2019

Exploring How EMDR Social Workers in Eastern Canada Experience Vicarious Trauma

Ashley Amara Spinney
Walden University

Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral study by

Ashley Spinney

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

Review Committee
Dr. Martha Markward, Committee Chairperson, Social Work Faculty
Dr. Debra Wilson, Committee Member, Social Work Faculty
Dr. Cynthia Davis, University Reviewer, Social Work Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2019

Abstract

Exploring How EMDR Social Workers in Eastern Canada

Experience Vicarious Trauma

by

Ashley Amara Spinney

MSW, Wayne State University, 2012

BA, University of Windsor, 2009

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Social Work

Walden University

August 2019

Abstract

Social workers are increasingly using eye movement, desensitization, and reprocessing (EMDR) to help clients recover from trauma. Little is known about how social workers who work with traumatic client material while using EMDR as their main psychotherapeutic modality experience vicarious trauma. The purpose of this phenomenological study was to explore the experience of vicarious trauma among social workers in Eastern Canada who used EMDR in their practice with clients. Constructivist self-development theory was the framework that informed this study. Data were collected using semistructured interviews with 7 EMDR social work participants who were selected using purposive sampling. Participants were required to have a masters level social work designation, EMDR training, and practice with trauma material at least 40% of the time they see clients. Findings from the narrative analysis showed that participants' concepts of "self" changed over time, with the changes becoming less acute. Understanding how EMDR social workers experience vicarious trauma has implications for policy, practice, future research, and for social change related to trauma. Social workers who are less likely to become traumatized may fit a prototype that may be more appealing to organizational stability. Clinicians may be able to see the signs and symptoms of vicarious trauma and take more time for education and self-care. Finally, study findings may further research on vicarious trauma and EMDR.

Exploring How EMDR Social Workers in Eastern Canada

Experience Vicarious Trauma

by

Ashley Amara Spinney

MSW, Wayne State University, 2012

BA, University of Windsor, 2009

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Social Work

Walden University

August 2019

Dedication

To my darling soul mate, Joseph. Without you, I would not be the person I am today.

Acknowledgements

I want to thank *la mia familiga*. Thank you to my loving parents who always supported me in all my endeavors, Terri and Bruce Spinney. Thank you to my loving and hilarious brother, Aaron Spinney who has always been there for me. Thank you to my grandparents who always believed in me, Vera and very special grandfather, Edward Scott. Thank you to all my close relatives, in-laws, and closest friends, who have always offered their support. A very special thank you to all the teachers and professors who stand out and pushed me to do my best; Mr. Michael Beccaria of Notre Dame College School, Dr. Lauree Emery of Wayne State University, and especially Dr. Martha Markward of Walden University, without you it would not have been possible. Thank you for seeing my strength, and making it shine.

Table of Contents

List of Figures

Section 1: Foundation of the Study and Literature Review

Introduction

Little is known about how social workers who work with traumatic client material while using eye movement, desensitization, and reprocessing (EMDR) as their main psychotherapeutic modality experience vicarious trauma. To address this gap in the literature, I interviewed EMDR social worker participants using a semistructured interview method. Understanding how EMDR social workers experience vicarious trauma will allow for social change at the micro and macro levels, as well as inform future research. Social workers who are less likely to become traumatized may foster organizational stability. Clinicians may be able to see the signs and symptoms of vicarious trauma and take more time for education and self-care which may improve client care and job satisfaction. Finally, this study may lead to further research on vicarious trauma and EMDR.

In this section, I outline the problem statement, purpose statement and research questions, nature of the study, significance of the study, theoretical framework, and the values and ethics of the study. A review of the professional and academic literature follows and includes discussion of the prevalence of trauma in Canada, EMDR and trauma, vicarious trauma, negative outcomes of trauma, managing the impacts of work with trauma-affected clients, and EMDR social workers and their practice with trauma-affected clients. The sections concludes with a summary of key points and transition to Section 2.

Problem Statement

The problem is that very little is known about how social workers who use EMDR experience vicarious trauma. EMDR is a technique that trained clinical professionals use to help trauma-affected clients process their thinking about traumatic events and reduce their felt disturbances. Vicarious trauma refers to the effects of hearing about traumatic events on the entire self of social workers in terms of their frame of reference, self-capacities, ego resources, psychological needs/cognitive schemas, and memory and perception (Saakvitne & Pearlman, 1996). In being part of a client's healing, individuals in the helping profession may be affected. As such, understanding how vicarious trauma impacts the self of social workers who use EMDR is important to retain trauma workers to accommodate the number of trauma-affected individuals in Eastern Canada.

Using posttraumatic stress disorder (PTSD) as a measure of trauma, experts estimate that one third of Canadians have been in some way affected by trauma (Affifi et al., 2014), which is consistent with the global rate (Van Ameringen, Mancini, Patterson, & Boyle, 2008), though Bride (2007) estimated that between 40% and 80% of individuals in the United States may be trauma-affected. In terms of managing the effects of trauma work, there are negative professional outcomes of working with trauma-affected individuals. Negative outcomes includes practitioners experiencing burnout (Craig & Sprang, 2010; Diaconescu, 2015; Kim, Ji, & Kao, 2011), becoming incompetent (Clance & Imes, 1978; Jordan, 2010; Sherman, 2013), and leaving the profession (Boyas, Wind, & Ruiz, 2013; Cohen & Collens, 2013; Webb & Carpenter, 2012).

There are also negative outcomes at the personal level. In the field of social work, Figley and Ludick (2017) identified compassion fatigue, which is total mental exertion and exhaustion from working with others in emotional/physical pain. Compassion fatigue results in a lack of empathy and personal traumatization from attempting to help others (Figley & Ludick, 2017). In addition, Bride and Kintzel (2011; see also Bride, 2007) identified secondary traumatic stress, which is emotional disruption and posttraumatic stress symptoms through indirect exposure to survivors' traumatic events.

Despite the contributions of Figley and Bride (2017) to understanding compassion fatigue and secondary traumatic stress among social workers, little is known about vicarious trauma among social workers, especially those who use EMDR in practice with trauma-affected clients, according to my review of the literature. How the "self" is changed in a social worker who provides services consistently to trauma-affected clients is relatively unknown. As such, exploring how the "self" is changed in social workers who use EMDR has implications for understanding how social workers can manage vicarious trauma in order to address the needs of trauma-affected clients and avoid the negative outcomes that can occur as a result of working with these clients.

Purpose Statement and Research Questions

The purpose of this qualitative study was to explore how EMDR social workers in Nova Scotia, New Brunswick, and Ontario, Canada, experience vicarious trauma relative to change in the "self." In conducting the study, I sought to answer the following two research questions:

Research Question 1. Because EMDR practice often focuses on addressing client trauma events, what are the narratives of EMDR social workers regarding the change in the "self"?

Research Question 2. What phrases and words taken from the narratives of social workers regarding change in the self highlight how they experience vicarious trauma, if at all?

The following theoretical and operational definitions are important for a better understanding of the study:

Clinical social work: The provision of services by social workers to clients who are in need of support for mental illness, or mental health and wellness goals. Clinical social workers are therapists who are trained at the master's level as a minimum. Usually, this involves some type of specialized training.

Constructivism: The concept that individuals are able to create or construct realities based on their experiences, and that they are able to reject the idea of a universal worldview (D'Andrea, 2000).

Ego resources: Resources (e.g., self-awareness and interpersonal skills) that allow social workers to make good decisions and have insight for self-protection (Saakvitne & Pearlman, 1996).

Eye movement desensitization and reprocessing (EMDR): A technique used by trained clinical professionals to help trauma-affected clients process their thinking about traumatic events and reduce their felt disturbances. This methodology uses bilateral

stimulation of back and forth eye movements to unlock what might be "stuck" in the nervous system.

Frame of reference: The whole self, or the lens through which the social worker sees identity, world view, relationships, and spirituality (Saakvitne & Pearlman, 1996). Experiences are interpreted through the frame of reference.

Memory/perception: Constructs that reflect the stories individuals tell of their experiences; constructs include imagery, emotion and somatic experiences, and the resulting behaviors (Saakvitne & Pearlman, 1996).

Postmodernism: A theoretical premise that posits that humans can seek their individual truths while thinking critically about their view of the world (D'Andrea, 2000). The assumption is that individuals all have their own truths, and that there is not just one worldview.

Psychological needs and cognitive schemas: The basic psychological needs which may be affected by trauma, including safety, esteem, trust, control, and intimacy (Saakvitne & Pearlman, 1996). These needs are manifested in the social worker's beliefs about herself and himself and others (positive or negative).

Self-capacities: How well a social worker is able to mentally take care of herself or himself. This includes the ability to self-sooth and maintain emotional regulation. Saakvitne and Pearlman (1996) described self-capacity as having inner balance.

Vicarious trauma: Exposure to traumatic events that affects the entire self of the social worker in terms of her or his frame of reference, self-capacities, ego resources,

psychological needs/cognitive schemas, and memory and perception (Saakvitne & Pearlman, 1996). Working with clients who have experienced trauma, or hearing stories that may cause disturbance, may shift the social worker's views or beliefs as a result.

Nature of the Doctoral Project

For this phenomenological study, I used a scheduled interview approach to collect narrative data on how EMDR social workers experience vicarious trauma and whether and how their sense of "self" has changed since using EMDR in practice with trauma-affected clients. I identified potential participants using the websites of *EMDR Canada* and the *Psychology Today*. Those individuals were notified by e-mail and/or telephone once the proposal was approved by Walden University's Institutional Review Board (IRB). I interviewed seven EMDR social workers who practice at least 50% of the time with clients who have experienced trauma, such as, rape, assault, military/combat, childhood sexual/physical abuse, and other major trauma events. Appointments were scheduled with each EMDR social worker participant to administer a semistructured questionnaire with items focused on how working with trauma-affected clients has changed who they are and/or their sense of self. I used narrative analysis to interpret the collected data.

Significance of the Study

The major policy implication in this study concerns agencies' hiring of social workers who work with traumatized clients. The findings in this study can be used by administrators to identify a specific type of social worker, or prototype, who is able to

work with trauma most effectively. In addition, the information can inform agency administrators of how vicarious trauma may affect practitioner boundaries, turnover, and leaving the profession. Agency leaders may want to consider adopting a questionnaire/self-assessment measure for hiring purposes that identifies how social workers are affected by vicarious trauma, if at all. Social workers could be required to complete this self-assessment for vicarious trauma and self-care practices, so agencies can be supportive and review this with their social work teams.

The major practice implication in the study is that it provides information on social work practice with EMDR and trauma work. The knowledge may aid EMDR social workers in becoming aware of signs and changes in their sense of self as a result of practice with trauma-affected clients. EMDR social workers may be able to better understand how they are affected by vicarious trauma, as well as how vicarious trauma affects the self with respect to the five components laid out by Saakvitne and Pearlman (1996). Understanding vicarious trauma and having the tools for self-assessment may allow for a greater understanding of the self. In addition, understanding the effects of vicarious trauma may reinforce the importance of reflection, self-care, and therapy for the practitioner.

The implication for future research is that study findings may provide guidance to researchers seeking to develop a measure for assessing vicarious trauma. Once the qualitative data in this study are collected and analyzed, quantitative studies can be conducted in order to develop a measure for vicarious trauma, identify prototypes of

trauma social workers, and quantify the number of social workers who are trauma-affected themselves at the outset of becoming a worker. Furthermore, the differences in vicarious trauma between practitioners with childhood trauma and those without could also be explored.

The major implication for social change lies in the potential for more understanding of how EMDR social workers experience vicarious trauma. By better understanding themselves and how they are affected by vicarious trauma, these clinicians may have a better sense of competency and self-awareness, which in turn may positively impact clients and lead to a healthier society. Finally, social change at the macro level will allow provincial agencies and associations to provide guidelines or requirements for assessing vicarious trauma in social workers who provide services to trauma-affected clients, especially EMDR social workers who tend to work consistently with that population of clients.

Theoretical Framework

Postmodern and constructivist premises are the bases for constructivist self-development theory (CSDT; D'Andrea, 2000; Saakvitne, Tennen, & Affleck, 1998). The major proposition in CSDT is that individuals respond to trauma based on their perceptions, thoughts, and how they process information (Saakvitne, Tennen, & Affleck, 1998). Everyone experiences trauma differently, and as such, each person creates meaning for and constructs personal narratives about trauma as she or he experiences it (Saakvitne et al., 1998). This theory provides insight about how people adapt to trauma

based on their personality, history, and the social context in which they exist (Saakvitne et al., 1998).

In the context of CSDT, vicarious trauma is the means by which an individual processes information about the trauma experiences of others. Helm (2016) noted that CSDT enables an understanding of how vicarious trauma is manifested in those who experience the trauma of others, especially professionals who practice with trauma affected-clients. The contexts of a professional's life define how she or he experiences the trauma of clients; and if the professional is not cognitively protected by her or his experiences, she or he may experience vicarious trauma.

The focus of this study was on how social workers who use EMDR in practice with trauma-affected clients experience vicarious trauma. The experience of this type of trauma is dependent on how shifts in individuals' beliefs and schemas impact the "self," according to Saatvitne and Pearlman (1996). Although Saatvitne and Pearlman's research is dated, it still provides a means of understanding how practitioners experience vicarious trauma, a topic that has not been well researched. Specifically, components of the self that might change in hearing about trauma events include frame of reference, self-capacities, ego resources, psychological needs/cognitive schemas, and memory and perception (Saatvitne & Pearlman, 1996).

Frame of reference, self-capacities, and ego resources refer to a practitioner's world view, capacity for empathy/self-awareness, and interpersonal skills for maintaining boundaries, respectively (Saatvitne & Pearlman, 1996). Psychological needs/cognitive

schemas reflect the practitioner's need for safety, trust, control, and intimacy, as well as the practitioner's beliefs (Saatvitne & Pearlman, 1996). Last, memory and perception may be changed when a practitioner recalls memory without emotion. For example, if an EMDR social worker believes that the world is not a safe place as a result of hearing repeatedly about sexual assaults, then her or his sense of self has been transposed and she or he has thus experienced vicarious trauma (Saatvitne & Pearlman, 1996).

Values and Ethics

The Canadian Association of Social Workers (Canadian Association of Social Workers; 2005) outlined ethical values and practice principles for working in the field. With respect to trauma, some principles are important to note. The value of service to humanity involves the principle of social workers putting others' needs before their own interests (CASW, 2005). In adopting this principle, social workers may be more likely to put themselves at risk for vicarious trauma. The second relevant principle is competence in practice (CASW, 2005), which is important to note as it relates to working with clients' trauma experiences, as well as being aware of the risk of vicarious trauma. This study's potential contribution to research and the future of social work practice also falls within the second principle. Being able to offer information on vicarious trauma to current and future social workers, as well as impact policy and future research, may promote clinicians' competence in care.

Review of the Professional and Academic Literature

The purpose of this study was to explore how EMDR social workers experience vicarious trauma as a result of hearing the experiences of trauma affected clients. In order to provide a context for the study, the literature review was completed with a number of steps including searching Google Scholar databases, and at times following up with articles found in the Walden University library to find full text. Consultation with the capstone chair also supported the direction of the review. Using a broad to specific process, the theoretical framework begins the literature review with the descriptors "postmodernism, constructivism, and constructivist self-development theory (CSDT)" to provide the literature needed to outline the importance of postmodernism and constructivism as the underpinnings to the main theoretical framework.

The literature published between 2010 and 2018 was reviewed and at times where information was unavailable, or information was relevant, it dated as far back as 1996 was considered for review. The following descriptors were used to guide the review: (a) prevalence of trauma and post-traumatic stress disorder (PTSD) in Canada, (b) eye movement desensitization and processing (EMDR) and trauma, and EMDR and PTSD, (c) vicarious trauma and compassion fatigue, (d) managing vicarious trauma and compassion fatigue, and managing vicarious trauma, EMDR, and social work practice.

Review of Theoretical Framework

Constructivist self-development theory (CSDT, Saakvitne, Tennen, & Affleck, 1998) is undergirded by both postmodern and constructivist propositions. The major

proposition in this theory is that individuals respond to trauma based on their perceptions, thoughts, and how they process information. Because everyone experiences trauma differently, each person creates meaning for and constructs personal narratives about trauma as s/he experiences it (Saakvitne et al., 1998). Another proposition of CSDT is that it gives impetus for gathering information about how people adapt to trauma based on their personality, history, and the social context in which they exist (Saakvitne et al., 1998).

In this context, the concept of vicarious trauma takes on salience as the means by which an individual processes information about the trauma experiences of others. Helm (2016) noted that CSDT provides the link for understanding how vicarious trauma is manifested in those who experience the trauma of others, especially professionals who practice with trauma affected clients. The contexts of a professional's life define how she or he experiences the trauma of clients, and if the professional is not cognitively protected by her or his experiences, she or he may experience vicarious trauma.

Within the contexts of current and past experiences, which include interpersonal, intrapsychic, familial, cultural, and social contexts (Saakvitne & Pearlman, 1996), CSDT explains how vicarious trauma manifests itself in some social workers. These changes of context, or symptoms, present as adaptations to the information they process to reconfigure the self. Saakvitne and Pearlman note that distorted beliefs are a way of protecting oneself from the trauma and that a person's cognitions and schemas may shift

when they need protection, and if not, they may be traumatized through hearing about the trauma events of others.

Prevalence of Trauma in Canada

Traumatic events are unfortunate phenomena that affect many people in the world, which may include a single event or multiple events. Perrin et al. (2014) outlined from surveying numerous countries that between 20 and 90% of the population has been exposed at least once to some type of extreme trauma, which develops into PTSD anywhere from 1% to 11% of the time. The variation in these numbers may be due to the different definitions of trauma in different countries (Perrin et al., 2014) in the same way that there are different perceptions of what trauma means for each individual.

The prevalence of PTSD as the measurable outcome of trauma seems to be the best way to highlight the prevalence of trauma in Canada since trauma is so multifaceted. Trauma experiences as perceived by individuals include being bullying, being in a car accident, experiencing sexual or physical abuse, witnessing a horrific event, and/or engaging in war. Afifi et al. (2014) found that 32% of Canadian adults had experienced physical abuse, sexual abuse, or exposure to domestic violence, and these experiences were associated with mental health disorders later in life.

For example, childhood PTSD may result from one or more abusive and/or traumatic incidents. Van Ameringen et al. (2008) discussed the possibility that being exposed to just one traumatic event is at times sufficient to result in PTSD, which was reported by 76% of the participants in their study, and global prevalence rate of PTSD is

nearly 38%. Van Ameringen et al. (2008) reported the Canadian prevalence of lifetime PTSD to be 9%.

Eye Movement Desensitization and Reprocessing (EMDR) and Trauma

Eye Movement Desensitization and Reprocessing (EMDR) is a technique used among trained clinical professionals to treat many problems, symptoms, and traumatic events, including PTSD diagnoses. Van den Hout and Engelhard (2012) outlined EMDR as an empirically tested treatment for providing relief to trauma symptoms, which has been found to be effective in many controlled trials. In a meta-analysis of controlled trials for PTSD treatments including EMDR, CBT and other psychotherapies, pharmacotherapies, and somatic therapies, EMDR and CBT were both used often and found to be effective (Watts et al., 2013).

Using the EMDR techniques and protocols, a client can experience a reduction in disturbance related to their trauma experience and re-traumatization. The protocol for using EMDR involves having the client recall disturbing events while a therapist applies a type of bi-lateral stimulation, such as eye-movements or tapping. The disturbance is measured in subjective units of distress (SUDs) using a Likert-type scale (0 = No disturbance or neutral, 10 = Maximum disturbance the client could imagine).

Van den Hout and Engelhard (2012) pointed out that this intervention may seem rather odd, and in fact, it began as an outlandish intervention. However, the findings in most meta-analyses indicate that EMDR is effective (Watts et al., 2013). In professional practice, Jefferies and Davis (2013) found that the eye movements are an essential part of

the intervention and that they may also be more effective than trauma-focused cognitive behavioral therapy (TF-CBT). Professional training is necessary for a clinician to use EMDR, as well as practice, continued peer consultation, supervision, and education/training. These practices are recommended for clinicians to use EMDR most effectively.

Relative to the prevalence of trauma in Canada, there are 697 EMDR therapists registered on the EMDR Canada website (EMDR Canada, 2018). However, this includes both social workers and psychologists. Because EMDR social workers are not required to register on this site, the numbers are not clear how many EMDR social workers there are in Canada. Given the likelihood that social workers provide many clinical services in communities, one assumption is that at least half those on site are social workers.

Vicarious Trauma

Helm (2016) noted that vicarious trauma is defined is the "transformation of the helper's inner experience" (see also Saakvitne & Pearlman, 1996), and as such, it is trauma that results from continued empathy for trauma affected clients. Within the context of CSDT, vicarious trauma affects the "self" of clinicians whose realities are based on perceptions and schemas related to interpersonal, intrapsychic, familial, cultural, and social experiences over the lifespan. Vicarious trauma involves clinicians adapting their perceptions and schemas as they hear clients' descriptions of traumatic events. Newell and MacNeil (2010) also described vicarious trauma in terms of shifts in

clinicians' schemas, cognitions, and personal beliefs as they work with trauma affected clients.

The shifts in schemas and beliefs are both continual and additive as they impact the self of the clinician over time (Michalopoulos & Aparicio, 2012). The impact of those shifts related to the following aspects of the self: (a) frame of reference, (b) self-capacities, (c) ego resources, (d) psychological needs/cognitive schemas, and I memory/perception; these are affected by hearing the experiences of trauma affected clients (Helm, 2016; see also Saakvitne & Pearlman, 1996). The frame of reference, self-capacities, and ego resources refer to the clinician's world view, capacity for empathy/self-awareness, and interpersonal skills for maintaining boundaries, respectively. Psychological needs/cognitive schemas reflect the clinicians need for safety, trust, control, and intimacy, as well as for beliefs. Last, memory and perception may be impacted in terms of memory that is recalled without emotion.

Negative Outcomes of Trauma

Social workers in practice, especially those who use EMDR to address trauma primarily, may be at risk of experiencing vicarious trauma when exposed to client trauma material over time. Simultaneously, the result of vicarious trauma can lead to several outcomes, including clinician burnout/ineffectiveness, clinicians leaving the therapeutic environment, and feelings of incompetence. Vicarious trauma may lead to psychological distress and mental health issues for some clinicians, especially those who may have previous mental health concerns (Newell & MacNeil, 2010). Newell and MacNeil (2010)

discussed how working in the human services creates one of the highest chances of burnout, as well as constantly being empathic towards clients, repressing emotions, and/or exuding emotion. Working with client trauma may also bring out any of these three reactions.

Burnout. Craig and Sprang (2010) mentioned burnout as one of the results of prolonged work with trauma clients. Diaconescu (2015) described the burnout syndrome as depletion of empathy and emotional fatigue in helping professions, especially amongst those with much drive and passion. Burnout itself has negative impacts on the social worker. Kim, Ji, and Kao (2011) studied social workers in a longitudinal study who reported to be experiencing burnout, and they found that the higher levels of burnout also resulted in higher levels of physical health complaints which seemed to develop at a fast rate over only 12 months. Burnout and physical health issues can lead to a number of problems. Kim et al. (2011) suggested that these issues may result in higher turnover in social workers because of the high risk of burnout and intense client relationships. This creates both a social work practice and policy problem. Vicarious trauma should not be confused with burnout or vice versa, however it is important to note that one can accompany the other.

Sense of incompetence. The social worker's presentation of vicarious trauma may present as internal feelings of incompetence or develop imposter syndrome (Sherman, 2013), also known as imposter phenomenon (Clance & Imes, 1978). Due to change in the sense of self as a result of vicarious trauma, the social worker may actually

not be keeping up with the continuing competency requirements, or they may just not be suited for this type of work. In this case, they may actually be incompetent, which may also be noticeable to the client. Jordan (2010) described that some combat veteran clients see their therapists as naïve once they begin to experience vicarious trauma. Those clients described their experience with the social worker as having a lack of understanding and lack of expertise (Jordan, 2010).

Leaving the profession. With high burnout and traumatization, a social worker is more likely to think about leaving the profession. Boyas, Wind, and Ruiz (2013) indicated that high job stress and burnout can lead to increased thoughts of leaving and/or exiting the profession when discussing child welfare workers. Webb and Carpenter (2012) considered the consequences of high turnover in social work with some of the impacts affecting other social work employees who must then manage higher caseloads, which in turn can lead to more burnout and turnover. Cohen and Collens (2013) addressed several studies on the impact of trauma work and noted that in one study a participant reported that trauma workers will leave the profession if they cannot find "eternal hope" in the work.

Managing the Impacts of Work With Trauma-Affected Clients

Jordan (2010) discussed how the severity of vicarious trauma is dependent on whether the therapist is addressing important personal factors, and/or taking steps to reduce the affect. Because her research dealt with social workers working with veterans, some of the factors may be generalizable. These include: (a) personal history of trauma,

(b) managing case load numbers, (c) adequate training, (d) peer supervision/consultation, social support availability, (f) self-care, and (g) resilience. Where social workers have their own personal history of childhood trauma, some of these activities may not have as great a positive effect in mitigating vicarious traumatization.

More recently, Cohen and Collens (2013) explored the impact of trauma work on those working with trauma clients and found in their meta-synthesis of studies how organizational factors impact the extent to which trauma work will be harmful or not. Some of these factors include training, participating in roles besides that of therapist, and practicing inclusivity. The authors mentioned that peer support and consultation are important in coping with trauma work, as well as having support from friends and family members. Also important are self-care is engaging in activities, exercise, healthy eating, rest, and meditation that help with emotional regulation.

Training and education. Hernandez, Engstrom and Gangsei (2010) highlighted that training and education are important aspects of managing vicarious trauma. In this regard, they discussed that trauma therapists may also experience vicarious resilience (versus trauma) as a result of working with trauma clients. Experiencing vicarious resilience may develop as a result of making positive meaning from the work, allow for personal transformation, and engage in spiritual growth. If a therapist experiences vicarious resilience, s/he may be less likely to experience vicarious trauma. The authors noted the importance of looking at both positive and negative effects of working with trauma material, especially in training a trauma therapist.

Supervision. In using the constructivist self-development theory (CSDT), Williams, Helm, and Clemens (2012) examined the personal history of trauma among mental health workers. A model was created *a priori* that indicated supervision would lower the impact of vicarious traumatization, however the results of the study did not show a significant impact. Those results indicate that supervision is not necessarily helpful in lowering the chances of vicarious traumatization when a social worker has both a history of trauma and exposure to client trauma. Vicarious traumatization was still likely to occur even with supervision.

Working conditions. Wagaman, Geiger, Shockley, and Segal (2015) discussed the link between stressful working conditions and burnout. A social worker practicing consistently with client trauma may experience increased stress levels, lack of job variation leading to boredom, and burnout. These authors noted that empathy may reduce the effects of burnout on the social worker, though this is not in relation to working specifically with trauma clients. Cieslak et al. (2013) explored a meta-analysis of the research involving exposure to client trauma material, burnout, and secondary traumatic stress. The results indicated that health care workers in over 40 studies showed a strong connection between trauma work and burnout, and that citizenship and female gender were associated with burnout when the practice involved trauma material.

A social worker may experience more than burnout, vicarious traumatization, and other impacts discussed earlier. Dombo and Gray (2013) identified burnout as a psychological stressor while vicarious trauma is both a spiritual and psychological

violation. Moreover, it may be that experiencing serious stressors in the social work profession may be considered spiritual violations (Dombo & Gray, 2013). Therefore, not only are social workers at risk for burnout, compassion fatigue, secondary traumatic stress, and vicarious trauma, but also, spiritual violations.

EMDR Social Workers and Practice With Trauma-Affected Clients

In the field of social work, Figley and Ludick (2017; Figley, 1995), and Bride and Kintzel (2011; Bride, 2007), have explored the concepts of compassion fatigue and secondary traumatic stress, respectively. Figley and Ludick (2017) identified compassion fatigue as total mental exertion and exhaustion of working with others emotional/physical pain, which results in lack of empathy and increased personal traumatization for the clinician who attempts to continue helping trauma affected individuals. The research on compassion fatigue suggests that this phenomenon needs further attention in order to counteract its effects due to the lack of compassion fatigue training for helping professionals, which in turn mirrors the lack of attention to education and training with vicarious trauma (Figley & Ludick, 2007; Figley, 1995). Self-care and self-reflection are suggestions given to professionals that can help them build resilience necessary to counteract the potential for developing compassion fatigue.

Brian Bride's research (Bride, 2007; Bride & Kintzel, 2011) has resulted in identifying secondary traumatic stress (STS), which is considered to be more emotional disruption and posttraumatic stress symptoms that present as a result of indirect exposure to survivors' traumatic events. STS has been described as mimicking PTSD among social

workers (Bride & Kintzel, 2011) and may contribute to turnover in the counseling professions relative to work with vulnerable populations. In their study, Bride and Kintzel found that this was particularly true in the case of addiction counselors. Clinicians working together with their supervisors and educating themselves are two ways to mitigate the effects of STS.

Compassion fatigue, STS, and vicarious trauma are often used interchangeably in the trauma literature with respect to how one can impacts the other. However, in considering vicarious trauma/traumatization, how the sense of a clinician's sense of self is affected as s/he practices with trauma affected persons takes on particular importance. This is especially true for clinicians who use EMDR and who practice with trauma affected clients frequently. In order for EMDR social workers to more effectively prevent and/or manage vicarious trauma, research is needed that explores how the self of EMDR social workers is changed as they practice primarily with trauma affected clients.

Summary

In Section 1 of the project, the focus was on the problem statement, purpose statement and research questions, nature of the study, significance of the study, theoretical framework, and the values and ethics of the study. A review of the professional and academic literature began by reviewing the theoretical framework that guided the study. The prevalence of trauma in Canada, EMDR and trauma, vicarious trauma, negative outcomes of trauma, managing the impacts of work with trauma affected clients, and the need to understand how EMDR social workers who practice

routines with trauma affected clients experience vicarious trauma over time were then

discussed in subsections of the literature review. In Section 2, the research design and

methodology will be discussed.

Section 2: Research Design and Data Collection

Very little is known about how social workers who use EMDR experience vicarious trauma. How the "self" is changed in a social worker who provides services consistently to trauma-affected clients is relatively unknown, according to my review of the literature. As such, exploring how the "self" is changed in social workers who use EMDR has implications for understanding how social workers can manage vicarious trauma in order to address the needs of trauma-affected clients more effectively and avoid the negative outcomes that can occur as a result of working with trauma-affected clients. To understand the study phenomenon, I interviewed social workers who use EMDR with trauma-affected clients. In this section, I provide an overview of my research design, methodology, and ethical procedures. The section concludes with a summary of key points.

Research Design

The purpose of this phenomenological study was to explore the narratives of social workers who use EMDR in practice with clients in Nova Scotia, New Brunswick, and Ontario, Canada, regarding how they have experienced vicarious trauma since completing EMDR training. The main objective of the study was to elicit the narratives of EMDR social workers regarding whether and how practice with trauma-affected clients has changed their sense of self. I posed the following questions to participants in order to hear their narratives:

Interview Question 1. In what ways, if at all, has your frame of reference or view of the world changed as a result of practicing with trauma-affected clients?

Interview Question 2. How has your capacity for empathy changed, if at all, since you first began practicing with trauma-affected clients?

Interview Question 3. How has your ability to maintain boundaries that separate you from your clients changed (i.e., how often do you think about the events of clients in your personal life)?

Interview Question 4. In what ways has practicing with trauma-affected clients influenced your psychological needs (i.e., safety, trust, control, and/or intimacy)?

Interview Question 5. In what ways has practice with trauma-affected clients affected your ability to discuss their traumatic events either with our without emotion?

This study was qualitative in nature. I designed it to elicit the individual truths of social workers who may experience vicarious trauma. I conducted individual interviews with seven social workers. Interviewing social workers about intimate details required gathering sensitive personal information so an individual semistructured interview was chosen as the most appropriate data collection method over focus groups (see Appendix A).

Methodology

Prospective Data

In order to gather their opinions, thoughts, and feelings on the subject matter, I interviewed participants individually in an intimate setting that was comfortable to them.

This format and setting allowed for flexibility in the event that a participant became distressed. It also allowed me as the interviewer to move on to the next question or stop the interview altogether if necessary, which would have been more difficult to do in a group setting. Conducting individual interviews also allowed me to carefully attend to the answers of the participants; as Ravitch and Carl (2016) noted, individual interviews allow the researcher to pay close attention. Another benefit of individual interviews is that they are an appropriate method for gathering sensitive data (Ravitch and Carl, 2016). Because the research questions concern vicarious trauma experiences, an individual interview conducted in an intimate setting provided the participants a safe space where they could stop at any time they felt uncomfortable. My protocol included offering participants a list of free mental health services in their area should they become triggered by the interview or become distressed. All participants denied any distress post-interview.

Participants

The participants selected for this study were seven master's-level social workers who had completed Levels 1 and 2 EMDR training. Eligibility criteria included the requirement that participants have experience working with trauma-affected clients since their EMDR training. I recruited EMDR social workers who worked in private practice settings (see Appendix B for the recruitment letter).

I used a purposive sampling technique to recruit participants and contacted EMDR social workers by e-mail. Their e-mail addresses are available publicly from therapy websites. The social workers who responded positively were then asked to

answer qualifying questions including their training level and time practicing EMDR (see

also Appendix B). I identified more than 100 EMDR social workers in Eastern Canadian

provinces using the websites for *Psychology Today* and EMDR Canada. The social

workers who agreed to participate signed the consent form in person or via e-mail,

depending on whether the interview took place in person or online via Skype.

Instrumentation

I used a five-question semistructured interview schedule to collect data from

participants (see Appendix A). I introduced the study to each participant using the same

script (see Appendix C for the script) and asked each participant to complete a brief

demographic questionnaire (see Appendix D). In addition, I asked participants to answer

the five questions about vicarious trauma in the confidential settings of their choice.

These settings included private therapy offices or a space at their home; the format was

either in person or via Skype depending on the participant's proximity to me.

Specifically, the questions posed to the participants in the study were ones that I adapted

from the five components and self-assessment of Saakvitne and Pearlman's *Transforming*

the Pain (1996) including frame of reference, self-capacities, ego resources, basic

psychological needs, and sensory experiences. Based on the work of Saakvitne and

Pearlman, I asked questions such as the following: How has your capacity for empathy

changed, if at all, since you first began practicing with trauma affected clients?

If necessary, I asked follow-up questions to obtain further information or

clarification. I wrote the participants' answers down while also recording each interview

with a digital voice recorder. This recording was used for transcription purposes. I

transcribed each recorded interview myself.

Data Analysis

I used narrative analysis to identify how the self of participants has changed since

using EMDR with clients who are often trauma-affected. Barusch (2015) outlined the

following steps for conducting narrative analysis:

1. Compile the accounts of the social workers.

2. Read them several times.

3. Note responses to each story that include the researcher's beliefs, doubts, and

emotional responses.

According to Barusch, using brackets for those notes allows the researcher to control

bias, remain self-aware, and enter into the analytic process.

I manually entered the answers of participants to questions about the self as a

narrative account, and in this process, memos will be documented to note the researcher's

experience to those answers and the narrative as a whole. Within the context that

qualitative research has its origin in the notion that there are multiple realities in

subjectivity, this is especially true in narrative analysis because the researcher is using the

subjectivity inherent in the responses of participants. In fact, giving the data meaning is a

subjective act. In particular, the meaning that the researcher gives to the words and

phrases participants use in responding to questions posed to them about change in the self

takes on special importance for understanding of how vicarious trauma is experienced.

Credibility, transferability, dependability and confirmability will ensure the validity and reliability of the study. While credibility is evident in the alignment of the research design, instrumentation, and data analysis used (Ravitch and Carl, 2016), transferability is apparent in the possibility that the research process could be applied to other groups of EMDR social workers in different locations (Cope, 2014; Ravitch & Carl, 2016). Dependability will be seen in the answers to questions posed to participants (Shenton, 2004), and confirmability will be demonstrated in researcher notes that achieve subjective meaning but without a preconceived biased perspective.

Ethical Procedures

Working with the valuable information that participants provide and ensuring that confidentiality is respected and protected is an important ethical practice. The privacy of participants must be respected and data must be kept confidential and safeguarded from identification. The goal is to minimize any harm that a participant might endure while also practicing the utmost respect. The participants were offered information on counselling services should they be triggered in any way by the interview, however none of the participants found themselves triggered.

Protecting Privacy

To ensure the privacy of participants, I maintained confidentiality. One way this was be done was through using pseudonyms and changing any other identifying details when results were written (Ravitch and Carl, 2016). Personal information is safeguarded and kept confidential which was promised in the consent conversation. I will insure that

there is no way the participant can be identified by using no identifying information associated with the data (Ravitch & Carl, 2016). Any specifics that identify participants were also removed.

Minimizing Harm

Another important ethical practice is to minimize any harm to participants. Submitting work to the IRB checked for anything that might stand out that could potentially harm a participant. I addressed in the IRB application the use of language to frame questions, deceptive research, marginalization, asking for hours of commitment from participants, making informed consent too casual, and exposing any discomfort. I will base my research on the notion that I will do no harm.

Respecting the Experience

One of the most important pieces in conducting research is ensuring that informed consent is completed in a thorough and detailed way. Participants need to know what they are signing in terms of their rights and expectations of them. Informed consent means that the participants are in fact informed. I went over the informed consent form with each participant to make sure they understood the information, answered any questions, and let them know they could withdraw at any time. I also respected the time boundaries set between myself and the participants. Outlined in the consent form, participants were informed that 1.5 hours would be scheduled for their interview. This ensured enough time in case there is a lot of detail the participant shares. Ethical

considerations were approached from a positive viewpoint to allow a positive experience for both the researcher and participants.

Summary

The research design subsection of Section 2 highlighted the qualitative nature of study, and as such, reiterated the purpose of the study and questions that will be posed to participants regarding their experiences in response to questions adapted from the Saakvitne and Pearlman workbook (1996) that address vicarious trauma. The methodology subsection of Section 2 described how the proposed qualitative research study will be conducted in terms of data collection, data analysis, and ethical procedures. In Section 3, the study findings and experiences of participants relative to the research questions will be presented.

Section 3: Presentation of the Findings

The purpose of this phenomenological study was to explore how EMDR social workers in Eastern Canada experience vicarious trauma relative to change in the "self." I sought to answer the following two research questions: First, because EMDR practice often focuses on addressing client trauma events, what are the narratives of EMDR social workers regarding the change in the "self?" Second, what phrases and words taken from the narratives of social workers regarding change in the self highlight how they experience vicarious trauma, if at all? To answer these questions, I conducted individual interviews with seven social workers who use EMDR in their practice with clients.

In this section, I will review my data analysis techniques and present my main findings. First, I will discuss the data analysis techniques I used, providing an outline of the steps used for the narrative analysis. This discussion will be followed by a presentation of the findings of the data analysis. In the summary section, I will review key findings and offer a transition to Section 4.

Data Analysis Techniques

I collected the data over 24 days. Prior to collecting data, I invited 95 EMDR social workers in Eastern Canada via e-mail to participate in the study, but once the target sample of seven EMDR social workers was identified, no more recruitment was needed. Two participants were interviewed in person, and five participants were interviewed via Skype because of their geographical location. (Three participants were in Nova Scotia, one was in New Brunswick, and three were in Ontario.) The participants who agreed to

participate in the study were asked to answer three demographic questions to ensure they met the criteria for participation in the research study. Once eligibility was confirmed, the interview was scheduled. I interviewed the seven participants individually for approximately 30 minutes each.

After completing data collection, I downloaded the interview recordings onto my laptop computer and transcribed the interviews. Each interview was listened to twice to ensure accuracy of the transcription, and once all stories were compiled, data analysis began. Using the techniques prescribed for narrative analysis described in Section 2, I read and reread the stories several times in order to note thoughts, feelings, and assumptions about each story. After reading all interviews, I took notes on how each participant's story reflected how she or he experienced vicarious trauma based on answers to the five questions posed to them about change in "the self." I used pseudonyms for participants and included their demographic information in their stories. Within each story, the themes emerged and key phrases and words were recognized. This process was completed based on the text in each transcription and transferred to a separate document. I compared and contrasted each story to others for similarities and differences to understand participants' change in self.

Validation in qualitative research can be found in the trustworthiness of the study (Ravitch and Carl, 2016). During the interviews, I checked in with participants to make sure that I understood their responses, which constituted an in-interview member check. A limitation to this study is that not all participants were interviewed in the same way.

There may have been nuances, for instance, in the in-person interviews that were not present in the Skype interviews, which may have affected the collection and analysis of data. A second limitation of the study is that the use of a semistructured interview format meant that not every participant received the same follow-up questions.

Findings

I present the findings in response to the study's two research questions: First, because EMDR practice often focuses on addressing client trauma events, what are the narratives of EMDR social workers regarding the change in the "self?" Second, what phrases and words taken from the narratives of social workers regarding change in the self highlight how they experience vicarious trauma, if at all? I wanted to elicit information about whether participants perceived that practice with trauma-affected clients had influenced certain aspects of their "selves." In order to answer the two research questions, the following five question topics were posed to participants: (a) frame of reference, or view of the world; (b) self-capacities, or capacity for empathy; (c) ego resources, or establishing boundaries; (d) psychological needs/cognitive schemas, in terms of safety, trust, control, and intimacy; and (e) memory and perception, or, specifically, their emotional affect. In response to the second question, the findings show the words and phrases that social workers use to describe those effects.

Research Question 1

Lisa. Lisa is 46 years old and has practiced as a masters-level clinical social worker for 17 years. She completed her EMDR training in 2018 and has since completed

some advanced trainings as well. Lisa has approximately 10 supervision hours per year,

and she works with trauma-affected clients 90% of the time for about 22 hours per week.

She does not consider herself to have a personal history of trauma; she also reported that

she had never been diagnosed with PTSD. Lisa's story depicted a change in self reflected

in her emotional connection with herself and in her intimate relationships. She expressed

that

> I am very good at disconnecting from my own emotions, and I know that that
>
> follows me into every area of my life. It has caused problems, but it also has
>
> forced me to really become more self-aware and grow my self-care abilities
>
> because of the fact that I don't open myself up to vulnerability very much with
>
> others.

Lisa discussed that trust for her is related to vulnerability in her life. She shared

that she is uncomfortable with vulnerability in everyone except herself and stated

> I've always been a little bit cautious and a little bit guarded in regard to
>
> vulnerability. I guess vulnerability is a significant one since working with trauma,
>
> because working with women, especially First Nation women, who cannot access
>
> vulnerability, I was able to realize how much that was my issue as well.

The most impactful shift in Lisa's "self" was in sharing her feelings about intimacy--that

the work she does has a major impact on her marriage:

> I think that I have struggled with making space for my most intimate
>
> relationships… could be influenced by the fact that it's a highly emotional

journey with my clients and that's highly connected to the fact that there's so much trauma. I find I give probably way more of me to the work and don't save very much for home. So there have definitely been struggles, even very recently with regard to I'm not sure I even want to be married because I think I just don't have the emotional energy…I give a lot. Emotionally I'm often drained going home, especially if it's been a long day.

Sarah. Sarah is 55 years of age and has practiced as an MSW clinical social worker for 10 years. She completed her EMDR training in 2015, has since completed some advanced trainings, and works with trauma affected clients 100% of the time. She does consider herself to have a personal history of trauma but reported no PTSD diagnosis. Sarah shared that she is able to shift from one client to the next during the day, but that she notices a need to check in on clients who have had a difficult session.

I have been known though to reach out after a session if I feel has been particularly hard on a client as I did the other night, just checking-in because… I need that.

When expressing her thoughts about her views on personal safety, Sarah explained that she has noticed some changes.

I think that I've become a little bit more cautious, less naïve… the problem with private practice is that I could be the only one here and it could be night time so that I find I have to work on in terms of a safety issue… I've tried to configure the office… I like this office closer to the door. That particular office back there

(pointing to the office beside hers) you can be trapped in that office and that's

where one of the incidence with the couple happened… that was one of the things

that did impact me.

Sarah went on to explain how she uses safety precautions when leaving her office as well.

I check the back of my car every night when I get in especially if I'm coming out

of here and going to the parking lot… I have spoken to clients who have had

experienced different types of assaults over their lifetime… I have upped that as a

result of working in the social work field. So I check the back seat, and if I can't I

will actually look in the car as opposed to getting in the car and then turning

around. So I make sure I see what's in the car before when I turn the light on.

Especially if I'm the only car left there. I [also] lock my doors at night.

David. David is 36 years of age and has practiced as an MSW clinical social

worker for 7 years. He completed his EMDR training in 2018 and has not yet completed

any advanced EMDR trainings. David's has approximately 16 hours of supervision per

year, and he works with trauma affected clients 70 % of the time and is engaged in work

with trauma 22 hours per week. He considers himself to have a personal history of trauma

but reported no PTSD diagnosis. David's story is a positive one. He mentioned that client

trauma may have affected him more in the past, but he does not find he carries it with

him after work as much as it had.

When I first started I was more impacted by client experience and so the vicarious

side of things would affect me a bit more, but I've learned to compartmentalize by

recognizing that in terms of my impact and change on the client, I'm only a small

part of their experience. So it's acknowledging my presence in their lives has

helped me to manage those boundaries a lot clearer. It doesn't affect me in a way

that I take it home with me as much.

David expressed throughout his story that when he feels the need, he will seek

support.

I think what I'm more concerned about now is how I can better serve them, rather

than the impact of trauma on me… including getting help when you're under

psychological distress… if you're not dealing with your own stuff, then that's

going to be problematic in your work… and also working partly maybe on my

own stuff, has allowed me to sort of create this boundary. So their experience is

unique to themselves and we have to honour that and accept that for that, however

though when I go home, I need to have my own safety space and I need to indulge

myself into that. And so how does that look like? It's sort of doing those self-care

things that you should do. For me it's playing sports or spending time with family.

Justin. Justin is 32 years of age and has practiced as an MSW clinical social

worker for 4.5 four and a half years. He also holds a Masters in Divinity. He completed

his EMDR training in 2016 and has since completed some advanced trainings. Justin's

supervision hours are approximately 20 per year He works with trauma affected clients

85% of the time for about 18 hours per week. He does consider himself to have a

personal history of trauma due to working from a trauma-informed perspective but he

reported to never have been diagnosed with PTSD. Justin's story begins with his

recognizing how working with trauma has changed his sense of humor. "I would also say

it's affected my sense of humor, my sense of humor has really darkened over the years."

Although Justin seemed optimistic and upbeat, he expressed how his empathy has really

shifted over his experiences.

> For one thing, when people complain about things that aren't that big of a deal,
>
> there's definitely a part of me that's like 'oh man, like if only you knew what's
>
> happening to people in this world you wouldn't be complaining about your car
>
> payment or whatever.' So I think it actually has made me a bit more blunted
>
> around those kind of issues with people, maybe a little more impatient, which I
>
> don't like… so, in my personal life actually it has, to some degree affected my
>
> ability to empathize with people with things that I don't deem to be that big of a
>
> deal.

Emotionally, Justin explained that he finds his work very draining to the point that

he may shut off when he gets home.

> In session, I am totally empathetic… so it's weird like if I have the person sitting
>
> in front of me talking about it… but if it's in my personal life and it's a friend or a
>
> loved one, then I can be kind of numb, often because I've been at work all day,
>
> and that's the biggest thing for me, like I just have no capacity by the end of the
>
> day, like if we want to talk about the single greatest affect that this work has on
>
> me, it's that when I get home I am done… the capacity I have to hold people's

suffering when I'm not at work, that's taken a major hit. I get home and I'm like… I can't, it's like 8 O'clock at night and I just want to read and go to bed.

Justin expressed how his boundaries have become extremely firm over his practice for survival sake. He shared how he is impacted by client stories that trigger his own trauma.

My boundaries have gotten… probably more rigid is an accurate word… in terms of what I carry home with me from my clients, coming up on two years ago I lost my mom to cancer, and she was really young she was 53. It was awful, it's like the fucking worst. If it hasn't happened to you I hope you never see anyone you love die of cancer. It was so bad, and I've done a bunch of EMDR therapy, but there still is the cases that I take home with me, is like when somebody's mom dies of cancer… you know it's the grief stuff that will follow me home… I can't fix grief… PTSD I wave my hand in front of your face for a few sessions and then you're fine, but grief, it's one of those moments where I feel powerless, and I very rarely feel powerless in individual therapy.

Mallory. Mallory is 44 years of age and has practiced as an MSW and clinical social worker for 16 years. She completed her EMDR training in 2018 and has completed no advanced trainings. Mallory has approximately 40 supervisory hours per year and she works with trauma affected clients 100% of the time for about 18 hours per week. She considers herself to have a personal history of trauma and reported no PTSD diagnosis. Mallory shared that over her practice and experience she has been able to develop some

helpful skills, however there are times when thinking about client's outside of work still affects her.

> When I first started I would go home and I would lose sleep. I would think about them. And I still do. I have to be aware and intentional about reminding myself about what my role actually is.

Mallory also noted how her awareness of safety has shifted as a mother.

> It shows up in my feelings for my children. That's where it shows. And it's sort of when you hear atrocities and if it is related any way to the ages of my children. Or the story is around abuse in childhood, those are the parts that are difficult for me where I get triggered… I believe in them developing resilience and independence so my kids… but that doesn't mean that after I come home from listening to stories about teacher… or other people, that I don't feel a sense of anxiousness about my own kids… It was a lot worse before when I was unsupported and less from an attachment and trauma lens. I think I would really not know what to do with that material and the anxiety would be… you know for example it would be, 'I don't want my kids to be alone with grandpa', and I could hear myself saying that and then because I have now… I have really good supervision support that I have learned to be aware of how that shows up. So their stories do show up in my personal life, in those sort of ways.

> **Crystal.** Crystal is 54 years of age and has practiced as an MSW clinical social

worker for 25 years. She completed her EMDR training in 2014 and has since completed

some advanced trainings as well. Crystal as 32 supervision hours per year, and she works with trauma affected clients 100% of the time for about 25 hours per week. She reports to have a personal history of trauma working from a trauma-informed perspective but has never been diagnosed with PTSD. Crystal narrated her emotional sensitivity levels in her personal life.

> [I've become] more sensitive. I'm more sensitive with family, with friends, with TV commercials. I don't go see certain movies. I don't listen to the news… I would avoid movies that have overt violence in them. Anything that has to do with violence against women. Like, for instance, this week I went to see the *Colour Purple*, the musical. And I wasn't going to go see it because I was worried about seeing the violence that was in the story. But it actually was really amazing. So it would be stuff like that that I would avoid. But on the other hand, movies like Deadpool, I'm all over that, because that's just cartoon violence - it's not real and its' funny. So it's not all violent movies it's specific ones that would be too traumatic. I wouldn't do a military war one anymore either.

In terms of thinking about clients or their stories, Crystal reported that she will at times find herself thinking about them during the night.

> I don't think about their specific trauma stories but I do have a couple of clients that I might find myself thinking about, like if I woke up in the middle of the night, a worry about them might pop up. Like how isolated or how alone they are, those ones in particular for me pull at my heartstrings more. So not about the

trauma, but how's it's causing suffering for them in the present moment… I mean it could probably last for ½ hour or so, or I might think of them a few times, and then when I realize that's what I'm doing I try to on purpose shift my thoughts to something else, and not give my weekend time to thinking about clients any more. And it doesn't happen all the time, just once in a while.

Amy. Amy is 36 years of age and has practiced as an MSW clinical social worker for five years. She completed her EMDR training in 2017 and has not yet completed any advanced trainings and has no one-on-one supervision hours, though she accesses peer consultation throughout the year. She works with trauma affected clients 70% of the time for about 19 hours per week. She does not consider herself to have a personal history trauma and has never been diagnosed with PTSD. Amy's story touches on her sensitivity to hearing client trauma material at work and then wanting to avoid that in her personal life with media.

> I think I've become more sensitized, because when I leave my work at work and I go home, I don't want to watch anything with crime shows or dramas, and I'd rather just watch fluffy entertainment shows because if I've been hearing it all day, in that case in kind of a superficial way I think it has affected me.

Amy then expressed how she tries to have more control in her life to protect herself psychologically.

> I do try to have more control over things, just in terms of boundaries, in terms of my time, with who I interact with, who I choose to be around, because I want to

create a positive environment for me, to make sure my psychology is protected

and that could be indirectly influenced, because understanding how people, how I

could potentially be exposed to things I don't want to be exposed to so that I

avoid kind of traumatic situations or negative situations. So I do try to control

what goes on in my life a bit more and not leave it up to someone else's control.

Research Question 2

In considering the narratives/stories of the participants in this study, numerous

phrases and words in their narratives show the influence of practicing with trauma

affected clients on the "self" as a means of understanding how they experience vicarious

trauma. In this analysis, once the words and phrases were grouped into themes, those

themes were identified relative to the five components of the self. Those words and

phrases, the themes they create, and which of the five components of self the theme
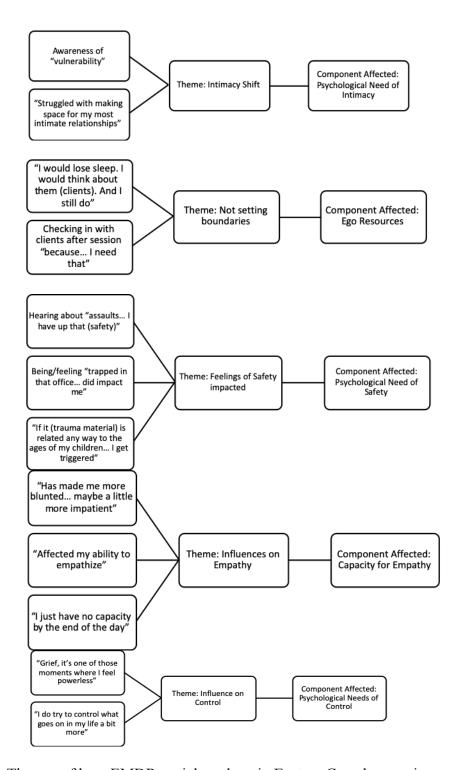
speaks to, are shown in Figure 1.

Figure 1. Themes of how EMDR social workers in Eastern Canada experience vicarious

trauma.

Several findings were unexpected. First, Justin was in the process of grieving the loss of his mother at the time of the interview, which was in and of itself a trauma experience. "Coming up on two years ago I lost my mom to cancer, and she was really young she was 53. It was awful…if it hasn't happened to you, I hope you never see anyone you love die of cancer." His story showed how personal grief and client grief and trauma work affects him as a clinician. Second, Mallory noted the need for good supervision in her experience of practicing with clients. "I have really good supervision support that I have learned to be aware of how that shows up". For David, working with trauma affected clients has made him more self-aware and therefore stronger in practicing good boundaries. "Acknowledging my presence in their lives has helped me to manage those boundaries a lot clearer. It doesn't affect me in a way that I take it home with me as much."

Summary

Section 3 included the presentation of findings in the study. In the first subsection, the data analysis procedures were discussed. In the second subsection, the actual findings were presented in narratives/stories that illustrated how participants experience practicing with trauma affected clients. In Section 4, the findings will be applied to ethical practice in the social work profession with recommendations for policy, practice, and future research, as well as with implications for social change.

Section 4: Application to Professional Practice and Implications for Social Change

The purpose of this phenomenological study was to explore how EMDR social workers in Eastern Canada experience vicarious trauma relative to change in the "self." I sought to answer two research questions: First, because EMDR practice often focuses on addressing client trauma events, what are the narratives of EMDR social workers regarding the change in the "self?" Second, what phrases and words taken from the narratives of social workers regarding change in the self highlight how they experience vicarious trauma, if at all?

I used a scheduled interview approach to collect narrative data on EMDR social workers' perceptions of vicarious trauma and changes in the "self" since using EMDR with trauma-affected clients. I recruited prospective participants from *Psychology Today* and EMDR Canada websites. Seven EMDR social workers were interviewed using a semistructured questionnaire with items focused on how working with trauma-affected clients has changed who they are and/or their sense of self. Narrative analysis was used to analyze the collected data.

The narratives of the participants demonstrate that the "self" of these EMDR social workers was changed in unique ways over time. For instance, participants used phrases such as "struggled with making space for my most intimate relationships" and "affected my ability to empathize," along with the words *vulnerability* and *impatient*. These phrases and words show the ways the self was affected.

Given the changes in the self, the narratives/stories show how participants experienced vicarious trauma. Also, the finding that six of seven participants had experienced trauma themselves but none had been diagnosed with PTSD seems to reinforce the notion that changes in the "self" changed over time and were less acute. Study findings extend knowledge about vicarious trauma in the discipline of social work, especially among EMDR social workers who practice primarily with trauma-affected clients. In this section, I discuss how findings can be applied to professional ethics in social work; offer recommendations for social work practice, policy making, and research; and discuss the study's implications for broader social change.

While some responses seem normative with regard to the descriptions of vicarious trauma, most descriptions suggest that aspects of the self were affected beyond the norm. For example, Sarah described that some notions of safety she learned in life, such as walking to the car and checking it, but she attributes her work with trauma affected clients to her heightened sense of safety. Another example is seen in Lisa's description of how she learned more about her own vulnerability by seeing the lack of vulnerability in her First Nation clients who experienced trauma. As a result and beyond the norm, she questioned her intimacy in marriage, which would be unlikely in work with clients who were not trauma affected.

Application to Professional Ethics in Social Work Practice

CASW (2005) outlined ethical values and practice principles for working in the field. With respect to trauma, some principles are important to note. The value of service to humanity involves the principle of social workers putting others' needs before their own interests (CASW, 2005). In adopting this principle, social workers may be more likely to put themselves at risk for vicarious trauma. The second relevant principle is competence in practice (CASW, 2005), which is important to note as it relates to working with clients' trauma experiences, as well as being aware of the risk of vicarious trauma. This study's potential contribution to research and the future of social work practice also falls within the second principle. Being able to offer information on vicarious trauma to current and future social workers, as well as impact policy and future research, may promote clinicians' competence in practice.

The findings of this study speak to both of these ethical principles. First, understanding how putting other's needs before your own interests as a social worker may directly impact how the "self" is influenced when working with client trauma material. Social workers may enter into the practice with this principle in mind; however they may not be fully aware of the impact the trauma work may have on their "self." The narratives/stories, and words and phrases, of the social workers interviewed showed how uniquely each person can be affected by working with client trauma material. In regard to competence in practice, these findings are useful for understanding competence about

vicarious trauma and being ethically prepared for this principle. The information may help social workers understand the risk of vicarious trauma.

Recommendations for Social Work Practice

The findings in the study have implications for how agencies recruit and hire social workers for practice with traumatized clients. Although this study may not have found a "prototype" social worker for practice with trauma, it may be important for agencies to require social workers who practice with trauma-affected clients to engage in self-assessment regarding vicarious trauma when they consider their self-care practices. Agency leaders can then be supportive of this process and review it with their social work teams.

The idea of self-assessment is also important for social workers in private practice based on the experiences of some participants in this study. The EMDR social worker is a times the only clinician, business owner, and single employee in her or his clinic. This means that outside support is of the utmost importance, especially in regard to the possibility of vicarious trauma. Provincial colleges may be interested in changes to policies already in place for those engaged in private practice to ensure they are meeting requirements for supervision and adding a self-assessment for vicarious trauma in the future. Continual self-assessment and evaluation of vicarious trauma may allow the social worker to be supported in supervision, continuing education, and self-care.

The major practice recommendation in the study is to inform social workers, especially EMDR social workers, how trauma work may affect their practice with

trauma-affected clients. Understanding how they experience vicarious trauma may aid

EMDR social workers in becoming aware of signs and changes in the "self" as a result of

practice with trauma-affected clients. EMDR social workers may be able to understand

how they may be affected by vicarious trauma, and in turn, how they can practice more

effectively with the trauma-affected clients they serve, whether in an agency setting or in

private practice. Ultimately, the intent is for professional helpers to stay healthy in order

to better serve clients.

   With regard to implications for future research, study findings might be useful to

researchers seeking to develop measures for assessing vicarious trauma. The responses in

this study that show how social workers are influenced by practicing with trauma-

affected clients could be used as Likert-type items on a questionnaire to measure the

extent to social workers have experienced vicarious trauma over a designated period of

time. A quantitative study that includes this type of questionnaire is needed to further

validate that practitioners do experience change in the self, and in turn, experience

vicarious trauma over time.

   I plan to disseminate study findings primarily in two ways. First, a summary of

findings will be disseminated to the participants of the study as promised. Second, this

project will be reworked to submit for publication in a journal appropriate for the subject

matter addressed in the study. The information can be disseminated to program directors

and administrators of agencies and organizations in Canada with a request that they

include this work in their monthly newsletter. I will also pursue opportunities to present

this study at conferences, such as the annual EMDR conference and the Nova Scotia College of Social Workers Annual Conference.

Implications for Social Change

The major implication for social change will be at the micro level. Because so many persons in Canada and across the world will experience trauma in their lives, there will continue to be a need for professionals to address needs of clients that are trauma-related events. Social work professionals, especially those who practice with trauma-affected clients the majority of the time in the workplace, must be knowledgeable about how practicing with trauma-affected clients may result in vicarious trauma as a function of change in their "self" over time. As professionals experience changes in the self that reflect vicarious trauma, it will continue to be important for them to engage in self-care in order to meet the needs of the many persons in Canada who will experience serious trauma events.

Summary

Who will help the helpers when they need help, especially those who may not know they need help? In conducting this study, I explored the possibility that helpers, particularly those in the social work profession, who practice with trauma-affected clients experience change in themselves that is different from PTSD. As the results of this study suggest, the experience of hearing about the trauma events of others as a means of earning a living over time may affect change in who a particular helper actually is for the worse, such as seeing the world as a frightening place, perceiving what is safe differently,

and losing the need for intimacy. In the same way that PTSD warrants attention, the vicarious trauma that "helpers" experience in practicing with trauma-affected persons over time warrants attention as well. This study was an attempt to find out how those helpers experience vicarious trauma in terms of change personally and professionally over time as a result of trauma work.

References

Afifi, T. O., MacMillian, H. L., Boyle, M., Taillieu, T., Cheung, K., & Sareen, J. (2014). Child abuse and mental disorders in Canada. *CMAJ, 186*(9), E324-E332. http://doi.org/10.1503/cmaj.131792

Barusch, A. (2015). Step-by-step approach to narrative analysis [Message]. Retrieved from http://amandabarusch.com/tools-for-narrative-research/step-by-step-approach-to-narrative-analysis/

Boyas, J. F., Wind, L. H, & Ruiz, E. (2013). Organizational tenure among child welfare workers, burnout, stress, and intent to leave: Does employment-based social capital make a difference? *Children and Youth Services Review, 10*, 1657-1669. http://doi.org/10.1016/j.childyouth.2013.07.008

Bride, B.E. (2007). Prevalence of secondary traumatic stress among social workers. *Social Work, 52*(1), 63-70. http://doi.org/10.1093/sw/52.1.63

Canadian Association of Social Workers. (2005). *Code of ethics.* Ottawa, ON: Author.

Cieslak, R., Shoji, K., Douglas, A., Melville, E., Luszczynska, A., & Benight, C. C. (2013). A meta-analysis of the relationships between job burnout and secondary traumatic stress among workers with indirect exposure to trauma. *Psychological Services, 11*(1), 75-86. http://doi.org/10.1037/a0033798

Clance, P. R., & Imes, S. A. (1978). The imposter phenomenon in high achieving women: Dynamics and therapeutic intervention. *Psychotherapy: Theory, Research & Practice, 15*(3), 241-247. http://doi.org/10.1037/h0086006

Cohen, K. & Collens, P. (2013). The impact of trauma work on trauma workers: A

metasynthesis on vicarious trauma and vicarious posttraumatic growth.

Psychological Trauma: Theory, Research, Practice, and Policy, 5(6), 570-580.

http://doi.org/10.1037/a0030388

Cope, D. G. (2014). Methods and meanings: Credibility and trustworthiness of qualitative

research. *Oncology Nursing Forum, 41*(1), 89-91.

http://doi.org/10.1188/14.ONF.89-91

Craig, C. D., & Sprang, G. (2010). Compassion satisfaction, compassion fatigue, and

burnout in a national sample of trauma treatment therapists. *Anxiety, Stress &

Coping, 23*(3), 319-339. http://doi.org/10.1080/10615800903085818

D'Andrea, M. (2000). Postmodernism, constructivism, and multiculturalism: Three

forces reshaping and expanding our thoughts about counseling. *Journal of Mental

Health Counseling, 22*(1).

Dombo, E. A. & Gray, C. (2013). Engaging spirituality in addressing vicarious trauma in

clinical social workers: A self-care model. *Social Work and Christianity, 40*(1),

89-104. https://psycnet.apa.org/record/2013-05122-005

EMDR Canada. (2018). *Find a therapist.* Montreal, Canada: Author.

Figley, C. R. (1995). Compassion fatigue: Toward a new understanding of the costs of

caring. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for

clinicians, researchers, and educators* (pp. 3-28). Baltimore, MD: Sidran Press.

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

 S. N. Gold (Ed.), *APA handbook of trauma psychology: Foundations in*

 knowledge (pp 573-593). Washington DC: American Psychological Association.

 http://doi.org/10.1037/0000019-029

Finklestein, M., Stein, E., Greene, T., Bronstein, I., & Solomon, Z. (2015). Posttraumatic

 stress disorder and vicarious trauma in mental health professionals. *Health &*

 Social Work, 40(2), 25-31. http://doi.org/10.1093/hsw/hlv026

Helm, H. (2016, January 4). *Managing vicarious trauma and compassion fatigue.*

 Message posted at

 www.researchgate.net/publication/265361070_Managing_Vicarious_Trauma_and

 _Compassion_Fatigue.

Hernandez, P., Engstrom, D., & Gangsei, D. (2010). Exploring the impact of trauma on

 therapists: Vicarious resilience and related concepts in training. *Journal of*

 Systemic Therapies, 29(1), 67-83. . http://doi: 10.1521/jsyt.2010.29.1.67

Jefferies, F.W. & Davis, P. (2013). What is the role of eye movements in eye movement

 desensitization and reprocessing (EMDR) for post-traumatic stress disorder

 (PTSD)? A review. *Behavioural and Cognitive Psychotherapy, 41*, 290-300. .

 http://doi.org/10.1017/S1352465812000793

Jordan, K. (2010). Vicarious trauma: Proposed factors that impact clinicians. *Journal of*

 Family Psychotherapy, 21, 225-237. doi:10.1080/08975353.2010.529003

Kim, H., Ji, J., & Kao, D. (2011). Burnout and physical health among social workers: A

three-year longitudinal study. *Social Work, 56*(3), 258-268. .

http://doi.org/10.1093/sw/56.3.258

Michalopoulos, L.M. & Aparicio, E. (2012). Vicarious trauma in social workers: The role of trauma history, social support, and years of experience. *Journal of Aggression, Maltreatment & Trauma, 21*(6). 646-664. .

http://doi.org/10.1080/10926771.2012.689422

National Association of Social Workers [NASW]. (2018). *Code of ethics.* Washington, DC: National Association of Social Workers

Newell, J.M. & MacNeil, G.A. (2010). Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue: A review of the theoretical terms, risk factors, and preventive methods for clinicians and researchers. *Best Practices in Mental Health: An International Journal, 6*(2), 57-68.

Perrin, M., Vandeleur, C.L., Castelao, E., Rothen, S., Glaus, J., Vollenweider, P., & Preisig, M. (2014). Determinants of the development of post-traumatic stress disorder, in the general population. *Social Psychiatry and Psychiatric Epidemiology, 49*, 447-457. http://doi10.1007/s00127-013-0762-3

Ravitch, S. M., & Carl, N. M. (2016). *Qualitative research: Bridging the conceptual, theoretical, and methodological*. Thousand Oaks, CA: Sage Publications.

Saakvitne, K.W., & Pearlman, L.A. (1996). *Transforming the pain*. New York: W.W. Norton.

Saakvitne, K., Tennen, H., & Affleck, G. (1998). Exploring thriving in the

context of clinical trauma theory: Constructivist self-development theory. *Journal of Social Issues, 54*(2), 279-299. http://doi.org/10.1111/j.1540-4560.1998.tb01219.x

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information, 22*(2), 63–75.

Sherman, R.O. (2013). Imposter syndrome: When you feel like you're faking it. *American Nurse Today, 8*(5), 57-58.

Van Ameringen, M., Mancini, C., Patterson, B., & Boyle, M.H. (2008). Post-traumatic stress disorder in Canada. *CNS Neuroscience & Therapeutics, 14*(3), 171-181. . http://doi:10.1111/j.1755-5949.2008.00049.x

Van den Hout, M.A. & Engelhard, I.M. (2012). How does EMDR work? *Journal of Experimental Psychopathology, 3*(5), 724-738. doi:10.5127/jep.028212

Wagaman, M.A., Geiger, J.M., Shockley, C., & Segal, E.A. (2015). The role of empathy in burnout, compassion satisfaction, and secondary traumatic stress among social workers. *Social Work, 60*(3), 201-209. http://doi.org/10.1093/sw/swv014

Watts, B.V., Schnurr, P.P., Mayo, L., Young-Xu, Y., Weeks, W.B., & Friedman, M.J. (2013). Meta-analysis of the efficacy of treatments for posttraumatic stress disorder. *Journal of Clinical Psychiatry, 74*(6), 541-550.

Webb, C.M. & Carpenter, J. (2012). What can be done to promote the retention of social workers? A systematic review of interventions. *British Journal of Social Work, 42*, 1235-1255. http://doi.org/10.1093/bjsw/bcr144

Williams, A.M., Helm, H.M., and Clemens, E.V. (2012). The effect of childhood trauma, personal wellness, supervisory working alliance, and organizational factors on vicarious trauamatization. *Journal of Mental Health Counseling, 34*(2), 133-153. http://doi.org/10.17744/mehc.34.2.j3l62k872325h583

Appendix A: Semistructured Interview

Participant Question 1. In what ways, if at all, has your frame of reference or view of the world changed as a result of practicing with trauma affected clients?

Participant Question 2. How has your capacity for empathy changed, if at all, since you first began practicing with trauma affected clients?

Participant Question 3. How has your ability to maintain boundaries that separate you from your clients changed, i.e. how often do you think about the events of clients in your personal life?

Participant Question 4. In what ways has practicing with trauma affected clients influenced your psychological needs, i.e. safety, trust, control, and/or intimacy?

Participant Question 5. In what ways has practice with trauma affected clients affected your ability to discuss their traumatic events either with or without emotion?

Appendix B: Recruitment Process

The recruitment process will begin as soon as IRB approval is given. This

researcher will begin to reach out to masters level clinical EMDR social workers, living

in Eastern Canada, and listed on the Psychology Today website and the EMDR Canada

website. The provinces of Ontario, Quebec, New Brunswick, Prince Edward Island,

Newfoundland, and Nova Scotia will be searched for EMDR social workers. These social

workers will be asked to take part in this research study, and if they are willing, to

provide the names and contact information of any other clinical EMDR social workers

they know who this researcher can contact to request participation.

Initial Sample E-Mail

"Dear (social worker's name),

I am currently in the process of completing my research capstone project for the

Doctorate in Social Work program (Clinical Expertise) with Walden University. I want to

recruit EMDR social workers who are practicing this modality with trauma affected

clients to participate in a short, recorded interview for the purpose of gathering

information about your experiences with vicarious trauma. It would be very beneficial to

me in conducting the study if you are willing to be a participant.

If you are willing to participate, I will schedule an appointment to meet with you

in a comfortable and confidential place, free of interruption (ie: your private work office,

my private work office). I am willing to travel to a location of your choice. Thank you

again for your consideration."

Acceptance or Declination Email

Dear (social worker's name),

"Thank you so much for agreeing to participate in my study. Please let me know where and when you would like to meet for the interview. I will do my best to accommodate your schedule. Please answer the following demographic questions to confirm your eligibility for the study:

- You are a Masters Level (minimum) Social Worker

- You have your Level 1 (minimum) EMDR training

- You practice EMDR with trauma affected clients <u>at least</u> 40% of the time (i.e., 40% trauma, 60%); nontrauma (i.e,, marital issues)"

<div align="center">Or</div>

"Thank you so much for your time in reading my invitation to participate, and I understand you are declining to participate at this time.

Appendix C: Introduction to the Interview Script

"Good [morning, afternoon, evening], I am Ashley, and thank you for consenting to participate in this research study to explore how EMDR social workers experience vicarious trauma. I will ask you five questions related to your experiences working with clients who have presented with trauma effects, but I may also ask you to elaborate on your initial response. We will have an hour to complete this recorded interview, but we might finish before that time, or if you need more time, we can go beyond the hour.

Please know that you are welcome to ask to take a break at any time or discontinue the interview process entirely. When we are finished, I will ask you if participating in the study has upset you in any way. If so, I will help you to find any type of support service you need. Options for supportive counselling following this interview will be made available should you feel the need to engage post-interview. Before we begin the recorded interview, do you have any questions?"

Appendix D: Demographic Questionnaire

1. What is your age? _____

2. What your highest educational degree? _____

3. How long have you practiced as a clinical social worker? _____

4. In what year did you complete EMDR level 1? _____

5. List your EMDR level 2 participation.

   _____

6. What is the percentage of work you do with trauma affected clients, opposed to non-

   trauma material? (eg; 60% trauma, 40% non-trauma ie: marital issues)?

   _____/_____

7. How many hours do you practice with trauma affected clients on average each week?

   _____

8. What is the approximate number of supervisory hours completed each year as an

   EMDR social worker? _____

9. Have you ever considered yourself to have a personal history of trauma (single event

   or ongoing trauma), PTSD? Yes/No

   a. Have you ever been diagnosed with PTSD? Yes/No