be used to develop necessary strategies needed to cope with vicarious trauma. Counselors, educators, and supervisors can use the information in this study to gain deeper understanding of how clinicians can cope with vicarious trauma. Furthermore, this data can also be used in the training of new clinicians and the helping profession as a whole by educating them on the risk factors and helpful preventative measures discovered in my study.

Counselors will benefit from the results of the study. They could use the results to evaluate themselves whether they have the coping resources to survive vicarious trauma and how they could further boast the personal and organization resources to aid them from future vicarious trauma. In this study, I discussed specific experiences of the counselor concerning the personal and organizational resources they adopted. Counselors searching for information concerning this phenomenon may apply the information discussed in this study to their own lives.

The results revealed that individual resources such as (a) physical wellness, (b) engaging in relax and fun activities, (c) self-control, (d) talking with family and friends outside work, and (e) talking with like-minded people for personal resources are effective tools to successfully cope with vicarious trauma. The counselors who may want to practice their profession free from vicarious trauma may need to prioritize self-care of their physical, psychological, and sociological wellbeing. The experiences of the counselors who took part in this study clearly demonstrated these themes in coping with the trauma acquired with their clients. More importantly, counselors would need to reflect

and acknowledge the presence or absence of these resources to determine what and how they could start or enhance these resources within their sphere.

Organizational resources such as (a) supportive coworkers, (b) attendance to organization events, and (c) middle management leadership or supervisor were effective ways that organizations can support counselors who are at risk for vicarious trauma. Organizations should ensure that these three approaches are considered. Programs, services, events, and workshops that address interaction with co-workers, organization events, and communication with middle management or supervisor should be developed and implemented.

Conclusion

The purpose of this qualitative multiple case study was to examine the individual and organizational resources that counselors who have self-reported vicarious trauma used to cope with the experience to continue practicing their profession effectively. The research questions of the study are as follow: (a) What individual resources do counselors who have self-reported vicarious trauma use to cope with the experience in order to continue practicing their profession effectively, and (b) What organizational resources do counselors who have self-reported vicarious trauma use to cope with the experience in order to continue practicing their profession effectively? The study recruited a purposive sample of 10 counselors who have successfully coped with vicarious trauma based on their own self-report.

The themes for individual resources: (a) physical wellness, (b) engaging in relax and fun activities, (c) self-control, (d) talking with family and friends outside work, and

(e) talking with like-minded people for personal resources. In terms of the organization resources, the emerging patterns include: (a) supportive coworkers, (b) attendance to organization events, and (c) middle management leadership or supervisor. The results are aligned with the two theoretical frameworks: self-efficacy and social cognitive theory (SCT) (Bandura, 1989) and constructivist self-development theory (McCann & Pearlman, 1990). Individual and organizational resources help increase the self-efficacy of counselors to deal and manage with vicarious trauma. Moreover, these resources also help in how counselors construct and understand their experiences of vicarious trauma. Discovering how practicing clinicians have successfully coped with this form of trauma could dramatically increase the effectiveness of new ones. This in turn could allow the profession to focus on what is most important, help.

Furthermore, I want to give thanks to my wife and family who have helped me thought this qualitative process. Without their help, I would not have been able to dedicate the time or energy into this study. As the age old saying goes it talks a neighborhood to raise a child, it takes a close family to complete a scientific study. Thank you all for your love and support.

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Appendix A: Semi-structured Interview Guide

1. How did you cope with vicarious trauma?
2. In terms of your behaviors/practices, what personal resources do you think contributed to your coping of vicarious trauma?
3. In terms of your way of thinking, what personal resources do you think contributed to your coping of vicarious trauma?
4. In terms of your personal relationships, what resources do you think contributed to your coping of vicarious trauma?
5. Can you give specific examples in terms of how a personal resource helped in your coping with vicarious trauma?
6. What organizational resources do you think contributed to your coping of vicarious trauma?
7. Can you give specific examples in terms of how an organizational resource helped in your coping?
8. Do you have anything relevant to add that we did not discuss?

Appendix B: Observation Notes

Organizational Resources	Observation Notes
Collaboration/communication with coworkers	
Availability of Resources	
Policies/Practices	
Organizational Climate	