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Elizabeth Reinecke
The Exploration of
Therapists' Personal
Experiences With Secondary
Trauma and Their Personal
Mindfulness Practice

ABSTRACT

This qualitative study investigated the use of mindfulness by therapists treating trauma victims. The purpose of this study was to better understand ways in which a mindfulness practice, such as yoga and/or meditation, can affect the experience of secondary trauma in trauma therapists working with clients who are diagnosed with Post Traumatic Stress Disorder (PTSD). Six female trauma therapists working with the VA system in Colorado were interviewed. Each participant was asked to reflect upon their experiences with secondary trauma and how their mindfulness practice has impacted both their personal and professional lives. Participants were all at least Master level clinicians from a range of professional backgrounds, working with clients who are diagnosed with PTSD. Participants identified both rewards and challenges of working as a trauma therapist and were asked how they manage and/or address the impact of their work. In addition, they were asked to discuss specifically how their mindfulness practice impacts their work as a trauma therapist.

While each participant defined their own personal mindfulness practice, all six participants stated that their mindfulness practice has impacted their ability to manage and/or address the effects of working with trauma survivors. The findings of this study are relevant to clinicians and practitioners who are concerned about preventing and/or managing the effects of secondary trauma.

THE EXPLORATION OF THERAPISTS'
PERSONAL EXPERIENCES WITH SECONDARY TRAUMA AND THEIR
PERSONAL MINDFULNESS PRACTICE

A project based upon an independent investigation,
submitted in partial fulfillment of requirements for
the degree of Master of Social Work.

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2010

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CHAPTER I

INTRODUCTION

While the field of mental health can be very rewarding, it can also be very challenging. Recently, there has been a great deal of literature on the risks of working with those who have experienced on-going trauma (Basham & Miehl, 2004; Figley, 1995; Maltz, 1992; Murphy, 1995; Pearlman & Saakvitne, 1995; Tyson, 2007; Yassen, 1995) as well as ways to manage these effects (Catherall, 1995; Cerney, 1995; Cunningham, 2004; Harrison & Westwood, 2009; Hick, 2008; Pearlman & Saakvitne, 1995; Salston & Figley, 2003; Tyson, 2007; Williams, 2008; Yassen, 1995). The purpose of this study is to explore the ways in which a mindfulness practice, such as yoga and/or meditation, can affect the experience of secondary trauma in trauma therapists working with clients who are diagnosed with PTSD.

Hesse (2002) discusses the ethical dilemmas of mental health professionals who do not address and/or manage the effects of secondary trauma while continuing to treat those who have experienced trauma. She argues that this may lead to psychological harm or possibly the retraumatization of our client(s) if these reactions enter into the therapeutic relationship (Hesse, 2002). In addition to this, Tyson (2007) highlights that mental health professionals may be more at risk of experiencing these effects while working with combat-related trauma due to the collective shared trauma of 9/11 and the ongoing wars in Afghanistan and Iraq. With that said, both trauma therapists and their clients may benefit from this research. Therapists may gain knowledge of ways in which

to manage and/or address secondary trauma, and their clients may benefit from their therapists' ability to remain present and contained in therapy.

The interest in this topic arose from the lack of literature on this very subject. The concepts of mindfulness practice and secondary trauma are relevant to the field of social work both separately and in relation to each other, especially when considering the fact that secondary trauma can greatly impact therapists' personal and professional well-being (Yassen, 1995). Considering that our country is currently in war, mental health professionals need to continue to examine the effects of working with trauma as well as ways to manage and/or address these effects in order to better serve our clients. Because of this, this research will focus on the specific population of mental health professionals working in the Veteran's Affairs setting who practice mindfulness as a way to manage and/or address the effects of working with those who have experienced on-going trauma. The research will explore their personal experiences with secondary trauma and what their mindfulness practice means to them both personally and professionally.

CHAPTER II

LITERATURE REVIEW

Introduction

When helpers lose their faith and fervor, despair paralyzes the world-

Pearlman & Saakvitne (1995, p.159)

The purpose of this study is to explore the ways in which a mindfulness practice, such as yoga and/or meditation, can affect the experience of secondary trauma in trauma therapists working with clients who are diagnosed with PTSD. In order to create a context for this study, literature on the following topics will be reviewed: (1) defining secondary trauma (2) the effects of secondary trauma on mental health professionals (3) ways in which to manage the effects of secondary trauma, and (4) the usefulness of yoga and meditation as a form of mindfulness practice.

Defining Secondary Trauma

While this study will use the term secondary trauma to describe the “insidious impact on therapists that work with traumatized individuals” (Basham & Miehl, 2004, p. 236) and the “natural consequence of caring between two people, one of whom has been initially traumatized and the other of whom is affected by the first’s traumatic experiences” (Figley, 1995, p.11), there are several different terms that are used to describe this phenomenon throughout our literature. The terms that are used and will be

reviewed throughout this research are “secondary trauma” and/or “secondary traumatic stress” (ST and/or STS) “compassion fatigue” (CF), “vicarious traumatization” (VT) and “burnout”, as well as “countertransference” as it relates to this phenomenon. While researchers have attempted to differentiate these terms and general psychological distress conceptually, these terms still remain vague (Boscarino, Figley & Adams, 2004).

While some researchers suggest that there are differences between the terms “compassion fatigue”, “vicarious traumatization”, “secondary traumatic stress” and “burnout” (Najjar, Davis, & Doebbeling, 2009), at times our literature may use these terms interchangeable. For instance, Jenkins and Baird (2002) stated: “Vicarious trauma (VT) and secondary traumatic stress (STS) or compassion fatigue both describe effects of working with traumatized persons on therapists” (Jenkins & Baird, 2002, p.423). In their review of Figley (1995a), Pearlman (1995), Sexton (1999) and Stamm (1995), Jenkins and Baird (2002) state:

Secondary traumatic stress (STS; also called “compassion fatigue”) and vicarious traumatization are conceptualized as reactions to the emotional demands on therapists and social network members from exposure to trauma survivors’ terrifying, horrifying, and shocking images; strong, chaotic affect; and intrusive traumatic memories (p.423).

Figley (1995) speaks to why some may be uncomfortable using the terms “secondary trauma” and/or “vicarious trauma”, favoring terms like “compassion stress” and “compassion fatigue” instead. He states, “...such discomfort might arise from a concern that such labels are derogatory. Feeling the stress, and even the fatigue, of compassion in the line of duty as a nurse or therapist better describes the causes of manifestations of their duty-related experiences” (Figley, 1995, p. 15). Tyson (2007) also highlights that Figley (1995) suggests, “compassion fatigue conveys the impact of empathic immersion

in another human being's suffering, without pathologizing the clinician" (p.184). The discrepancy in the use of these terms highlights the stigmatization around experiencing this phenomenon and underscores the lack of cohesion and the nuance in meaning of the various terms.

To understand these terms by what they are not, we must first differentiate these terms from a more commonly known psychological effect of working with traumatized clients known as countertransference. Basham and Miehl (2004) argue, "Vicarious traumatization is different from, but interrelated with, countertransference responses" (p.237). In Basham and Miehl's (2004) review of Pearlman and Saakvitne (1995) they state:

Pearlman and Saakvitne make the distinction between the two concepts. They say that while countertransference is present in all therapies, the shape that it takes is specific to the particular client-therapist dyad. On the other hand, the effects of vicarious traumatization "are felt beyond a particular therapy relationship... and are permanently transformative... Vicarious traumatization represents changes in the most intimate psychological workings of the self of the therapist" (p.33) (p.237).

While countertransference is the therapist's response or feelings towards the client or the material that is being presented in session, Figley (1995) defines vicarious traumatization as "a *transformation* in the therapist's (or other trauma worker's) inner experience resulting from empathetic engagement with client's trauma material" (p.12). Pearlman and Saakvitne (1995) also state:

By definition, the effects of vicarious traumatization on an individual resemble those of traumatic experiences. They include significant disruptions in one's sense of meaning, connection, identity, and world view, as well as in one's affect tolerance, psychological needs, beliefs about self and others, interpersonal relationships, and sensory memory, including imagery (p. 151).

Similar to this, Figley's comparison between the diagnostic criteria for primary and secondary traumatic stress disorder points out that there are very few differences in symptoms. His comparison illustrates that while many of the criteria are identical, the main difference is that those who have experienced primary trauma have effects/symptoms (i.e., recollections, dreams re-experiencing, hypervigilance) related to the trauma they, *themselves* have experienced, while those who suffer from secondary trauma will experience these effects related to another person's trauma (i.e., client or loved one) as a result of learning about this traumatic event (Figley, 1995).

Despite the research that may argue the differences between compassion fatigue, secondary trauma, and vicarious traumatization, Arvay (2001) suggests that vicarious trauma and secondary trauma stress are the same phenomenon (Harrison & Westwood, 2009). In addition to this, similar to the definitions of vicarious traumatization and secondary trauma (Figley 1995), compassion fatigue also highlights that the mental health provider experiencing this phenomenon takes on the symptoms of their clients (Figley, 1995; Tyson, 2007).

Clinicians affected by compassion fatigue can experience a syndrome of symptoms which many parallel their client's diagnosis of post traumatic stress disorder (PTSD) (e.g. reexperiencing, avoidance, psychic numbing and hyperarousal), as defined by the Diagnostic Statistical Manual of Mental Disorders (DSM-IV) (APA, 1994) (Tyson, 2007, p.184).

However, much like the description of vicarious traumatization (Figley 1995), Tyson (2007) states, "compassion fatigue can also transcend the mirroring of their client's PTSD symptoms and express itself in alterations in a clinician's self-identity, cognitive schemas, interpersonal relationships, physical health, job morale, world view, and spirituality" (p.184). While the majority of research being reviewed for this study

suggests that the major difference between the terms secondary trauma and compassion fatigue is that secondary trauma “focuses primarily on the symptoms, while vicarious-traumatization approach focuses on the individual as a whole ” (Pearlman & Saakvitne, 1995, p.151), Munroe, Shay, Fisher, Makary, Rapperport, and Zimering (1995) state:

In clinical work, secondary trauma involves a violation of the therapist’s sense of basic trust, where the therapist’s assumptions are undermined or shattered. As assumptions are undermined, the behavior of the therapist is likely to be altered as well. Secondary trauma occurs not only by being exposed to the clients’ trauma material (McCann & Pearlman, 1990), but also by being engaged to participate in reenactments of the themes and relationships inherent in the client’s trauma. Like direct trauma, then, secondary trauma violates trust, severs connections to community, and destroys meaning (p. 213).

Contrary to the belief that secondary trauma can violate trust, sever connection to community and destroy meaning (Munroe, et al., 1995), Pearlman and Saakvitne (1995) state that:

Vicarious traumatization differs from STS in focus and context. The latter term is based on a diagnostic conceptualization of post-traumatic stress disorder (PTSD). Consistent with the version of PTSD given in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), such a conceptualization focuses on observable symptoms, and while acknowledging context and etiology, gives them less attention. In contrast, the vicarious traumatization concept presumes a particular development and constructivist model of personality, one in which meaning and relationship are integral parts of the human experience. These two conceptualizations are not orthogonal to one another; the STS approach focuses primarily on the symptoms, while the vicarious-traumatization approach focuses on the individual as a whole, placing observable symptoms in the larger context of human adaptation and quest for meaning (pg. 151).

Focusing on the observable symptoms, Randal D. Beaton and Shirley A Murphy (1995) argue, “all crisis workers are at risk of experiencing secondary traumatic stress” (p. 51). Figley might argue that this is because “those who have enormous capacity for feeling and expressing empathy tend to be more at risk of compassion stress” (Figley, 1995, p.1). According to Tyson’s (2007) article, *Compassion Fatigue in the Treatment of Combat-*

related Trauma during Wartime, the majority of literature in recent years on this phenomenon has found that “compassion fatigue (Figley, 1995; Figley 2002), secondary traumatic stress disorder (Stamm, 1999) and vicarious traumatization (McCann & Pearlman, 1990; Pearlman & MacIain, 1995; Pearlman & Saakvitne, 1995) are related constructs that have also extensively elucidated the occupational hazards of trauma work (Jenkins & Baird, 2002)” (Tyson, 2007, p. 184).

Burnout is another phenomenon that many people could argue crisis workers are at risk of experiencing. Figley (1995) quotes Pines and Aronson (1988) stating, “burnout is a state of physical, emotional and mental exhaustion caused by long term involvement in emotionally demanding situations” (p.9). To compare burnout to compassion fatigue, secondary trauma, and vicarious trauma:

Burnout emerges gradually and is a result of emotional exhaustion, while STS (compassion stress) can emerge suddenly with little warning. In addition to a more rapid onset of symptoms, with STS, in contrast to burnout, there is a sense of helplessness and confusion, and a sense of isolation from supporters; the symptoms are often disconnected from real causes, and yet there is a faster recovery rate (Figley, 1995, p. 12).

It is also important to note that secondary trauma is *not* shared trauma. Tyson (2007) states, “The construct of ‘shared trauma’ encompasses the symptoms described in compassion fatigue, secondary traumatic stress disorder and vicarious traumatization, but also speaks to the effects of primary traumatization of the therapist from the experience of collective shared trauma” (p.195). Unlike secondary trauma, one who experiences shared trauma has symptoms related to trauma they have experienced first hand.

While this study will not limit participant's description(s) on how they have been affected by working with traumatized individuals, the researcher will be working off of Figley's (1995) definition of secondary trauma:

The natural consequent behaviors and emotions resulting from knowledge about traumatizing event experienced by a significant other or from helping or wanting to help a traumatized person. In addition to this working theoretical definition, STS has three operational components: (1) having witnessed or been confronted by actual or threatened death or injury, or by a threat to the physical integrity of oneself or others; (2) provocation by the stressor of responses of fear, horror, and helplessness; and (3) direct or indirect exposure to an exceptional mental or physical stressor, either brief or prolonged (p. 53).

At the same time, this researcher acknowledges that there are several terms and ways to describe this phenomenon other than the term "secondary trauma" that participants may readily identify. In that case, this research will focus on the symptoms and observable effects participants have experienced from working with traumatized individuals.

The Effects of Secondary Trauma on Mental Health Professionals

Since secondary trauma can be seen as a cost of caring (Figley, 1995), it is important to note that there is a price to pay if we do not face the issues of secondary trauma in the mental health profession. Beaton and Murphy (1995) state:

The costs of not attending to the problems of STS in crisis workers include short-term and long-term emotional and physical disorders, strains on interpersonal relationships, substance abuse, burnout, and shortened careers (p. 53).

While the literature on the effects of working with traumatized clients is lacking conceptual clarity, the healthcare field continues to become more aware of these effects. Maltz (1992) focuses on how this phenomenon can affect a therapist in their personal life, stating: "it can have an impact on the therapist's own sexual relationship" (Basham &

Miehls, 2004, p.238). Pearlman and Saakvitne (1995) go into detail about how it can impact not only the mental health provider but also the client(s) and the “organizations and the society that provide the context for their work together” (p. 157).

The profound personal costs to the therapist can include depression, despair, and cynicism; alienation from friends, colleagues, and family; professional impairment, often resulting in premature job changes; and a host of psychological physical symptoms similar to those experienced by untreated trauma survivors (Pearlman & Saakvitne, 1995, p. 157).

English (1976) in Cerney (1995) states:

The therapist must be fully conscious of the needs of his or her patient, and fully aware of the tactics he uses in an attempt to repair himself. If he is not, the therapist may find he has taken over the pathology of his patient within himself to such an extent that the therapists himself feel ‘sick’ (p. 137).

More specifically than this, Janet Yassen (1995) charts the impact of secondary trauma on professional functioning. She categorizes the impact on one’s professional functioning into four subgroups: Performance of Job Tasks, Morale, Interpersonal, and Behavioral:

<u>Performance of Job Tasks:</u>	<u>Morale:</u>	<u>Interpersonal:</u>	<u>Behavioral:</u>
<ul style="list-style-type: none"> ▪ Decrease in quality ▪ Decrease in quantity ▪ Low motivation ▪ Avoidance of job tasks ▪ Increase in mistakes ▪ Setting perfectionist standards ▪ Obsession about details 	<ul style="list-style-type: none"> ▪ Decrease in confidence ▪ Loss of interest ▪ Dissatisfaction ▪ Negative attitude ▪ Apathy ▪ Demoralization ▪ Lack of appreciation ▪ Detachment ▪ Feelings of incompleteness 	<ul style="list-style-type: none"> ▪ Withdrawal from colleagues ▪ Impatience ▪ Decrease in quality of relationship ▪ Poor communication ▪ Subsume own needs ▪ Staff conflicts 	<ul style="list-style-type: none"> ▪ Absenteeism ▪ Exhaustion ▪ Faulty judgment ▪ Irritability ▪ Tardiness ▪ Irresponsibility ▪ Overwork ▪ Frequent job changes

(Yassen, 1995, pg. 191)

In addition, Yassen (1995) also charts the personal impact of secondary trauma on mental health professionals. She does this using six subgroups: Cognitive, Emotional, Behavioral, Spiritual, Interpersonal, and Physical.

<p><u>Cognitive:</u></p> <ul style="list-style-type: none"> ▪ Diminished concentration ▪ Confusion ▪ Spaciness ▪ Loss of meaning ▪ Decreased self-esteem ▪ Preoccupation with trauma ▪ Trauma imagery ▪ Apathy ▪ Rigidity ▪ Disorientation ▪ Whirling thoughts ▪ Thoughts of self-harm or harm towards others ▪ Self-doubt ▪ Perfectionism ▪ Minimization 	<p><u>Emotional:</u></p> <ul style="list-style-type: none"> ▪ Powerlessness ▪ Anxiety ▪ Guilt ▪ Anger/rage ▪ Survivor guilt ▪ Shutdown ▪ Numbness ▪ Fear ▪ Helplessness ▪ Sadness ▪ Depression ▪ Hypersensitivity ▪ Emotional roller coaster ▪ Overwhelmed ▪ Depleted 	<p><u>Behavioral:</u></p> <ul style="list-style-type: none"> ▪ Clingy ▪ Impatient ▪ Irritable ▪ Withdrawn ▪ Moody ▪ Regression ▪ Sleep ▪ Disturbances ▪ Appetite changes ▪ Nightmares ▪ Hypervigilance ▪ Elevated startle response ▪ Use of negative coping (smoking; alcohol or other substance misuse) ▪ Accident proneness ▪ Losing things ▪ Self-harm behaviors
<p><u>Spiritual:</u></p> <ul style="list-style-type: none"> ▪ Questioning the meaning of life ▪ Loss of purpose ▪ Lack of self-satisfaction ▪ Pervasive hopelessness ▪ Ennui ▪ Anger at God ▪ Questioning of prior religious beliefs 	<p><u>Interpersonal:</u></p> <ul style="list-style-type: none"> ▪ Withdrawn ▪ Decreased interest in intimacy or sex ▪ Mistrust ▪ Isolation from friends ▪ Impact on parenting (protectiveness, concern about aggression) ▪ Projection of anger or blame ▪ Intolerance ▪ Loneliness 	<p><u>Physical:</u></p> <ul style="list-style-type: none"> ▪ Shock ▪ Sweating ▪ Rapid heartbeat ▪ Breathing difficulties ▪ Somatic reactions ▪ Aches and pains ▪ Dizziness ▪ Impaired immune system

(Yassen, 1995, p. 184)

In Tyson's (2007) article, *Compassion Fatigue in the Treatment of Combat-Related Trauma during Wartime*, she explains that there are many clinical challenges facing therapists working with combat-related trauma due to both 9/11 and the ongoing wars in Afghanistan and Iraq. Tyson argues that it is an "ethical imperative that the complex challenges facing clinicians treating combat trauma are addressed, not only on an individual and supervisory level, but on an educational, organizational, and societal

level as well” (p.190). In addition to this, Pearlman & Saakvitne (1995) discuss how this phenomenon can also affect supervisors and their supervisees both directly and indirectly.

Supervisors may be withdrawn and fail to take adequate interest in their supervisees’ development. They may fail to model adequate personal and professional self-care, and can be at risk of violating boundaries in supervisory as well as therapy relationships.... They may be cynical or excessively critical or judgmental, thus diminishing their colleagues’ professional esteem.... Finally, the social cost of vicarious traumatization is difficult to measure, but critical; it is reflected in the tragic transformation of hope to cynicism. As trauma therapists and researchers, we carry hope, the legacy of trauma becomes more ominous, leaving survivors alone with the grief and despair that follow traumatic loss. Overall, cynicism represents a loss to society of positive energy, optimism, and hope. When helpers lose their faith and fervor, despair paralyses the world (Pearlman & Saakvitne, 1995, p. 159).

Understanding the array of impacts of secondary trauma on mental health providers, it is imperative to explore ways in which to manage these effects of secondary trauma not only as a field, or an institutional level, but on a personal level as well.

Managing the Effects of Secondary Trauma

While the risks of working directly with traumatized individuals on a regular basis are well documented, “it is equally important to understand what protects and sustains clinicians in their work with traumatized populations” (Harrison & Westwood, 2009, p.204). To date, there is also very little literature on the success and satisfaction of clinicians who are able to manage the demands of their work with traumatized clients (Harrison & Westwood, 2009). However, according to the existing literature, we can categorize interventions for this phenomenon into three categories: personal, professional, and organizational. Still, it is important to note that these interventions

“must be tailored to the needs and preferences of the particular therapist” (Pearlman & Saakvitne, 1995, p. 165).

Yassen (1995), Cerney (1995) and Cunningham (2004) all speak to the category of personal interventions. Yassen (1995) in Basham & Miehl (2004) state, “...psychical activities, such as yoga, dance, drumming and gardening, can be useful tools in maintaining a physically balanced perspective” (p.240), while Cerney (1995) suggests “...therapists should limit their practice and take time to refresh themselves in their private lives through leisure and relaxation” (p. 145). Lastly, Cunningham (2004) argues that self-care is indeed one way a trauma therapist can manage and/or prevent experiencing secondary trauma. And while it is important to explore what form of self-care is most helpful to the individual, it is the commitment to self-care that is most important (Cunningham, 2004).

Speaking to the personal and professional interventions, Williams (2008) focuses on the “transitory states of awareness such that we may become more or less attuned to our internal states at various times” (p.140), which she describes as self-awareness. Using this framework, Williams (2008) examined naturally occurring states of therapist self-awareness and their use of strategies to manage distracting awareness. She argues that there is a good deal of contradictory information in the empirical studies on this issue, which leaves us with “a complex and contradictory state of affairs in the research on therapist self-awareness, with a great deal of room for future research” (p. 142). In addition, she suggests that studying the relationship of therapist self-focused attention and mindfulness would be very helpful (Williams, 2008).

Salston and Figley (2003) discuss implications for treatment and prevention with the belief that “there needs to be a balance between home, work, self, and others. There needs to be a balance between the physical self, the emotional self, and the spiritual self in order to continually work with those who are struggling through the impact of the traumatic experience” (p.171-172). Some of the ways to manage the effects of secondary trauma that Salston and Figley (2003) list are “journaling any dreams, process the intrusions and integrate the memories, progressive relaxation, imagery, physical activity, appropriate diet, drawing upon spiritual strengths, and seek involvement in an activity of interest, that brings pleasure” (p.172).

Considering the increase in demand for trauma related mental health services due to our current war (Tyson, 2007), it is critical that interventions on a macro level are examined as well. Catherall (1995) discusses the importance of these interventions on an organizational level in order to better protect those who are at risk of experiencing “secondary trauma”. He breaks this down into five steps: (1) projection of exposure, (2) development of plans, (3) psychoeducation of staff, (4) implementation of preparedness structure, and (5) evaluation of the program.

Catherall (1995) explains that the first step of “projection of exposure” is “for the policy makers and administrators to assess the likelihood of exposure to STS and identify the likely avenues of exposure” (p.241). He argues that while the second step, “development of plans” is the responsibility of the policy makers and administrators, they must value and utilize the input of the trauma workers and supervisors for this to be successful. Catherall (1995) also speaks to the importance of feedback and response in step three, “psychoeducation of staff”. He states, “They need to be educated about the

prevention process and the responsibilities of institutional staff. But most important, they need to be educated about the nature of traumatic stress and secondary traumatization” (p.242). For steps four and five, Catherall (1995) stresses that the prepared material should be distributed to all staff and lastly, “the development of an institutional program for handling traumatic stress is incomplete without a mechanism for evaluating the program’s effectiveness” (p.243).

While it is important for research to continue to examine the effects of working with traumatized clients and implications for prevention on a personal, professional, and organizational level, this study will only be examining how mental health professionals manage these effects on a personal level through their mindfulness practice. Bearing in mind that mindfulness can be defined in a number of ways, the researcher for this study will be focusing specifically on the participant’s yoga and/or meditation practice.

The Mindfulness Practice of Yoga and Meditation

Mindfulness changes our relationship to the moments when we are most upset and distressed. Instead of seeing those moments in a purely negative light, if we bring mindfulness to them we can see the possibilities for change they offer. (Bennett-Goleman, 2001, p.150)

Hick (2008) argues that mental health professionals, including psychotherapists, social workers, and psychiatrists are showing a growing interest in mindfulness, both as it relates to their work and their personal lives. Hick (2008) also explains that “defining mindfulness is a paradoxical undertaking” (p.3) and that it is best understood when personally experienced. He argues that mindfulness is a “preconceptual and presymbolic

notion” (p.3) that is an embodied state of being which makes it difficult to articulate accurately (Hick, 2008). Because of this, the participants for this study will be asked to answer questions based off what mindfulness means to them. However, there are numerous working definitions for mindfulness that are used throughout the literature.

One way mindfulness can be described is “focusing attention, being aware, intentionality, being nonjudgmental, acceptance, and compassion” (Hick, 2008, p.5).

Hick (2008) also states:

It is defined by some as having a spiritual quality and by others within a strictly scientific orientation. Still others combine the two, seeking scientific evidence for what are essentially traditional spiritual practices. Most see it as a way of living or being in the world, rather than a set of techniques—a path that is cultivated through experience rather than absorbed from a book (p. 4).

However, mindfulness can also be defined as a practice of living in the present moment; an “enhanced attention to and awareness of current experience of present reality” (Brown & Ryan, 2003, p.822) or “keeping one’s consciousness alive to the present reality” (Hahn, 1975, p.11). Mindfulness “teaches the practice of observing thoughts without getting entangled in them, approaching them as though they were leaves floating down a stream” (Hick, 2008, pp. 9-10).

Meditation is one practice of mindfulness. In Eugene Taylor’s (1997) introduction to *The Physical and Psychological Effects of Meditation* by Murphy and Donovan (1997), Taylor (1997) states that the term “meditation” comes from the term “Dhyana”:

Dhyana is the generic Sanskrit term for meditation, which is the *Yoga Sutras* refers to both the act of inward contemplation in the broadest sense and more technically to the intermediate state between mere attention to an object (*dharana*) and complete absorption in it (*Samadhi*) (p.1).

However, similar to Hick (2008), Taylor (1997) highlights the complexity in defining meditation:

As for modern developments, in trying to formulate a definition of meditation, a useful rule of thumb is to consider all meditative techniques to be culturally embedded. This means that any specific technique cannot be understood unless it is considered in the context of some particular spiritual tradition, situated in a specific historical time period, or codified in a specific text according to the philosophy of some particular individual (p.2).

Yassen (1995) further defines meditation and discusses how it can impact one's health:

Meditation can be healing to the body and the spirit. Flannery (1990), Borysenko (1988), Kabat-Zinn (1990), Benson (1976), and others document how meditation can affect the wellbeing of the body. Blood pressure is lowered, breathing becomes more regular and efficient, and muscles are more relaxed. Such practice does not change the reality of the external traumatic events, but it does minimize the wear and tear on the body, and assists in developing healthy coping strategies. The practice of meditation does not have to involve fancy techniques, following a certain guru, or many years of study. At its most basic level, it means paying attention to one's breathing and approaching life with an attitude of mindfulness (p. 187).

In terms of how meditation affects one's body and their functioning of their nervous system, Hanson (2009) states:

The limbic, HPPA, and sympathetic nervous systems react to each other in circular ways. For example, if something frightening occurs, your body will tend to become activated (e.g., increased heart rate, sweaty palms); those bodily changes will be interpreted by the limbic system as evidence of a threat, which will trigger more fear reactions in a vicious cycle. Through activating the parasympathetic nervous system (PNS), you prevent the stress-response system from reacting to its own reactions. This is one reason why the training for equanimity in contemplative settings involves considerable relaxation and tranquility (p. 113).

For the sake of this research, this explains how mindfulness meditation can help regulate mental health professionals' reactions to the narratives of their client(s) trauma.

Another form of mindfulness practice that will be discussed and explored throughout this study is yoga. Similar to meditation, yoga can be defined in a variety of ways and often can be defined similarly to mindfulness. Some fundamentals of Yogic philosophy and practice are stillness, non-activity of the mind and concentration, which are also fundamentals in the practice of meditation. Both yoga and meditation seek “mental modifications” of current reality (Crawford, 1989, p.16). Apart from the definition, many view yoga as the union of the body, breath, and mind (Ramaswami, 1989).

Woolery, Myers, Sternlieb, and Zeltzer (2004) discuss that while “yoga teachers and students often report that yoga has an uplifting effort on their moods” (p.60) there is limited research on yoga and depression. However, existing research suggests, “yogic techniques may help alleviate symptoms of depression. Other studies on non-depressed persons have found increased positive and decreased negative mood following yoga practices” (Woolery, Myers, Sternlieb & Zeltzer, 2004, p.60).

In Woolery, Myers, Sternlieb and Zeltzer’s (2004) randomized, case-controlled study that examined how the moods of the participants in a 10-session yoga course were affected found that “participants in the yoga group evidenced higher morning cortisol levels than the controls” (p.62). They explain, “although elevated cortisol responses to stress are associated with pathophysiological consequences, higher morning cortisol levels have been associated with self-esteem, hardiness, and tenacity, and lower levels of nervousness, depression, and emotional liability” (Woolery, Myers, Sternlieb, & Zeltzer, 2004, p.62).

Bower, Woolery, Sternlieb, and Garet (2005) examined the effects of yoga on cancer patients and survivors. They found:

Cancer patients and survivors yielded modest improvements in sleep quality, mood, stress, cancer-related distress, cancer-related symptoms, and overall quality of life. Studies conducted in other patient populations and healthy individuals have shown beneficial effects on psychological and somatic symptoms, as well as other aspects of physical function (Bower, Woolery, Sternlieb & Garet, 2005, p. 165).

Understanding that yoga and meditation are only two forms of mindfulness, and that this study encourages the participants to define their mindfulness practice in their own terms, I will conclude with Thich Nhat Hanh, a Vietnamese Zen monk, poet, and peacemaker's summary of the essence of mindfulness, quoted by Hick (2008):

Mindfulness is a part of living. When you are mindful, you are fully alive, you are fully present. You can get in touch with the wonders of life that can nourish you and heal you. And you are stronger, you are more solid in order to handle the suffering inside of you and around you. When you are mindful, you can recognize, embrace and handle the pain, the sorrow in you and around you...And if you continue with concentration and insight, you'll be able to transform the suffering inside and help transform the suffering around you (p.6).

As a mental health professional, one's job involves being able to be present, to be empathetic to client(s) suffering, and to nourish healing; but, as Figley (1995) points out, there is a cost to caring. This research will examine what these costs have been for each participant and will explore ways in which they have managed to be present in their own lives, and to nourish their own healing as they may have experienced suffering as a cost of caring.

CHAPTER III

METHODOLOGY

Formulation

This research will examine the ways in which a mindfulness practice, such as yoga and/or meditation, can affect the experience of secondary trauma in trauma therapists working with clients who are diagnosed with PTSD. Ultimately, the research focused on gathering data on therapists' beliefs about the impact of mindfulness practice and their experience with secondary trauma.

Data Collection

This thesis was a qualitative study that investigated the use of mindfulness practice by therapists treating trauma victims. The purpose of this study was to better understand the ways in which a mindfulness practice, such as yoga and/or meditation, can affect the experience of secondary trauma in trauma therapists working with clients who are diagnosed with PTSD. While there is significant research on the impact of secondary trauma on therapists, there is limited research that examines how a therapists' mindfulness practice can affect their experience with secondary trauma.

In order to explore this relationship, the researcher looked for participants who had both a mindfulness practice and a mental health practice. Each participant was pre-screened to ensure each participant met the criteria for the study. After each participant

provided a verbal agreement to participate in the study, they were then asked to review and sign the informed consent (Appendix C). After the each informed consent was signed and returned to the researcher, interviews were scheduled and conducted. All six interviews were audiotaped with the consent of each of the participants. This study was approved by the HSR at Smith College School for Social Work.

Each participant was interviewed using a semi-structured interview format. Each participant was asked a set of open-ended questions related to their work as a trauma therapist, their mindfulness practice, and their experiences with secondary trauma (Appendix B). Specifically, questions were asked regarding their ideas about their yoga and/or meditation practice, the presence of this mindfulness practice in their day-to-day life, their personal experiences with secondary trauma, and whether or not they feel there is a connection between their mindfulness practice and their ability to manage the effects of secondary trauma while working with clients who are diagnosed with PTSD.

The researcher created the interview questions based on a review of the literature and personal experience in the field. These questions were generated to best answer the research question and to explore how each participant has been personally impacted by secondary trauma and their mindfulness practice. The researcher conducted two pilot tests of the interview to ensure that each question was open-ended and were not leading.

Other topics related to one's mental health practice such as transference/countertransference and caseload were explored to examine whether or not these factors possibly influenced ones job satisfaction or experiences with secondary trauma. The researcher also collected demographic data from each participant in order to highlight similarities and differences within the sample, as these factors may also impact

one's experience with secondary trauma. An example of this may be the length of one's mental health practice or their mindfulness practice.

The data collected was analyzed using Interpretative Phenomenological Analysis (IPA) in order to capture the voices of my participants. IPA allowed my research to explore how participants themselves make sense of their experiences and the meaning behind those experiences. Ultimately, my research focused on gathering data on therapists' beliefs about the impact of their mindfulness practice and their experiences with secondary trauma.

Sample

The sample for this study was comprised of six mental health professionals. Each participant met the following inclusion criteria:

- a) All participants must be licensed therapists; working with clients diagnosed with PTSD.
- b) All participants must be currently working with at least five clients diagnosed with PTSD and have been treating them for at least six months.
- c) Participants must practice yoga and/or meditation at least twice weekly and have been practicing these forms of mindfulness for at least a year.
- d) Participants must be fluent in the English language.

The researcher for this study gathered this sample by utilizing the snowball sampling technique. The researcher first spoke to a mental health professional who was known to utilize mindfulness techniques to ground her clients prior to each session. This mental health professional agreed to participate in this study and referred the researcher to

several other mental health professionals that would qualify for this study. Using purposive sampling techniques, the sample was narrowed down to 6 trauma therapists who identify as female and work in the VA system in Colorado. Each participant has a caseload that consists of at least five clients with a diagnosis of Post Traumatic Stress Disorder (PTSD).

Deliberate efforts were made to recruit participants of color. Understanding that Interpretative Phenomenological Analysis (IPA) research focuses on a specific segment of a population, the researcher made an effort to only recruit female mental health professionals working in the VA system in order to create room for racial diversity in her sample. In other words, the researcher made efforts to secure a homogenous sample while still making room for the complexities within the narratives of a racially diverse sample.

Data Analysis

Narrative data from this study was analyzed utilizing Interpretative Phenomenological Analysis, identifying themes relevant to three different areas: 1) mental health practice 2) mindfulness practice and 3) the intersection of the two. Each interview was conducted, transcribed, and coded by the researcher to ensure confidentiality. In addition to this, each recorded interview was listened to several times to ensure accurate transcriptions.

The IPA approach does not rely on formal hypotheses, but instead examines the construct under investigation as it unfolds in the participant's narrative, from both a thematic and phenomenological point of view. Thus, while there was not a pre-ordained list of themes expected based on the interview questions, the researcher explored the

participants' perceptions of what is important in relation to the phenomenon of secondary trauma and their personal mindfulness practice. The researcher read through each transcription to identify themes that were relevant to each interview and to collect data on the phenomenology of the construct under investigation. This was first done by using colored pencils to categorize themes and then was organized electronically by cutting and pasting excerpts from each interview and compiling them by theme in a Microsoft Word document. In a second analysis of the transcripts, non-verbal communication, tone of voice and use of defenses, such as humor were noted and considered in relation to the themes identified. These data provide information from which to interpret the impact of mindfulness practice and secondary trauma from a clinical perspective.

CHAPTER IV

FINDINGS

This study examined the use of mindfulness practice by therapists treating trauma victims. The research sought to learn more about the ways in which a mindfulness practice, such as yoga and/or meditation, can affect the experience of secondary trauma in trauma therapists working with clients who are diagnosed with PTSD. Interviewees addressed issues such as the challenges of working with those who have experienced on-going trauma, as well as the ways their mindfulness practice has changed and/or influenced both their mental health practice and their personal lives. The participants were asked a series of questions about their work as trauma therapists, followed by a series of questions about their mindfulness practice. These questions explored the impact that both their mental health practice and their mindfulness practice has on their lives and if there is a relationship between the two.

The findings of this study are divided into four sections: 1) Participants' demographics, 2) Participants' mental health practice, 3) Participants' mindfulness practice, and 4) The intersection of participants' mental health practice and their mindfulness practice.

Participant Demographics

Demographic data collected on the six participants in the sample are included in Tables 1 and 2. While all participants identified as female and all work with clients

diagnosed with PTSD within a VA hospital setting, there was some variation in their race/ethnicity and how they identified their religious beliefs (Table 1). For example, half of the participants (N=3) expressed that they did not identify with a church, faith community or religion. Two participants identified as Christian, however one stated, “Christian...not religious per say”, and another participant identified as a member of the “Church of Jesus Christ of Modern Day Saints”. Each participant was asked several questions related to her trauma work and mindfulness experience, as well as other factors that may or may not have influenced her experiences with secondary trauma (Table 2). For instance, each participant was asked to identify how long she had been working as a trauma therapist as well as how long she had been practicing mindfulness. This data reflects additional variations in the sample in terms of their level of experience with trauma work, which ranged from 2 to 17 years, and their mindfulness experience, which ranged from 3 to 16 years.

While all participants (N=6) identified PTSD as one of the most commonly diagnoses in their caseload, their identified percentage of clients diagnosed with PTSD ranged from 35% - 100%. The participants’ caseloads also ranged from 2 – 210 individual clients. However, the participants that identified the two smallest individual caseloads both work in locked units that are primarily focused on group therapy. You will also notice that when asked about modalities used to treat PTSD, participant 006 stated, “Med Management”. This participant differs from all the other participants because she is a psychiatrist. In addition to these questions, each participant was asked which she started first: mindfulness practice or mental health practice. Most of the participants (N=5) started their mental health practice before or at the same time that they began

practicing mindfulness techniques. The one participant that started her mindfulness practice prior to her mental health practice was also the only participant who denied having experienced secondary trauma.

Lastly, each participant was asked to describe both their mental health practice and their mindfulness practice in one word (Table 2). While some participants struggled with this, it was interesting to see the similarities in the answers. For example, two participants struggled with choosing one word to describe their mental health profession, however their responses were very similar. While one participant stated, “Intense and rewarding”, the other participant said, “challenging and rewarding”. While half of the sample described their mental health practice as “rewarding”, one participant described it as “healing” and another described it as “fulfilling”. Similar to this, there were similarities in the way the participants described their mindfulness practice. While two participants described it as “soothing”, others described it as relaxing, essential, or healing.

Mental Health Practice

While each participant was interviewed to explore their personal experiences within their mental health practice and the experiences with secondary trauma, there were superordinate themes identified across all six participants. These themes are organized in order of most prevalent to least prevalent. The following themes in this section are as follows:

Theme:	# Of participants:
Self-care	N=5
Trauma stories	N=5
Taking the work home	N=4
Stress/Burnout	N=4
Caseload	N=3
“Practice what you preach”	N=3
Managing the effects	N=2
Symptoms of secondary trauma	N=2
Processing	N=2
Sleep	N=2
Worldview	N=2
Transference/Countertransference	N=2
Client Motivation	N=1
Balance	N=1
Threat	N=1
Escape	N=1
Therapeutic relationship	N=1
Admiration	N=1
Combat	N=1
Interventions	N=1
Suicidal ideations	N=1
Survival	N=1
Hopelessness	N=1
Self-care vs. experience	N=1
Job Satisfaction	N=1

Self-Care:

Participants were asked how they manage or address the impact of working with clients who have experienced ongoing trauma. The majority of participants (N=5) spoke about the importance of self-care in relation to their work as trauma therapists. While their self-care practices may vary, the five participants all spoke to the importance of it in order to work with trauma to the extent that they do.

I asked for some time, I went and talked to someone and asked for time off. I took 6 weeks off and it was really helpful. It was really good to just get away and do some, actually I did a lot of some spiritual stuff and took a week away in a monastery and did a lot of some kind of meditating and preying. It was really restorative.

Regular exercise. I try to keep a regularly healthy diet and regular therapy.

I do a lot of self-care kind of stuff... I have my own life outside of work that I enjoy and I spend time with friends and family.

I take regular vacations (laughs), I do yoga and meditation, I do physical exercise and I speak to someone. It is important to make time to do all of this because if not, I start to feel the difference.

I do yoga practice myself and meditation and that really helps to take it away.

Each participant that spoke about self-care (N=5) in relation to her trauma work stated that it impacts her mental health practice. When asked if these strategies have been helpful and/or successful in managing the affects of their work, each participant (N=6) said yes.

Trauma Stories:

Each participant was asked to define secondary trauma and then based on their personal definition, where asked whether they had experienced secondary trauma since working as a trauma therapist. In response to these questions, the majority of participants (N=5) mentioned they were impacted by hearing the trauma stories of their client(s).

The more horror stories I hear, the more hypervigilant I am about things and the more, certainly the more aware of people's intentions of homicidal acts I become.

But maybe three weeks ago I had a very difficult suicidal traumatized patient umm... and just trying to get him discharged and going through his whole life story ...actually this morning I heard a very traumatizing story that was just horrible- abused as a child and as an adult and I found that quit disturbing but where it will come out, maybe secondary trauma.

At times, it is rough and it is kind of hard to hear their stories. I feel like I have become a little immune to it by now but in the beginning it was harder to hear the stories.

Most of them (N=4) even spoke about the trauma stories in their definition of secondary trauma:

I would say it is the traumatization that occurs when hearing about trauma consistently and then it starts to transfer into your own life so, um...

Um...I would define it as me being traumatized or the therapist being traumatized either from the stories wearing you down or from threats from clients.

Being traumatized by our patient's trauma. Being affected by all the horrible trauma stories we hear on a daily basis....It is hard to hear all of their trauma stories and not be affected by them.

Taking the Work Home:

Similar to the theme *trauma stories*, many participants (N=4) talked about the concept of taking the work home with them as a negative effect of their trauma work. The participants who spoke of this also discussed this theme in relation to their self-care. They spoke to how it was important for them to practice self-care in order to prevent or reduce the incidents where they find themselves thinking about work while at home. One participant stated, "so I don't replay the stories at the end of the day" when discussing the importance of self-care. Another participant stated, "I make sure to not take work home with me. I do end up staying late a lot, which is not a good thing, but once I am gone, I am gone (laughs)". Other participants discussed the impact of taking the work home with them:

There were times when, well in fact, I took it home nearly every day when I started and it was much, it was way too much.

I think you think about what happens to people. I think you think about what they went through. Often times with the really difficult clients or someone I have met for the first or second time, when talking about the some of the traumas they have survived, I will go home and I cannot get it off my mind. I am going over what happened to them...I am thinking about it.

It is hard to not take the work home with you.

Stress/Burnout:

Stress and Burnout was another leading theme that arose when asking the participants questions about their mental health practice and their experiences with secondary trauma. Many participants (N=4) expressed that they have felt extreme stress and/or burnout as a result of their work as trauma therapist. Many participants discussed this when they were asked about the size of their caseload and how they felt about their current caseload. One participant stated that she felt “Stressed out and slightly burnt out”. Another stated, “...you are just feeling burnt out”. Other participants stated,

...just that feeling of being burnt out sometimes....I was really struggling with this um...more so, I think even last year, I came to a point where I was just really emotionally tired and I was getting more and more clients and I was just really, really, getting exhausted from it. I was just losing my ability to kind of discriminate and I think I was just really emotionally tired.

Other people are just winning and complaining and they are struggling and they are burnt out.

And also the physical stress; the stress can manifest itself physically.... I mean burnout is the other part of secondary trauma. We need to be very careful of...but it is hard to avoid it.

Casload:

While one participant expressed that she felt comfortable with her caseload, stating:

Um...it's good. I have a dual role here because I am admissions coordinator here so half of my time is devoted to that so that feels like a comfortable number.

Other participants (N=3) expressed a discomfort with the amount of clients they currently have. As mentioned above, one participant expressed that she was feeling “stressed out and slightly burnt out” but her current caseload. Others made similar statements, indicating that they felt as though their caseloads were too large. One stated, “Oh, I think it is a struggle. I think it is a pressure. It is too many to manage well”. Another stated, “I think it is too many to be as affective as we would like to be”.

“Practice what you preach”:

Many participants (N=3) spoke to the idea that they felt as though they had to practice what they preached in terms of taking care of themselves to better serve their clients. One participant stated, “I wanted to sorta put my money where my mouth was ya know, and actually do it”. Another participant stated,

And interestingly...in my early years I would encourage people to go to therapy as apart of my own job but didn't really feel like I needed it myself and when I finally did go, I couldn't believe how long it took me to get there and how um...and how much, how helpful it was, um...to deal with the trauma that I was experiencing in my job and also in just, ya know, my own life, so hopefully it helps me be a better therapist.

Another participant spoke of this theme but in relation to the importance of self-care,

Well, I didn't do it for a long time. It isn't talked about. Nobody ever talks about how hard the work is and how to take care of yourself... so I kept thinking something was wrong with me and I kept pushing myself and then I just stopped and realized that I needed to take care of myself”

Managing the Effects:

Two participants used the term “manage” when discussing the effects of working with those who have experienced ongoing trauma. One participant stated, “It is too many to manage well” when discussing her feelings about her current caseload. Another participant stated, “ I don’t do these things to manage what is going on at work necessarily” when discussing the relationship between her self-care and her trauma work.

Symptoms of Secondary Trauma:

When discussing the participants’ personal experiences with secondary trauma, two participants highlighted certain symptoms that they felt were descriptive of secondary trauma:

I have had flavors of it, I wouldn’t say that I have developed full blown secondary trauma but I certainly find myself more aware of foot steps behind me or um being in the grocery store and someone, ya know...that kind of stuff so I am definitely like the hypervigilance piece has increased (laughs)...I started to have the same generalizations about populations or people in situations that my patients do or um...started to have nightmares.

Sometimes I will dream about it. So it will take me, you know a day or two to kind of sometimes to really process what I am feeling inside, reflecting on what they have survived and often times I feel overwhelmed...I cannot get it off my mind, I am going over what happened to them, I am thinking about it.

Processing:

Two participants discussed the importance of having to process the material that they hear in sessions with clients. While they (N=2) express different ways to process, they both discuss the importance of taking the time to work through this material.

I went home and I just had to continue to write about everything they had talked to me about and kind of categorize it.... I remember getting up and I wrote some more stuff down and ya know....I allow myself to write and process and to think about it, and I will also talk to people if I...I talk to a lot of people. I mean not just other colleagues here, but sometimes I have friends in private practice that I will run things by and they are eager to hear because they kind of want to know what is going on with these veterans (Laughs).... But I will, I will grab someone here at the VA and just process it with them too. Especially if there is one that I am really chewing on and I am having trouble with.

I talk about it a lot. I mean obviously not using any identifying information but um...just to get it outside of myself and say, “isn’t this a crazy story” or “isn’t this horrible” and just utilize my support network.

Sleep:

Two participants discussed their ability to sleep. While one participant discussed the impact her trauma work as has had on her sleep in the past, stating, “I didn’t sleep very well”, another participant discussed the concept of sleep in terms of experiencing secondary trauma, “...and you start having trouble sleeping”.

Worldview:

Throughout the questions about their trauma work, two participants mentioned the concept of worldview. While one participant discussed how her worldview has changed since working as trauma therapist, stating, “Yeah, and well just thinking that this world is F-ed up.... Yeah, it adds to my pessimistic views of the world”, another participant discussed how the worldview of her clients impact her work with them:

...sometimes there is a rigidity in the way that they think so trying to do cognitive processing therapy can sometimes be difficult because they are um... committed to their beliefs that the world is dangerous and they can’t trust anyone and that they are horrible people and all of these kinds of things, so that is pretty difficult.

Transference/Countertransference:

While all participants (N=6) admitted that transference and countertransference is present in their work with their clients when asked during the interview, only a few participants (N=2) discussed how this impacts their work:

Um, you know it varies from every client. I think that every time you sit in the room with a client they are going to feel something. I mean we are humans. Sometimes we might like them, we might not like them, they remind of us someone, and vs. versa too. You know they have a lot of that with us. And I think that for the most part we have had, in this program I have had general positive transference from the clients um...to me but not always. Um... there is definitely the issue of being an authority, which they don't trust. Um... which can be pretty difficult from the get-go. But um...yeah I think it is a really important piece of working with all clients, not only trauma.

Well, I think that it is hard for these guys to trust people, so when they come in and they don't know me and don't trust me, there is going to be a lot of transference and when I am hearing all of their trauma I am going to be affected by that which is my countertransference.

Client Motivation:

One participant discussed the theme of the client's motivation when asked about the challenges of her work as a trauma therapist. She stated, "I think clients that continue to come in and expect change without doing anything outside of the hour of therapy".

Balance:

Another participant discussed the concept of balance in terms of her feelings towards her work as a trauma therapist. She stated, "...sometimes it is a little much but I love the work so.... It feels like a healthier balance now".

Threat:

The same participant that discussed the concept of balance also discussed the concept of feeling threatened in her definition of secondary trauma. She stated, “Um...I would define it as me being traumatized or the therapist being traumatized either from the stories wearing you down or from threats from clients”.

Escape:

Another participant talked about her yoga practice and how it helped her escape from the work. She stated, “...you can’t concentrate on clients at all (starts to laugh) when doing those things”.

Therapeutic Relationship:

One participant spoke about the importance of the therapeutic relationship and what it means to play the role as the therapist in that relationship. She stated,

I think that in our work one of the things that we do that is most important is that we are able to be kind of a witness. We are present with that person as they are describing what has occurred to them and we have a unique role in the sense that we, we have to participate in order to have empathy. We participate, we listen, and we are impacted by what they went through. And that connection, that feedback to them is um, is validating. It is acknowledging, it is very important

I think to the extent that you engage with the client and really hear what it is that they are going through and you know, respond to that, you can’t not, you can’t help but experience it a little bit.

Admiration:

The same participant discussed the admiration and the respect she has for her clients. "...sometimes I will feel, you know sometimes I feel incredible admiration and respect for their abilities and what they were able to do".

Combat:

When discussing one of this subject's personal experiences with secondary trauma, she highlighted the combat experience of the veteran she was working with. She stated, "It was with a man who really, really saw a significant amount of combat".

Interventions:

She also spoke to the importance of setting up interventions for secondary trauma; this responsibility not only being on an individual basis but also on a management level. She stated,

Yeah, because it is really, really hard work so... I think we can do so much more to respect this work and to, I think we need to do a whole lot more to really provide supervision and support because trauma work is tough.

This is really tough stuff and I think we are more known for burning people out rather than, you know, trying to keep good workers and, I mean that is an over generalization. I think, I think there could be a lot more supervisory support and um...management support but regardless you have to take responsibility for taking care of yourself and you can do it! You know? Even if nobody is else is suggesting it, you can do it and this is an institution that I felt supported by when I really needed to do that.

Suicidal Ideation:

Another participant spoke about suicidal ideation when discussing her experiences with secondary trauma and the impact of hearing the trauma stories. She stated, "...maybe three weeks ago I had a very difficult suicidal traumatized patient".

Survival:

The same participant spoke about self-care as though it was necessary for survival as a trauma therapist. She stated, "It is kind of like do or die".

Hopelessness:

Another participant spoke about the issue of hopelessness when asked what is most challenging about working with those who have experienced ongoing trauma. She stated, "I would say, um...probably the hopelessness that a lot of them come in with".

Self-care vs. Experience:

This participant also questioned whether it was either her self-care or her professional experience or a combination that influences her more recent experiences with secondary trauma. She stated, "I feel like I have good enough self-care and I maybe just haven't experienced enough of the work but I don't think I have yet".

Job Satisfaction:

This same participant spoke to the importance of job satisfaction and how it may play a role in her belief that she has not experienced secondary trauma. She stated,

I really just love my job so it is not like I feel like I have do stuff to distress from it so um... so yeah, I think that helps. Oh, one thing I forgot to mention is that the team here is an incredible sense of support, which I think really helps with any of the effects of working with trauma... that we have a great sense of support that we can talk to, people hear about stuff and if we are starting to feel traumatized there is a lot of opportunity to work that out. So um...I don't know if it has changed that much over the years.

Mindfulness Practice

Similar to the mental health section, there were superordinate themes identified across all six participants when interviewed about their personal mindfulness practice. These themes are organized in order of most prevalent to least prevalent. The following themes in this section are as follows:

Theme:	# Of participants:
Awareness	N=5
Self-care	N=4
Anxiety	N=3
Spirituality	N=3
Sleep	N=2
Acceptance	N=2
Accomplishment	N=1
Escape	N=1
Personal relationships	N=1
Self-care vs. experience	N=1
Managing the effects	N=1
Existentialism	N=1
Processing	N=1
Cultural influences	N=1
Happiness	N=1
Taking the work home	N=1

Awareness:

The majority of participants (N=5) spoke to the concept of awareness when addressing questions about their mindfulness experience. All of these participants (N=5) expressed an increase in awareness since starting their mindfulness practice and the importance of awareness during their work with clients.

I think that being very aware of my own symptoms that arise from doing therapy I think is part of what I do and trying to um...I think being aware for me is important because then I can kind of step back from getting grumpier or if I am losing sleep or feeling more anxious about things.

I pay attention to my breathing if I notice something is bothering me and get myself settled here if I start to get into too much of my clients story so it is wonderful.... If they were getting upset I probably would have tried to help them think about it differently. And now I really pay attention to what is happening to their body and I can help them do some deep breathing and some of my clients meditate in here when they are getting upset.

I will just be in the middle of a session and I will start to focus on my breathing and tuning into where I am at and trying to stay focus on the moment in the moment.... It is a feeling, it is thought and some of that mindfulness that meditation practices is saying "oh there it is again" and returning your thoughts and your focus to your breathing or to whatever you are doing.... I think it has helped me to understand and know myself.

I think it's something that maybe happened on an unconscious level but I think that being more present in those situations has helped me to know what that kind of means to be present with myself and with another person in the room and be mindful of all the things that are going on in that situation.

Yes. I am more calm when hearing their stories and I am aware of how I am feeling and can provide them with better care.

Self-care:

The theme self-care was a major theme in both the Mental Health Practice (N=5) section and the Mindfulness Practice section (N=4). The majority of the participants (N=4) spoke to the concept of self-care and its importance while being asked a series of questions about their mindfulness practice. Many participants identified their mindfulness practice as their self-care.

I definitely try to exercise and try to take a break from therapy, um...you know like, friends who might be needing some therapy I might not call back for a few hours, or put it off for a couple days which may not be good. Um, and then I think

doing stuff like yoga or palates or just running, lifting weights and trying to exert energy and trying to find a centerpiece of calm for me.

I started doing yoga, which is an hour and a half of mindfulness and feel much more relaxed after that. I also do meditation, which is um...an hour or an hour and a half of group mediation that I do and um...it is very soothing and I use mindfulness skills throughout the day.... Um...reasons why...emotional health, so that I don't take everything home, so that I don't replay the stories at the end of the day and um...physical health and just feel better when I do these things. Um...peace of mind. It is just really helpful to be centered.

Most of it's physical at this point and I used to meditate a lot but it has been years since I have done that but most of it is in the form of exercise and yoga and therapy which is somewhat, I mean it is not meditative but it is getting the pipe cleaner in there (laughs).

Um...and also, I used to have a really regular yoga practice that I would do once a week but since the winter started I have started to do more snow boarding which has become a part of my mindfulness practice as well because you are alone up on the mountain, you know just up in your head.

Anxiety:

Several participants (N=3) spoke to the concept of anxiety. While all three of these participants discussed the change in their own feelings of anxiety while sitting with clients, one participant also spoke to her increased ability to sit with her clients' anxiety. In addition to this, one participant discussed how her sense of awareness has increased her ability to manage her anxiety:

I think being aware for me is important because then I can kind of step back from getting grumpier or if I am losing sleep or feeling more anxious about things.

Yeah, I am not as anxious. I look forward to coming to work. And I am just not as frazzled when I have a busy schedule.

Umm... yes. It has reduced my anxiety significantly- my own personal anxiety and as a result I am able to sit with other peoples depression and anxiety.

Spirituality:

This was another major theme that came up for several participants (N=3) when discussing their mindfulness practice. The concept of spirituality was often talked about when participants defined their mindfulness practice and when answering questions about the impact their mindfulness practice has on their lives, both professionally and personally. While one participant simply stated, “It has also brought me closer to my spiritual life”, other participants (N=2) went into greater detail:

I have specific periods of kind of...you can call it contemplative prayer that I use.... I use that for the most part on a daily basis.... I think it has really deepened my faith.

I think that my spirituality is a huge part of my mindfulness practice so like, daily prayer-meditation is a big part of it and that is actually something that I forgot to mention before I mean, I really work out a lot of the stuff that is going on inside through that, though my spirituality.... I feel like I would be pretty lost without some sort of meditative process and for me it happens to be meditative prayer and it feels really grounding for me and um.... It helps me feel connected to myself and to the universe and to people around me. Um... it helps me kind of feel like I can unload whatever it is that I am dealing with or going through so I don't have to just hold that myself. Um... It, yeah, I think it just mostly keeps me centered and grounded.... I guess I have felt a lot of guidance through my meditative prayer practice and also a lot of relief from stress or from worry or whatever might be going on.

Sleep:

This was another theme that was discussed in both the Mental Health Practice section and the Mindfulness Practice section. However, the participants that discussed it in the Mental Health Practice section (N=2) differ from the ones that discussed it in this section (N=2). Both participants that spoke to the concept of sleep while addressing

questions about their mindfulness practice expressed that their sleep has either increased or has gotten better since they started their mindfulness practice. While one participant stated, “It gives me a little nap (laughs) in between work and yoga because I will get there early and pass out on the floor for a half an hour”, another participant simply stated, “I sleep better”.

Control:

While reflecting on how their mindfulness practice has impacted their lives, two participants discussed the concept of control. One participant spoke to how her awareness has given her a greater sense of control, stating:

Um...I think it does so many things. I think it gives you individually as a person more control. I think that more you are more aware of both coming from internally as well as externally the more choice you have. I think you are more able to respond rather than react.

Another participant joked about how her daughter has noticed a change in her, stating:

“My daughter said that I used to be angry and controlling and now she says I am just controlling (laughs)”.

Acceptance:

When discussing how their mindfulness practice has created change in their lives, two participants expressed how they have become more accepting of themselves since practicing mindfulness. One stated, “It has made me much more accepting of myself and my life”, while another stated, “Um... I think it has helped me accept my own limitations

and my own humanity as well as my, you know, that sort of like, my capacity and my abilities”.

Accomplishment:

One participant spoke about the sense of accomplishment she gets from her mindfulness practice, specifically her yoga practice, stating, “It gives me a sense of accomplishment when I can, you know, do different fancy yoga moves (laughs)”.

Escape:

While only one participant spoke to the concept of escape while answering questions about her mindfulness practice, another participant also mentioned it when answering questions about her mental health practice. In this section, one participant discussed how her yoga practice allows her to escape from her work, which then prevents her from taking the work home with her. She stated:

I have to concentrate so much on the moment that I have completely forgotten about everything and yeah, when I get home I will have completely have forgotten an annoying conversation or ya know, a frustrating patient.

Personal Relationships:

This is another theme that was also addressed in the Mental Health Profession in addition to this section. While being asked how her mindfulness practice has impacted her life, this participant stated, “My family likes me more”.

Self-care vs. Experience:

While a few participants (N=2) discussed this theme throughout the interview, only one participant spoke to this theme while being asked a series of questions about her mindfulness practice. This participant stated “I think I am more settled and it is easier for them and it could be the combination of the mindfulness and the experience” while discussing how her mindfulness practice has impacted her ability to sit with clients who have experienced ongoing trauma.

Managing the Effects:

One of the participants that discussed how she manages the effects of her work in the Mental Health Practice section also discussed it in the Mindfulness Practice section of the interview but in greater detail.

It is such a great strategy for kind of managing all of this stuff that is coming at you, whether it is a lot of clients, a lot of stress, a lot of really, really busy days...it is just absolutely amazing to say “well all I have to do is really one thing”. What I have to do is right in front of me now, to just focus on this one thing that I have to do is incredibly smoothing and it is a great way to manage a really crazy schedule or a busy life or a difficult circumstance or even some really painful emotions I think.

I think it is really an aid to both your relationship with yourself and your relationship with other people and especially in this stressful work that we do. It just helps you manage in so many ways.

Because trauma by its nature is a sense of overwhelm and chaos and terror and fear and so there are a lot of very difficult emotions that you have manage and, and not, and have great tolerance for and I think that the mindfulness expands that ability to tolerate those emotions and those thoughts as well as somebody else, in the presence of and it allows them a kind of an anchor and a grounded person as well.

Existentialism:

While this theme only came up in one interview, it is similar yet different than how other described their mindfulness practice. However, only one participant related her mindfulness practice to the philosophy of existentialism.

Yeah, you know there is something about, and even about yoga it allows me to live in the moment and I am a bit of an existentialist. I might not have the spiritual um... the spiritual group but as a philosophy; I think existentialism is an interesting one. I think that living in the 'here and now' is a pretty stressful thing to do sometimes so, there is something to be said about processing it through your own therapy and your own physical exercise so that you are prepared to constantly, to be present.

Processing:

In the above quote, the participant discusses the importance of processing as well by stating, "...there is something to be said about processing it through your own therapy and your own physical exercise so that you are prepared to constantly, to be present".

Cultural Influences:

While the sample for this study was diverse (refer to Table 1), only one participant spoke to the idea of cultural influences in relation to their mindfulness practice. This participant stated, "I am Indian so mindfulness is a huge part of my culture so I have always been around it but it wasn't until 3 years ago that I really started to be active in my mindfulness practice".

Happiness:

This same participant also spoke to the concept of happiness when discussing how her mindfulness practice has impacted her life. She stated, “It has made me a happier person and made me better at what I do”.

Taking the Work Home:

While this was a major theme in the Mental Health Practice section, only one participant spoke to this concept while answering the mindfulness questions. While speaking to how her mindfulness practice has impacted her mental health profession, she stated, “It helps me stay present and not take my work home with me”.

*The Intersection of the Participants’ Mental Health Practice and
their Mindfulness Practice*

The following superordinate themes were found across all six participants:

Themes:	# Of Participants:
Practice to teach	N=5
Direct relationship	N=1
Necessity	N=1

Practice to Teach:

This was one of the major themes that came up throughout the interviews. The majority of the participants (N=5) spoke to this theme when answering the questions related to how their mindfulness practice has impacted their mental health practice.

Having them do mindfulness stuff I think is um...ya know...it's important that I practice it myself so I know what it is like to actually truly be in my body and in the moment and grounding myself in that moment and instead of being flooded by the past, or anticipating the future.

Because I teach DBT and mindfulness, it really helps clients that I practice the skills that I teach because I identify with the struggle with doing that and then it seems more real to them and less academic.

I think it has helped me to work with my clients and to be really connected with them and um...present as opposed to you know, playing some kind of role.

Yeah, I think I kind of do it unconsciously to prepare for groups or to prepare to meet with a difficult client. I will use that prayer or meditation or just kind of sit through stuff and I also use grounding techniques and other kinds of mindfulness practices with my veterans.

It has not only made me better at my job but I also talk to my patients about mindfulness and sometimes when I notice that a patient isn't breathing I will have them breath with me and we will breath together. This really helps them, ya know. It makes them calm down and they are better able to talk about what is troubling them.

Direct Relationship:

One participant stated that there was a direct relationship between her Mental

Health Practice and her Mindfulness Practice:

There is a direct relationship. My work traumatizes me and then I go and exercise and have therapy and can come back and still be uh, effective hopefully and, I mean some days are better than others but still come back and be affective and not burn out.

Necessity:

To conclude, one participant spoke very strongly about the relationship between her Mindfulness Practice and her Mental Health Practice when discussing why her

Mindfulness Practice is so important to her. She stated, "...I need to if I want to continue to do this work. It is really important that we take care of ourselves".

Conclusion

This chapter outlined the findings of six interviews with trauma therapists who work with veterans diagnosed with PTSD. Participants were asked a series of questions about their mindfulness and mental health practice to explore how their personal mindfulness practice may or may not impact their experiences with secondary trauma. Participants explored the relationship between their mindfulness practice and their mental health practice and the impact both have had on their personal and professional lives. The following chapter will discuss these findings and consider the implications of the data and for the field of social work.

CHAPTER V

DISCUSSION

The purpose of this study was to explore the ways in which a mindfulness practice, such as yoga and/or meditation, can affect the experience of secondary trauma in trauma therapists working with clients who are diagnosed with PTSD. This chapter will discuss: 1) key findings of this study, 2) how the findings are consistent or inconsistent with the literature, 3) strengths & limitations and 4) the implications this study has for the field of clinical social work.

Key Findings

Each participant was asked a series of questions divided into two sections: 1) their mental health practice and their work as a trauma therapist and 2) their mindfulness practice and how it has impacted their work as a trauma therapist. Within the first section of questions, each participant was asked to define secondary trauma in their own words. While common themes came up throughout these definitions, the definitions also varied as it reflected each of the participants' personal experience with this phenomenon. The definitions that were given throughout the six interviews were as follows:

Mmm...I would say it is the traumatization that occurs when hearing about trauma consistently and then it starts to transfer into your own life so, um...I started to have the same generalizations about populations or people or situations that my patients do or um...started to have nightmares...yeah.

Um...I would define it as me being traumatized or the therapist being traumatized either from the stories wearing you down or from threats from clients.

Um... I think that, I think that in our work, one of the things that we do that is most important is that we are able to be kind of a witness. We are present with that person as they are describing what has occurred to them and we have a unique role in the sense that we, we have to participate in order to have empathy. We participate, we listen, and we are impacted by what they went through. And that connection, that feedback to them is um, is validating. It is acknowledging, it is very important. But that cost you to do that. I think you think about what happens to people; I think you think about what they went through. Often times with the really difficult client or someone I have met for the first or second time were talking about some of the traumas that they have survived, I will go home and I can not get off my mind, I am going over what happened to them, I am thinking about it. Sometimes I will dream about it. So it will take me, you know, a day or two to kind of sometimes to really process what I am feeling inside, reflecting on what they have survived and often times I feel overwhelmed, or sometimes I will feel, you know sometimes I feel incredible admiration and respect for their abilities and what they were able to do. Um.... but it, I think to the extent that you engage with the client and really hear what it is that they are going through and you know respond to that, you can't not, you can't help but experience it a little bit.

Um...I would uh...I would say it's um...that most of the time it is a subtle presentation by, I think it manifests itself in my relationships with my own family, with my own significant others and my own relations to society. So, I would that is where it manifests itself. And also the physical stress. The stress of it can manifest itself physically.

Um...I would say that it is the traumatization of the, of anyone whether it is clinicians or family members who are working with, or living closely with someone who has been traumatized.

Being traumatized by our patient's trauma. Being affected by all the horrible trauma stories we hear on a daily basis. It is hard to not take their stories home with you and you start having trouble sleeping and you are just feeling burnt out.

Within these definitions, the majority of the participants (N=5) spoke to their own personal experience with secondary trauma in one way or another. They were honest and allowed themselves to be vulnerable while answering this question. Interestingly enough, the one participant that did not speak in first person or from a place of personal experience was the only participant that denied ever experiencing secondary trauma.

While the literature points out that there are many different ways to define the phenomenon of secondary trauma, the researcher of this study understood it to be the “insidious impact on therapists that work with traumatized individuals” (Basham & Miehl, 2004, p. 236) and the “natural consequence of caring between two people, one of whom has been initially traumatized and the other of whom is affected by the first’s traumatic experiences” (Figley, 1995, p.11). It was fascinating to see how each of the participant’s definition of secondary trauma fit into these working definitions while still expressed in their own words. However, some can argue that the participants’ description of secondary trauma can also fit into the definitions of other terms to describe this phenomenon, such as vicarious trauma. For instance, Pearlman and Saakvitne (1995) state:

By definition, the effects of vicarious traumatization on an individual resemble those of traumatic experiences. They include significant disruptions in one’s sense of meaning, connection, identity, and world view, as well as in one’s affect tolerance, psychological needs, beliefs about self and others, interpersonal relationships, and sensory memory, including imagery (p. 151).

Similar to this definition of vicarious trauma, several participants in this study shared how their worldview, their beliefs about others and themselves, their interpersonal relationships, and their sensory memory and imagery have been affected by their experiences with secondary trauma. This is illustrated in multiple themes that will be

discussed below, including: *symptoms of secondary trauma, taking the work home, trauma stories, sleep, personal relationships, worldview, awareness, anxiety, and self-care.*

The second major theme in this study was the impact of hearing *trauma stories*. While four of the participants spoke to this theme in their definition of secondary trauma, almost all of the participants (N=5) mentioned that the trauma stories are one of the challenges of working with clients diagnosed with PTSD. While discussing this theme, the participants would often emphasize the impact of hearing these stories by either shaking their heads and/or looking down, breaking eye contact or making direct eye contact and/or changing the tone of their voice. This shift in affect was also demonstrated in several participants (N=4) when discussing the theme of *stress/burnout*. One participant appeared to become frustrated when discussing the issues of burnout at the VA and why it was difficult for her to request time off when she last experienced secondary trauma. She stated, “Other people are just whining and complaining and they are struggling and they are burnt out”. Many participants expressed that the issues of secondary trauma and self-care are not discussed enough within the VA. Another participant stated, “Nobody ever talks about how hard the work is and how to take care of yourself... so I kept thinking something was wrong with me and I kept pushing myself and then I just stopped and realized that I needed to take care of myself”. This brings attention the second most present theme in this study: *self-care*.

Most of the participants (N=5) discussed the theme of *self-care* when answering the questions about their mental health practice and four participants discussed this theme in answering the questions about their mindfulness practice. When examining the themes

that overlapped between the Mental Health section and the Mindfulness section, it was discovered that all of the participants (N=6) discussed this theme at one point during their interview. All of the participants (N=6) discussed the importance of self-care in relation to their work as trauma therapist and shared examples of their own personal self-care and how that has impacted their personal and professional lives. One participant spoke specifically about how she took time off of work in order to practice necessary self-care.

This participant stated:

I asked for some time, I went and talked to someone and asked for time off. I took 6 weeks off and it was really helpful. It was really good to just get away and do some, actually I did a lot of some spiritual stuff and took a week away in a monastery and did a lot of some kind of meditating and preying. It was really restorative.

Another participant spoke to the importance of self-care when discussing her mindfulness practice.

I started doing yoga, which is an hour and a half of mindfulness and feel much more relaxed after that. I also do meditation, which is um...an hour or an hour and a half of group mediation that I do and um...it is very soothing and I use mindfulness skills throughout the day.... Um...reasons why...emotional health, so that I don't take everything home, so that I don't replay the stories at the end of the day and um...physical health and just feel better when I do these things. Um...peace of mind. It is just really helpful to be centered.

This participant also spoke to how her mindfulness practice helps her manage the effects of secondary trauma when she discussed reasons for why she practices mindfulness. She stated, “so I don’t take everything home, so that I don’t replay the stories at the end of the day”, which brings up the next theme of *taking the work home*.

More than half of the participants (N=4) discussed the theme of *taking the work home* either in their description of secondary trauma or in discussing the challenges of working with those who have experienced ongoing trauma. One of these participant

stated, “there were times when, well in fact I took it home nearly every day when I started and it was much, it was way too much”. While all the participants except one admitted to having experienced secondary trauma (N=4) or at least experiencing “flavors of it” (N=1), the one participant that denied ever experiencing secondary trauma stated, “I make sure to not take work home with me. I do end up staying late a lot, which is not a good thing, but once I am gone, I am gone (laughs)”. This participant was also the only participant that discussed the theme of *job satisfaction*, stating, “I really just love my job so it is not like I feel like I have to do stuff to de-stress from it so um...so yeah, I think that helps”. While I believe job satisfaction is an important factor in how one experiences secondary trauma, other factors that may have contributed to her not experiencing secondary trauma are the size of her caseload (2 individual clients) and the fact that she primarily focuses on group therapy. Another potential factor is that she has been practicing her mindfulness practice for longer than any other participant, this being for 16 years (Table 2).

One theme that was also not discussed by many participants (N=2), contrary to my expectations, was *transference/countertransference*. This came as a surprise to me since it was discussed in the literature on secondary trauma that I reviewed. Figley (1995) defines countertransference as the therapist’s response or feelings towards the client or the material that is being presented in session. Understanding this, each participant was asked if transference and countertransference was present in their work. This question was asked to measure the participants understanding of this phenomenon and how they felt it impacts their work with clients who have experienced ongoing trauma. While all

participants admitted that it is present in their work, only two participants discussed this in detail:

Um...most of the time at least I try to be very aware of it and not act on it.... I guess I work with it when it is coming from my patients and for me I try and step out of that.

Well I think that it is hard for these guys to trust people so when they come in and they don't know me and don't trust me there is going to be a lot of transference and when I am hearing all of their trauma I am going to be affected by that which is the countertransference.

As for the Mindfulness Practice section, the major theme that came up during the interviews other than *self-care* (N=4) was *awareness* (N=5). While many in the field of social work would agree that awareness, as Williams (2008) would define as becoming “more or less attuned to our internal states at various times” (p. 140) is very important while conducting therapy, this theme was not discussed by any participant during the Mental Health section of the interview. It wasn't until the participants were asked questions about their mindfulness practice that many of the participants (N=5) discussed how their MP has increased their awareness in their work, both in relation to their clients and to their own sense of awareness. One reason for this may be that the MH section of the interview might have been a place for many of these participants to discuss some of the realities of their profession in a way that they often do not. In other words, some of the participants may not have many opportunities to explore or focus on the negative impacts of their work; making it more difficult to focus on the positive aspects of the work while finally being given the opportunity to explore the challenges. It was also interesting to see how each participant responded to the interviews once they were

finished. Participants expressed gratitude for considering them in the study and for the reminder to take care of themselves while working with a traumatized population.

It was also interesting to discover that while most of the participants admitted to experiencing at least flavors of secondary trauma (N=5), only two participants discussed symptoms of secondary trauma. Only one out of the four participants that answered “yes” to whether or not they have experienced secondary trauma and the one participant that stated that she has experienced “flavors of it” discussed the symptoms. They stated:

I have had flavors of it, I wouldn't say that I would have developed full blown secondary trauma but I certainly find myself more aware of foot steps behind me or um being in the grocery store and someone, ya know...that kind of stuff so I am definitely like the hypervigilience piece has increased (laughs).

Sometimes I will dream about it... I cannot get it off my mind. I am going over what happened to them, I am thinking about it.

Lastly, I will discuss the use of laughter and humor throughout the six interviews. Every participant utilized laughter and humor as a defense at some point during their interview. More than half of the participants (N=4) used this defense when discussing their feelings around their caseload. Interestingly enough, the only two that didn't use laughter while answering this question were the two participants that had the lowest number of individual clients (Table 2). All of the participants that did use humor and laughter during this discussion then expressed unhappiness with the size of their caseload. As you can see above, one participant also used this defense when discussing her symptoms of secondary trauma. Another participant was facetious offering suggestions around ways to address secondary trauma, stating, “I think that they should give trauma therapists the summer off every year (laughs)”, while another participant made a joke about how her mindfulness practice has helped her manage the effects of her

work, “my daughter said that I used to be angry and controlling and now she says I am just controlling (laughs)”. The use of this defense suggests there is some anxiety around discussing this topic with others.

Similar to my participants, I also found myself laughing in order to defend from feelings of discomfort. I often laughed or made a joke in order to transition into the next question when I felt as though I wanted to respond to answers but could not due to my researcher role. However, I believe the laughter and humor overall was a good defense as it allowed for smooth transitions and made it more comfortable for the participants to discuss and share their experiences for the sake of this study.

The results of this study suggest that some of the effects of secondary trauma are similar to those of PTSD. This finding is similar to Figley’s comparison between the diagnostic criteria for primary and secondary traumatic stress disorder, which points out that there are very few differences in symptoms. His comparison illustrates that while many of the criteria are identical, the main difference is that those who have experienced primary trauma have effects/symptoms (i.e., recollections, dreams re-experiencing, hypervigilance) related to the trauma they, *themselves* have experienced, while those who suffer from secondary trauma will experience these effects related to another person’s trauma (i.e., client or loved one) as a result of learning about this traumatic event (Figley, 1995). Throughout this study, multiple participants admitted to experiencing recollections, dreams, a sense of hypervigilance, and loss of sleep, which are all symptoms of PTSD as well.

While the majority of the participants (N=5) admitted to experiencing secondary trauma while working as a trauma therapist, it is also important to point out that one

participant denied ever experiencing this phenomenon. However, focusing on the observable symptoms, I would say it is safe to agree with Randal D. Beaton and Shirley A Murphy (1995) as they argue, “all crisis workers are at risk of experiencing secondary traumatic stress” (p. 51).

While the risks of working directly with traumatized individuals on a regular basis are well documented, “it is equally important to understand what protects and sustains clinicians in their work with traumatized populations” (Harrison & Westwood, 2009, p.204). All of the participants (N=6) throughout this study expressed ways in which their mindfulness practice has helped protect and sustain their work as a trauma therapist. While all six of the participants identified meditation as a part of their mindfulness practice, they also all identified other mindfulness activities such as yoga (N=5), snowboarding (N=1), and exercising (N=4). One participant stated:

I used to have a really regular yoga practice that I would do once a week but since the winter started I have started to do more snow boarding which has become a part of my mindfulness practice as well because you are alone up on the mountain, you know just up in your head.

Another participant stated:

I take regular vacations (laughs), I do yoga and meditation, I do physical exercise and I speak to someone. It is important to make time to do all of this because if not, I start to feel the difference.

While there is significant research on the impact of secondary trauma on therapists, there is limited research that examines how a therapists’ mindfulness practice can affect their experience with secondary trauma. Although there was no formal hypothesis for this study, the researcher was not surprised to discover that the majority of the participants (N=4) had experienced secondary trauma. However, it was interesting to

see the relationship between each participants experience with secondary trauma and their mindfulness practice. As outlined in Table 2, all of the participants that admitted to experiencing secondary trauma (N=4) stated that they started their mental health practice prior to their mindfulness practice. The one participant that stated she had experienced “flavors of it” stated that she started her mindfulness and mental health practice simultaneously while in graduate school and the only participant that denied experiencing secondary trauma started her mindfulness practice prior to her mental health practice.

Although this study only represents the experiences of six participants, based off of these results one can begin to hypothesize that one’s mindfulness practice may potentially prevent one from experiencing secondary trauma if practiced before their exposure to trauma work. Based off of these results and the specific examples of how their mindfulness practice has impacted their mental health practice and personal lives (discussed above under *self-care*), there is some evidence that mindfulness as a form of self-care may impacted each participants’ experience with secondary trauma and managing the effects of working with trauma.

Strengths & Limitations

The data collected was analyzed using Interpretative Phenomenological Analysis (IPA) in order to capture the voices of my participants. IPA allowed my research to explore how participants themselves make sense of their experiences and the meaning behind those experiences. While research studies using IPA typically have a very homogenous sample, it was important for me to incorporate racial and ethnic diversity within my sample (Table 1).

In order to maintain racial and ethnic diversity while still having a homogenous sample, the participants were then limited to only women who all worked within the VA system. While this can be viewed as a strength in IPA research, it can also be viewed as a limitation since it is only representing female trauma therapists-who work at a VA in a specific region. While the sample captured racial and ethnic diversity, all of the participants serve the same veteran population with a high percentage of combat related PTSD which may differ from the work other practitioners may experience with other trauma related PTSD.

In addition to this, each participant was asked to define both secondary trauma and their mindfulness practice in their own words. While this allowed the researcher to capture the true essence of each participant's personal experience, this may have reduced the validity of the results as each participant's answers were based off their own personal understanding of these concepts. However, to maintain reliability, each interview question was asked in a consistent manner throughout each interview by the same interviewer. The interviewer asked each participant the same questions and did not ask any additional questions that would have directed the interview elsewhere.

Implications of this Study

While this study focused on a specific population of trauma therapist who hold a personal mindfulness practice, the findings may be applicable to a larger population of psychotherapists and practitioners in the mental health field. Throughout the study, the participants not only spoke to their specific mindfulness practices but they also spoke to

the importance of self-care while working in the mental health field and how it has impacted their lives both personally and professionally.

Salston and Figley (2003) state “there needs to be a balance between the physical self, the emotional self, and the spiritual self in order to continually work with those who are struggling through the impact of the traumatic experience” (p.171-172). While this study focused on trauma therapists working with clients diagnosed with PTSD, it is the belief of this researcher that many mental health professionals work with those individuals who have experienced the impact of a traumatic experience to some degree and could benefit from learning how to manage the effects of this work. In addition to this, the participants of this study all shared intimate details related to both their mental health and mindfulness practice. They spoke to the challenges of their work and what interventions have helped them better serve their clients and protect their own well-being, such as their personal mindfulness practice. This study would be beneficial to anyone who is in or entering the field of mental health and is looking for ways to better serve their clients and sustain their own sense of happiness and fulfillment throughout their careers.

Conclusion

All of the participants in this study spoke to the importance of self-care, whether that was through a mindfulness practice or other activities of enjoyment or the processing of their experiences. As many focus on protecting their clients and creating change, many lose focus on taking care of themselves. This study speaks to the importance of making this a priority; not only for themselves, but also for those they serve. As stated towards

the beginning of this thesis, “when helpers lose their faith and fervor, despair paralyzes the world” (Pearlman & Saakvitne, 1995, p.159).

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APPENDIX A

HUMAN SUBJECTS REVIEW APPROVAL LETTER

December 21, 2009

Elizabeth Reinecke

Dear Elizabeth,

Your amended materials have been reviewed. You have done a careful job in their revision and all is now in order. We are therefore now happy to give final approval to your study.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your very interesting project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee
CC: Jill Clemence, Research Advisor

APPENDIX B

INTERVIEW GUIDE

- Demographic Questions:

1. What gender do you identify with most?
2. Do you identify yourself as belonging to a specific cultural, ethnic, or racial group? If so, which one(s)?
3. Are you a member of a church, faith community, or religion? If yes, which one(s)?

- Work related questions:

1. How long have you worked as a trauma therapist?
2. What are the most common diagnoses you find in the population you work with?
3. Generally how large is your caseload?
4. How do you feel about having this amount of clients?
5. In your current caseload what percentage of clients are diagnosed with PTSD?
6. What types of treatment modalities have you used while working with clients diagnosed with PTSD?
7. What is most challenging about working with clients who have experienced ongoing trauma?
8. Would you say transference and counter-transference is present in your work with your clients? How so?
9. How would you define secondary trauma?
10. Have you experienced secondary trauma while working as a trauma therapist? If so, when was the last time you experienced secondary trauma? What was that like for you?
11. How do you currently manage or address the effects of working with clients who have experienced ongoing trauma?
12. Do you find these strategies as helpful and/or successful?
13. How has this changed throughout your career?

- Mindfulness Practice related questions:

1. How would you define or describe your mindfulness practice?
2. Do you currently practice yoga and/or meditation as apart of your mindfulness practice?
3. How long have you been active in your mindfulness practice?
4. What are some reasons why you practice mindfulness?
5. Do you plan on continuing your mindfulness practice?
6. How has it impacted your life?
7. Is there a relationship between your mindfulness practice and your work as a trauma therapist? Please describe.
8. Has your mindfulness practice changed your experiences of sitting with clients while discussing their trauma? If so, in what ways?
9. Did you start your mindfulness practice after your mental health profession? If so, do you feel it has changed your mental health practice? If so, how?

*Final Questions:

1. In one word how would you describe your work as a trauma therapist?
2. In one word how would you describe your mindfulness practice?

APPENDIX C

INFORMED CONSENT LETTER

Dear Potential Research Participant:

My name is Elizabeth Reinecke. I am conducting a qualitative study that involves interviewing trauma therapists in order to explore their impressions of the relationship between a trauma therapist's mindfulness practice and their experiences with secondary trauma. This research is being conducted as part of the thesis requirements for my Master of Social Work degree at Smith College School for Social Work and future presentations and publications.

Your participation is requested because you have been identified as a trauma therapist in the field of direct service work with clients who have experienced trauma. You have also been identified as a trauma therapist who practices mindfulness. If you choose to participate, I will conduct an individual interview with you. I will ask you to provide demographic information about yourself, such as your age, where you are from, how long you have been a trauma therapist, the population with whom you work, etc. I will then interview you regarding your ideas about your yoga and/or meditation practice, the presence of this mindfulness practice in your day-to-day life, your experiences of secondary trauma, if any, and whether or not you feel there is a connection between mindfulness practice and your ability to manage the effects of secondary trauma as you work with clients who are diagnosed with PTSD. The interview will be conducted either in person or over the phone. You and I will determine what works best given our respective geographic locations and with consideration to what will be most convenient for you. Interviews will be conducted only after I have received a signed copy of this Informed Consent form. A signed copy will then be either given to you or mailed to you for your records.

The interview will last approximately 60 minutes. In order to ensure participant confidentiality, you will be given a code number, which I will use to identify and store your data. The data will be shared with my research advisor only under the code number given. Strict confidentiality will be maintained, as consistent with federal regulations and the mandates of the social work profession. Your identity will be protected, as your code number will be used in the reporting of the data. Your name will never be associated with the information you provide in the interview. The data may be used in other education activities as well as in the preparation for my Master's thesis. Coding the information, as well as storing the data in a secure file for a minimum of three years will protect your confidentiality. After three years all information will be destroyed unless I continue to need it, in which case it will be kept secured.

The potential risk of participating in this study may be that during the process of answering personal questions you may encounter some difficult emotions and/or feel triggered by the exploration of your secondary trauma history. In the case that you are triggered or feel uncomfortable during this process, you may request to postpone or stop the interview process at any time.

You will receive no financial benefit for your participation in this study. However, you may find it beneficial to explore the relationship between your mindfulness practice and your work as a trauma therapist as it may remind you of the importance of self-care. It may also benefit you to know that your participation may also benefit other therapists' working with trauma as they may learn from the experiences you share.

Participation in this project is entirely voluntary and you may refuse to answer any question I ask at any point during participation in the project. You may also withdraw from the study for any reason at any point up to May 14, 2010, at which point I am required to submit the bulk of my Thesis work to Smith College School for Social Work and will be unable to remove your contribution from the final product of the Thesis work. In order to withdraw from the study, you are asked to inform me of your decision to do so, but not the reasons for doing so. Once Informed Consent has been collected, you must inform me of your decision to withdraw verbally and in writing. If you have any concerns about your rights or about any aspect of the study, I encourage you to contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

SIGNATURE OF PARTICIPANT

SIGNATURE OF RESEARCHER

Table 1

Self-Identified Demographic Characteristics

	001	002	003	004	005	006
Gender	Female	Female	Female	Female	Female	Female
Ethnicity/Race	Chinese/Argentine/ Jewish	Caucasian	Caucasian	Hispanic	Caucasian	Indian
Religion	“Nope”	“Christian...not religious per say”	Christian	“No”	Church of Jesus Christ of Modern Day Saints	“No”

Table 2

Characteristics of Mental Health and Mindfulness Practice

Participant:	001	002	003	004	005	006
Trauma Work Experience	5 yrs	7 yrs	17 yrs	15 yrs	2 yrs	15 yrs
Personal Mindfulness Experience	7 yrs	3 yrs	8-10 yrs	4 yrs	16 yrs	3 yrs
Which came first MH or MP?	Simultaneously	Mental Health Practice	Mental health Practice	Mental Health Practice	Mindfulness Practice	Mental Health Practice
Size of Caseload	210	38	200	9-10 *	2 *	150
Diagnoses	<ul style="list-style-type: none"> ▪ PTSD ▪ Depression ▪ Anxiety 	<ul style="list-style-type: none"> ▪ PTSD ▪ Depression 	<ul style="list-style-type: none"> ▪ PTSD ▪ Depression ▪ Anxiety 	<ul style="list-style-type: none"> ▪ PTSD ▪ Depression ▪ Anxiety 	<ul style="list-style-type: none"> ▪ PTSD 	<ul style="list-style-type: none"> ▪ PTSD ▪ Depression
Estimated PTSD %	50%	50%	75%	35%	100%	100%
Experience with Secondary Trauma	"Flavors of it"	Yes	Yes	Yes	No	Yes
Modalities used for treatment of PTSD (Groups & Individual)	<ul style="list-style-type: none"> ▪ CPT ▪ Psycho-education ▪ DBT ▪ ACT ▪ Psycho-dynamic 	<ul style="list-style-type: none"> ▪ DBT ▪ Relapse Prevention ▪ Mindfulness ▪ "Cognitive approaches" 	<ul style="list-style-type: none"> ▪ Interpersonal psycho-therapy ▪ CBT ▪ CPT ▪ EMDR 	<ul style="list-style-type: none"> ▪ CPT ▪ Crisis intervention 	<ul style="list-style-type: none"> ▪ CPT ▪ Seeking Safety 	<ul style="list-style-type: none"> • Med. Management <p>*Psychiatrist</p>
Word for MH Practice	Intense & Rewarding	Healing	Challenging & Rewarding	Fulfilling	Rewarding	Challenging
Word for Mindfulness Practice	Relaxing	Soothing	Soothing	Essential	Grounding	Healing