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Sexual violence clinicians' views on protective factors for vicarious traumatization : a project based upon an independent investigation

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ABSTRACT

The purpose of this study was to explore sexual violence clinicians' views on protective factors for Vicarious Traumatization. The study sought to understand not only how participants have been affected by conducting therapy with survivors of sexual violence, but also how they and their colleagues are able to maintain their well-being.

In-person and telephone interviews were conducted with twelve licensed clinicians whose caseloads are comprised primarily of survivors of sexual violence. Participants were asked about personal and professional effects of doing clinical work with survivors, intentional practices and innate factors that they find helpful for their well-being, and their motivations for continuing in this work.

Findings suggest that sexual violence clinicians do experience symptoms of Vicarious Traumatization and are able to draw on numerous factors to maintain well-being. Protective factors identified were: *Coping Skills and Self-Care*, *Professional Factors*, *Personal Qualities*, and *Transformation and Meaning Making*. The study's findings yield insights to be explored in future research, including the possibility that there is a common trajectory with regard to Vicarious Traumatization – from initial discomfort and on through learning to protect oneself. The study's findings have implications for clinicians, agencies, supervisors, and educators.

**SEXUAL VIOLENCE CLINICIANS' VIEWS ON PROTECTIVE FACTORS FOR
VICARIOUS TRAUMATIZATION**

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

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2013

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CHAPTER I

Introduction

Sharing the burdens our clients carry has long been considered a crucial component of psychotherapy, but the nature of doing so has shifted over time. As predominant psychotherapeutic models have gradually changed from a “blank slate” approach to one focused more on the intersubjective relationship between therapist and client, it is possible that therapists have become more deeply engaged in their clients’ stories and experiences. Such deeper engagement and empathy can be beneficial to therapeutic outcomes, but can also lead to myriad personal and professional challenges for clinicians. Pearlman and MacIan (1995) point out that in recent decades, use of psychotherapy among particular populations that have experienced trauma, specifically survivors of violence, has greatly increased, creating new challenges for trauma therapists. “This burgeoning population of clients,” they state, “places new demands on both the expertise and the personal resources of psychotherapists...” (Pearlman & MacIan, 1995, p. 558).

Clinicians have long referred to burnout, compassion fatigue, or even secondary traumatic stress to describe the personal and professional challenges associated with conducting psychotherapy and being empathically engaged with clients’ struggles. More recently, however, the term Vicarious Traumatization (VT) was coined to describe the unique impact of hearing and absorbing clients’ traumatic stories. VT more fully considers the pervasive changes in clinicians’ cognitive schemas and emotional well-being that can result from working in such an intimate

capacity with trauma survivors (McCann & Pearlman, 1990). VT has far-reaching impacts that can include not only therapists' personal functioning, well-being and professional satisfaction, but also their capacity to remain empathic and adequately able to respond to the needs of their clients (McCann & Pearlman, 1990; VanDeusen & Way, 2006).

While clinicians working with all types of trauma may experience VT, the study reported here has focused specifically on those clinicians who work with survivors of sexual violence. On a personal level, sexual violence is of particular interest because it has deeply affected individuals in many areas of my life, all of whom deserve competent, empathic, and well mental health professionals to support them. Sexual violence is not only a mental health crisis for those affected, but a public health crisis for US society at large, causing both psychological and physical health effects for the estimated 53 million women and 25 million men who have experienced unwanted sexual contact in their lifetimes (Black et al., 2011). It is also a type of trauma that is stigmatized and misunderstood, leading to unique challenges for both survivors and mental health practitioners.

While previous research has looked extensively at the concept of vicarious trauma, as well as symptoms and risk factors, empirical research on protective factors for vicarious trauma is in short supply. The current study contributes to this necessary area of research by exploring sexual violence clinicians' views on how they and their colleagues can prevent or mitigate VT. Using qualitative methods and interviews with twelve clinicians, the study sought to answer the question, *Which protective factors do clinicians identify as helpful in preventing or mitigating vicarious traumatization that could result from their work with survivors of sexual violence?*

Participants were asked about how working with sexual violence survivors in a psychotherapy capacity has affected their lives and about the factors or practices that have helped

them to maintain their well-being. These twelve clinicians revealed numerous personal and professional experiences with VT, strategies they have found to be helpful, and significant wisdom gained throughout the courses of their various careers. Their subjective experiences will help to inform the understanding of protective factors for VT and to inform future research in this area.

CHAPTER 2

Literature Review

Through an examination of previous literature, I aim to define and contextualize relevant concepts and to locate the current study within an existing and evolving body of knowledge. The concept of Vicarious Traumatization (VT) is explored, both theoretically and empirically, and existing literature on protective factors for VT is examined. This review of literature occurs within the context of a particular type of pervasive trauma - sexual violence. The focus on sexual violence not only provides a more specific body of research within which to explore the concept of protective factors for VT, but also addresses a type of trauma that I believe requires considerably more attention and is significant to me personally as a woman, a feminist, an ally to the survivors in my life, and a student therapist treating survivors of sexual violence. Sexual violence has therefore been examined, both in terms of survivors' symptomatic experiences and the factors that make the healing processes for sexual violence unique from other types of trauma, for both clients and clinicians.

Vicarious Traumatization

Vicarious Traumatization describes changes in therapists' cognitive schemas and sense of self that are the unique result of hearing clients' traumatic experiences (McCann & Pearlman, 1990). Vicarious traumatization may cause helpers to become numb, less able to show empathy and warmth toward clients (McCann & Pearlman, 1990), cynical or detached from client experiences, less strengths oriented, or suspicious of clients (VanDeusen & Way, 2006).

Clinicians may also experience symptoms of VT that have a significant effect on their personal well-being. These symptoms can include imagery and emotions related to client traumatic memories (McCann & Pearlman, 1990), affective states such as anxiety and depression (Cunningham, 2003), and personal relationship difficulties (Pack, 2010) to name a few. These personal and professional effects of VT can cause therapists to leave the field of trauma work altogether or to continue to conduct trauma work despite symptoms, which can be damaging to the therapeutic encounter (Harrison & Westwood, 2009).

Prior to the formulation of the term *Vicarious Traumatization* to describe the changes in cognitive schemas that can occur as a result of working with trauma, cognitive distortions were attributed to burnout or countertransference (McCann & Pearlman, 1990; Trippany, Kress, & Wilcoxon, 2004). Neither of these concepts, however, addresses the specific changes to a therapist's sense of self and worldview that can occur as a result of working with trauma. Further, VT is distinct from burnout or countertransference given the particularly vivid and extreme nature of stories and images shared by trauma survivors (Cunningham, 2003). More recently, the terms Secondary Traumatic Stress (STS) and Compassion Fatigue have been used to describe therapists' reactions to traumatic material, but these terms refer more to symptoms without consideration of the internal and external influences affecting therapists' reactions to traumatic material. Additionally, Vicarious Traumatization is appropriately grounded in theory (Dunkley & Whelan, 2006). Therefore, Vicarious Traumatization is a preferable term to describe the phenomenon of interest in this study.

Theoretical Foundations of Vicarious Traumatization

The concept of Vicarious Traumatization emerged from Constructivist Self-Development Theory (CSDT), which posits that individuals' realities are constructed by their evolving

cognitive schemas. Cognitive schemas, the “cognitive manifestations of psychological needs” (McCann & Pearlman, 1990, p. 137), interact with individuals’ environments and shape their experiences (McCann & Pearlman, 1990; Trippany, Kress, & Wilcoxon, 2004). CSDT grew from a number of psychological orientations, including Object Relations, Self Psychology, and Social Cognitive theories (Moulden & Firestone, 2007). Among the cognitive schemas that can be affected by VT are one’s sense of self and the world, safety, trust, independence, ideas of power, esteem, and intimacy (Hesse, 2002).

Constructivist Self-Development Theory (CSDT) considers VT to be a normal response to hearing client traumatic material over time, framing the resultant changes in cognitive schemas as both pervasive and cumulative (Trippany, Kress, & Wilcoxon, 2004). Applying Constructivist Self-Development Theory to therapist experiences with traumatized clients can help to protect against VT. Specifically, an awareness of changes in cognitive schemas about self, others, and the world can help therapists to mitigate the effects of VT through the implementation of self-care practices (Trippany, Kress, & Wilcoxon, 2004).

Dunkley and Whelan (2006) draw attention to the limitations of CSDT as applied to vicarious trauma. In particular, they note the lack of distinction within CSDT between heightened awareness and cognitive distortion; cognition, they say, can change without necessarily indicating a cognitive schema disturbance (Dunkley & Whelan, 2006). Additionally, they point out that CSDT does not take into account the comprehensive array of possible effects from working with traumatized clients, particularly positive effects that occur in the form of post-traumatic growth. According to Calhoun and Tedeschi (1998), “Individuals’ self-perceptions can be changed to that of a person vulnerable to difficulties in life, but also to that of a person who is self-reliant and capable of coping with difficult challenges” (p. 358). Post-

traumatic growth, they explain, can also occur in the form of a perceived increase in emotional ties, ability to freely express feelings, and understanding of others' pain (Calhoun & Tedeschi, 1998).

Within the psychoanalytic realm, various theoretical frameworks aid in understanding vicarious traumatization. Brian Rasmussen (2005) has applied intersubjective theory, which frames experience as essentially interrelated, to an understanding of VT. Rasmussen states, "If we accept the idea that aspects of emotional trauma in our clients are not fully 'known' until validated by another, then we must acknowledge that the same is true for vicarious traumatization. Changes in the self that are a consequence of vicarious trauma, however subtle or profound, fleeting or enduring, live in the conscious or unconscious interaction between our self and the client" (Rasmussen, 2005, p. 25). Amy Hesse (2002) applies principals of ego psychology, noting that VT may impair ego resources including judgment, the capacity to be introspective, and the ability to maintain clear boundaries.

The latter authors did not specifically apply intersubjective and ego psychological theories to the idea of protective practices that can mitigate vicarious trauma. Constructivist Self-Development Theory, however, provides a solid basis for understanding both the overall phenomenon of VT *and* the idea that awareness of shifting cognitive schemas can serve as a protective factor in itself or encourage protective practices. The proposed study, therefore, has been grounded within the framework of CSDT and will examine how the effects of VT can be mitigated by protective factors. This will be explored within the context of trauma work with survivors of sexual violence.

Sexual Violence

For the purposes of this study, the term *sexual violence* will be defined as “any sexual act that is perpetrated against someone’s will” (Centers for Disease Control and Prevention, 2009), including adult sexual assault and Child Sexual Abuse (CSA). The terms “survivor” and “victim” will be used interchangeably. According to the 2010 National Intimate Partner and Sexual Violence Survey, approximately 1 in 5 women and 1 in 71 men have been raped in their lifetime. Approximately 1 in 2 women and 1 in 5 men have been the victim of sexual violence other than rape. Among female survivors of rape, 79.6% were raped before the age of 25 and 42.2% before the age of 18. Among male survivors, 27.8% were first raped before the age of 10. A majority of male and female victims knew their assailants prior to the assault (Black et al., 2011).

Survivors of sexual assault and childhood sexual abuse may experience numerous symptoms, some of the most common of which are anxiety, depression, anger, dissociation, problems in social functioning, sexual difficulties, and various symptoms associated with increased arousal such as difficulty with sleep or concentration and exaggerated startle response (Foa & Rothbaum, 1998). Studies have shown that nearly half of survivors of childhood sexual abuse (Putman, 2009) and rape (Jaycox, Zoellner, & Foa, 2002) experience symptoms consistent with a DSM IV diagnosis of Post-Traumatic Stress Disorder (PTSD). PTSD is characterized by a response to a traumatic event that involves “intense fear, helplessness, or horror,” accompanied by at least one month of symptoms that include re-experiencing, avoidance of stimuli associated with the trauma, and persistent symptoms of anxiety or increased arousal (American Psychiatric Association, 2000).

Sexual Violence Work and Vicarious Traumatization

Survivors of sexual violence require and deserve qualified, competent, experienced clinicians who can bear witness to their stories. Yet sexual violence work presents unique challenges for clinicians. In her paper examining theoretical orientations of sexual abuse therapists, Margaret Pack (2011) explains that many sexual abuse counselors began to practice in the 1970s and 1980s amidst a lack of theory or research that adequately recognized the needs of both survivors and therapists. Pack states, “Operating in a vacuum in terms of the availability of published knowledge and resources about trauma and recovery...created a field in which professional isolation and vicarious traumatization was an ever-present reality in practice” (Pack, 2011, p.80). Gradually, what Pack describes as the “New Trauma Therapy” began to emerge, combining traditional psychodynamic theories with newer theories that more adequately addressed themes of power, oppression, and social justice that are relevant to understanding and healing from sexual violence. These newer theories, including feminist, empowerment, and strengths-based approaches acknowledged the importance of the therapist’s allowing the client to be in control -- particularly important for survivors of sexual violence whose power has been forcibly removed by their perpetrators. Two of Pack’s counselor-participants described their approaches as ones of “partnership” or being “in solidarity” with clients rather than adopting the role of “expert” (Pack, 2011, p.87).

While Pack’s participants described tremendous benefits to this egalitarian approach, they also described the difficulty inherent in being fully engaged in a partnership with survivors of sexual violence whose stories are frequently stigmatized by society or met by others with skepticism and blame. Pack described the unique challenge this dissonance created for the therapists in her study: “They describe grappling with the societal disbelief and stigma that

surrounded abuse in all its various forms whilst themselves coming to terms with the prevalence of such events occurring across a range of social classes and cultures” (Pack, 2011, p.84).

Bearing witness to painful traumatic material, while difficult, is particularly crucial when society does not adequately acknowledge the trauma.

Myths regarding sexual violence continue to create a culture of victim-blaming in the United States. Representative Todd Akin’s comments during the 2012 election are representative of the type of stigmatizing, misinformed rhetoric that perpetuates the idea that sexual violence is deserved, fabricated, or that victims could or should have prevented their abuse or assault.

Responding to an interviewer’s question regarding his views on abortion in the case of pregnancy from rape, Akin responded, “If it’s a legitimate rape, the female body has ways to try to shut that whole thing down” (Cohen, 2012, para. 2). Likewise, in a 2008 legal case, Superior Court Judge Derek Johnson sentenced a defendant to six years in prison rather than the 16 years requested by prosecutors for the rape of his girlfriend due to his belief that the survivor “didn’t put up a fight.” In the 2008 sentencing hearing, Judge Johnson, who is still on the bench, said,

I’m not a gynecologist, but I can tell you something, if someone doesn’t want to have sexual intercourse, the body shuts down. The body will not permit that to happen unless a lot of damage is inflicted, and we heard nothing about that in this case. That tells me that the victim in this case, although she wasn’t necessarily willing, she didn’t put up a fight (Goffard, 2012, para. 5).

Survivors of other types of trauma, including non-sexual violent crimes, accidents, and military combat, are thankfully less often met with messages from their elected and legal officials that reinforce self-doubt, shame, and judgment. That sexual violence survivors *are* met with these

messages, however, means that having competent, empathic therapists who can bear witness to their stories while protecting themselves from vicarious trauma is all the more important.

In their qualitative study of ten therapists working with children who have been sexually abused, Pistorius, Feinauer, Harper, Stahmann, & Miller, (2008) found that these therapists “bear an immense burden of the trauma for their clients” and find the stories they hear “devastating” (p.186). Participants in their study reported various symptoms, including sadness, a tendency to isolate themselves from others, dissociation, difficulties with emotional and sexual intimacy, and difficulty maintaining boundaries. They also described an altered, more negative worldview after conducting work with child survivors and a more fearful and overprotective approach with their own children. Further, they explain that therapists who work with sexual abuse contend with the unique challenge of being unable to freely discuss the content of their field of practice: “they had to remind themselves that other people are not used to hearing about sexual abuse and either preferred not to discuss the issues or were disturbed by the information” (Pistorius et al., 2008, p.187).

In their mixed methods study of female sexual violence counselors, Schauben and Frazier (1995) found that therapists whose caseload includes a higher percentage of sexual violence survivors were more likely to have disrupted cognitive schemas regarding their beliefs about self and others and more symptoms of PTSD than their counterparts whose caseloads included a lower percentage of sexual violence survivors. Likewise, in a quantitative cross-sectional study, Maddy Cunningham (2003) tested the relationship between type of trauma work and impact on clinicians’ cognitive schemas among 182 individuals holding an MSW degree, selected from the International Society for Traumatic Stress Studies (ISTSS) directory. She found that among her sample, clinicians who worked with sexually abused clients experienced more symptoms of

vicarious traumatization than those who worked with clients with cancer. Specifically, on the Traumatic Stress Institute Belief Scale (TSI), clinicians working with sexual abuse reported more extensive disruption in measures related to their beliefs about the value and worth of others and their sense of how much they can rely on others (Cunningham, 2003).

Cunningham acknowledges a number of limitations in her study, including difficulty measuring clinicians' exposure to trauma, the racially homogenous nature of her sample, and a failure to take into account the personality factors of clinicians that may mitigate or aggravate vicarious trauma. She also suggests that while quantitative studies such as hers have provided some understanding of vicarious trauma, more qualitative studies need to be conducted in order to gain a more detailed and nuanced understanding of clinicians' experiences working with trauma (Cunningham, 2003).

The qualitative study I have undertaken and report on here has aimed to contribute just such detail and nuance. The study's focus on clinicians who work with sexual violence is appropriate given the association described above between this type of work and vicarious trauma in clinicians. It is important because of the particularly insidious effects of sexual violence on survivors and the ongoing societal myths that complicate the process of healing from this type of trauma, both for clients and clinicians. Given the high prevalence of sexual violence in our society, it is extremely likely that clinicians of all kinds and in all settings will encounter survivor clients. A better understanding of how clinicians can prevent or mitigate vicarious trauma will aid in our ability to serve those clients and to maintain our own well-being while conducting trauma work.

Protective Factors

The term *Protective Factor* will be used in this study to mean any factor or practice that prevents, mitigates, or reduces vulnerability for a condition. While significant empirical research on the symptoms and effects of Vicarious Trauma has been published, research on the protective factors that could prevent or mitigate VT is limited in scope and recognized as an area requiring further research (Harrison & Westwood, 2009; Williams, Helm, & Clemens, 2012). The current study has explored the question, *Which protective factors do clinicians identify as helpful in preventing or mitigating vicarious traumatization that could result from their work with survivors of sexual violence?* By exploring this question, I aim to better understand how clinicians working with survivors of sexual violence can enhance their personal well being, the effectiveness of their work with clients, and their longevity in the field of trauma work.

A number of studies identify practices and factors that may mitigate symptoms of vicarious trauma among clinicians. An understanding of these studies, many of which will be summarized here, is useful in order to frame the current exploratory study within an evolving body of research. In their article “Caring for the Carers in the Aftermath of Trauma,” Phelps, Lloyd, Creamer, and Forbes (2009) emphasize the importance of using such research to create strategies that can ultimately reduce the risks associated with conducting trauma work.

Pearlman and MacIain (1995) conducted one of the earliest studies on factors associated with VT. Their quantitative study explored relationships among demographic and personal characteristics (personal trauma history, age, education, income, personal use of therapy), professional and work-related characteristics (supervision, exposure to traumatic material), and psychological well-being in 188 trauma therapists who volunteered for the study. They found that therapists who had a personal history of trauma reported more significant symptoms of VT

than those who did not. Among those who reported a personal trauma history, they found that therapists newer to trauma work had more severe symptoms of vicarious trauma, as measured by the TSI Belief Scale. Those who had been conducting trauma work for the least amount of time and those who were not receiving supervision were found to have the most severe symptoms overall (Pearlman & MacIlan, 1995).

A limitation in the Pearlman and MacIlan study had to do with the nature of sampling and inclusion criteria. The study's sample was comprised of self-identified "trauma therapists"; more specific criteria in terms of professional identity, nature of trauma work, or amount of exposure to trauma survivors were not outlined. The authors reported that this lack of specificity not only impacted their response rate, but also made it difficult to assess how responses would have differed if inclusion criteria had been further defined. (Pearlman & MacIlan, 1995).

In their quantitative study exploring vicarious trauma among clinicians who treat sexual abuse survivors and sexual offenders, VanDeusen and Way (2006) mailed surveys to 1,754 members of the Association for the Treatment of Sexual Abusers (ATSA) and the American Professional Society on the Abuse of Children (APSAC). Their sample consisted of 383 clinicians who returned complete surveys and met the study's criteria. Among clinicians working with both survivors and offenders, those who had less experience working in the field reported greater cognitive disruptions as a result of their work, suggesting longevity of professional experience as a possible protective factor. This finding is consistent with Pearlman and MacIlan's findings. While this study did *not* find an association between a clinician's own history of childhood sexual abuse and vicarious trauma, it did find a significant correlation between other forms of childhood maltreatment and cognitive distortions in the areas of trust and intimacy, as reported by the TSI Belief Scale (VanDeusen & Way, 2006). Additionally, male respondents had

greater cognitive schema disruptions in the areas of self-esteem and self-intimacy than female respondents. Age was also found to be a significant predictor of vicarious trauma, younger clinicians having more severe cognitive disruptions in the area of self-intimacy than their older counterparts (Way, VanDeusen, & Cottrell, 2007).

The authors note as limitations the ethnically homogeneous nature of their sample, the failure to assess the amount of exposure participants had to traumatic material (Way, VanDeusen, & Cottrell, 2007), a low response rate of 33%, and the potential difficulty in respondent recall of historical experience. They suggest that future research should examine personal variables, personality characteristics, coping strategies, and professional variables, including the role of supervision, regular assessment for VT, and professional support (VanDeusen & Way, 2006).

A number of other studies have explored the possibility that professional variables, particularly quality of supervision, can serve as a protective factor. Sommer and Cox (2005) conducted a qualitative study exploring supervision as a mitigating factor for vicarious traumatization among nine sexual violence counselors. They utilized semi-structured interviews, which were transcribed and coded to determine themes. The study found that most participants found it helpful to have a supervisor who actively “acknowledged, validated, or recognized that vicarious traumatization existed” (Sommer & Cox, 2005, p. 126). A majority also referenced the detrimental nature of supervision that disregarded clinicians’ experiences with vicarious traumatization, some participants revealing experiences of feeling shamed in supervision or being afraid to reveal vulnerability. The sample size in this study was rather small, but yielded important information on the subjective lived experiences of the sexual violence counselors interviewed. The authors acknowledge researcher bias, including the principal researcher’s own

professional experience as a sexual violence counselor. They suggest that further studies continue to explore the subjective experiences of sexual violence clinicians and the importance of supervision as a potential route to developing more effective and specialized trauma-focused supervision models (Sommer & Cox, 2005).

In addition to the importance of supervision, past research has suggested that feeling grounded and effective within one's field of practice can be protective in mitigating vicarious traumatization. Pack (2011) conducted a qualitative study examining the historical context surrounding sexual violence counseling and the theoretical ingenuity of sexual abuse therapists. Her findings suggest that knowledge and application of a range of theoretical perspectives and a "critical-reflective" stance as a therapist can lead to increased feelings of professional efficacy and allow clinicians "to remain feeling connected to their value base for practice" (p.90). Therefore, she considers the integration of various theories, and by extension feeling rooted and effective within one's profession, to be a protective factor for VT, increasing what Pack calls "vicarious resilience."

Professional satisfaction was likewise identified as a protective factor in a qualitative study by Harrison and Westwood (2009). This study aimed to identify protective factors present among mental health clinicians who fare well working with trauma survivors. A purposive sampling technique and three-phase in depth interview process were utilized with six study participants. Interviews were transcribed and coded to identify themes and the authors were able to identify nine primary categories of protective factors that, together, appeared to mitigate experiences of Vicarious Traumatization across all of their participants: 1) countering isolation, 2) developing mindful self awareness, 3) consciously expanding perspective, 4) active optimism,

5) holistic self care, 6) maintaining clear boundaries, 7) exquisite empathy, 8) professional satisfaction, and 9) creating meaning (Harrison & Westwood, 2009).

The authors identified a number of limitations in this study. Their sample was small and was limited to clinicians who were peer- and organizationally-nominated, each of whom was well-educated, highly experienced in trauma work, and self identified as “having managed well in this work.” (p. 206). The authors suggest that future research should focus on both those who manage well in the work and those who struggle with VT (Harrison & Westwood, 2009). Taking this recommendation into account, the current study has not limited the sample according to the presence or severity of VT symptoms among clinicians. Further, the authors acknowledge that the clinicians in their sample typically had some variety within their roles at work and did not exclusively work with one type of trauma. “It is not clear,” they state, “why therapists who worked exclusively providing direct service to clients traumatized by a similar type of traumatic stressor did not present for inclusion in this study, but one possible hypothesis may be that they are not managing as well as those who have greater balance in professional responsibility or diversity of clientele” (Harrison & Westwood, 2009, p. 215). The current study has focused on a sample of clinicians who work primarily with one type of trauma to explore how those who do not have such varied roles or caseloads can also mitigate the effects of VT.

Coping skills and self-care are also featured prominently in the literature on protective practices for VT. Kyle Killian (2008) conducted a mixed methods study exploring the experiences of trauma clinicians with regard to stress, resilience, burnout, and self-care. The qualitative portion of the study utilized semi-structured interviews with 20 clinicians who work with survivors of childhood sexual abuse. Self-care practices found to mitigate the personal and professional effects of trauma work included professional processing and supervision, exercise,

spirituality, and spending quality time with friends and family (Killian, 2008). The quantitative portion of Killian's study, conducted with 104 trauma therapists, found that "emotionally positive" coping strategies such as decreasing workload, supervision, and colleague socialization were associated with decreased work stress. Coping strategies and styles were not, however, found to influence overall resilience in trauma work (Killian, 2008).

Like Killian's study, others have found that coping skills and self-care are important means of protecting oneself from vicarious trauma. Pistorius et al. (2008) report that in their study of 10 therapists working with sexually abused children, participants described exercise, sleep, and "tangible hobbies like painting or woodworking" (p.192) as self-care practices they've found to be effective. Other protective factors they mentioned were engaging in one's own personal therapy process, maintaining a sense of humor, and supervision and training within one's agency. Finally, most participants cited their support system, whether colleagues, family, or friends, as a primary means of coping with the effects of their work. "Speaking of the significance of being a witness to her clients' stories," Pistorius et al. state, "one participant added that therapists needed a witness too" (p.190).

As shown in the literature, studies have found a diverse array of factors and practices that may affect a clinician's experience with vicarious trauma. These factors can be categorized into four areas: 1) personal and demographic factors, such as age, gender, education, personal history of trauma, and personal use of therapy, 2) coping skills and self-care, such as exercise, spirituality, and spending quality time with friends and family, 3) personality and existential factors such as self-awareness, optimism, and meaning-making, and 4) work-related factors, such as supervision, years of experience, theoretical orientation, and feeling rooted and effective in one's area of practice. As empirical research in this area continues to evolve and researchers

attempt to gain consensus, a greater understanding of protective factors and their relationship to vicarious trauma is needed. The current study contributes to this evolving understanding by seeking an in depth understanding of the lived experience of clinicians working with one type of prevalent trauma.

CHAPTER 3

Methodology

As shown in the review of relevant literature, an ongoing need for further research that explores protective factors in depth among individual clinicians was identified. The purpose of this study has been to explore sexual violence clinicians' views about protective factors that may prevent Vicarious Traumatization (VT) or mitigate its effects. The study sought to explore the primary research question, *Which protective factors do clinicians identify as helpful in preventing or mitigating vicarious traumatization that could result from their work with survivors of sexual violence?* Other questions pertained to the personal and professional impacts of working with sexual trauma and clinicians' motivations for continuing to work with this population (See interview guide in Appendix C). Given the need for a deeper understanding of this issue, particularly as it affects clinicians who work primarily with one type of trauma, an exploratory study was conducted, utilizing qualitative research methods. In depth, semi-structured interviews and open-ended questions were used to seek a better understanding of the subjective experiences of individual clinicians.

Sample

Participants in this study included 12 psychotherapists who are licensed within their fields of practice. The inclusion criteria outlined that participants would be English-speaking, have worked for a minimum of the previous 12 months with clients who are survivors of sexual violence, have a current caseload consisting primarily (at least 50% of caseload) of clients

affected by sexual violence or childhood sexual abuse, and practice in the United States. During the course of recruitment, the particular criterion regarding length of time working with sexual violence survivors was broadened in the case of one participant who had worked with a different type of trauma previously, coupled with sexual violence work specifically for the six months leading up to the study. The sample included ten female clinicians and two male clinicians, ranging in age from 26 to 69. Nine participants identified as white, two as African-American, and one as mixed race.

Recruitment

Once the study was approved by the Human Subjects Review Committee (HSRC), I utilized a convenience, snowball sampling method to select licensed psychotherapists who met the study's inclusion criteria. Throughout the recruitment period, I was conducting a graduate internship at a metropolitan rape crisis center, which allowed access to a network of area sexual violence clinicians, as well as connections to similar organizations that focus on responding to survivors of sexual violence. Recruitment of participants took place by contacting, by telephone or email, sexual violence clinical service providers to determine interest in taking part in the study, as well as by word of mouth and forwarding of a recruitment flyer by email. Interested individuals were asked to contact me directly. Once a prospective participant contacted me, I reiterated the inclusion criteria for the study. If any individuals indicated that they did not meet the inclusion criteria outlined, they were thanked for their time and notified that they would be unable to participate. If the potential participant indicated s/he qualified and was interested, a copy of an Informed Consent form was mailed to the participant to be signed and returned in a self-addressed stamped envelope. Upon receipt of the Informed Consent, a mutually convenient interview time was selected.

Data Collection

During the interview, I reiterated the purpose of the study and anticipated structure of the interview and answered any questions participants had prior to beginning. Demographic information was collected, including each interviewee's age, racial and/or ethnic identity, and gender, along with information on the clinician's work setting, years of therapy experience, years working with trauma and sexual violence specifically, and percentage of clients who are survivors of sexual violence. The aim of beginning with less intense general and demographic information was to build rapport with the participant before beginning potentially more emotional discussion, as recommended by Rubin and Babbie (2011). Informal conversational interviews followed the collection of demographic data. The interview focused on those aspects of clinicians' personal, professional, social, and environmental lives that they have found to be protective in mitigating vicarious traumatization or increasing their resiliency with regard to conducting trauma work. A flexible approach to open-ended questions was utilized to seek a better understanding of the subjective experiences of individual clinicians and the qualities and factors they experience to be protective when conducting work with sexual violence survivors. Data were collected through detailed note taking and audio recording.

Data Analysis

I myself transcribed the interviews in their entirety and I made memos throughout the interviews and analysis to elaborate on what the transcripts offered. Qualitative narrative data were coded and sorted to determine patterns and themes. Four primary themes of protective factors emerged from the data: *Coping Skills and Self-Care*, *Professional Factors*, *Personal Qualities*, and *Transformation and Meaning Making*. Data were therefore sorted into these thematic areas for analysis. Other themes – for example, about the circumstances that tended to

promote VT -- particularly emerged in response to the interview question about how the work with sexual violence impacted each participant, and this information was also analyzed for recurrent or unusual themes.

Ethical Considerations

A number of ethical concerns were addressed throughout the study. Signed informed consent was obtained from all participants. Participants were notified of the voluntary nature of the study, their rights to refuse to answer any questions, and the possibility of emotional discomfort associated with discussing VT. Because the participants were licensed clinicians, lists of resources for dealing with any resulting emotional discomfort were not provided. Additionally, participants were notified of procedures for withdrawing from the study should they wish to do so and made aware of measures that would be taken to safeguard their identities including the removal of identifying information. Participants were asked to refrain from using identifying information when discussing their clients. Finally, given the qualitative and subjective nature of this study, patterns that emerged from the data are identified and discussed, but are not intended to be used to infer generalizable results.

CHAPTER 4

Findings

The goal of this study was to explore sexual violence clinicians' views about protective factors that may prevent Vicarious Traumatization (VT) or mitigate its effects.

Major Findings

The major findings were that the 12 clinicians in this study who work primarily with survivors of sexual violence have all experienced symptoms of VT and were able to identify a number of personal qualities and factors, as well as intentional practices, that they believe to be protective in preventing or mitigating these symptoms. Protective factors identified included *Coping Skills and Self-Care, Professional Factors, Personal Qualities, and Transformation and Meaning Making*. The reported effects of working with sexual violence survivors and protective factors identified will be discussed in this chapter.

Effects of Working with Survivors

Each interview began with an exploration of how working in a psychotherapy capacity with survivors of sexual violence has affected the lives of participants. Responses indicated that among this group of clinicians, symptoms of VT have occurred as a result of doing this work. In fact, participant 12 shared the opinion that all clinicians who work with this population will experience VT: "It's not... that you don't have vicarious trauma, you are going to have vicarious trauma. It's knowing what to do when that happens to you."

Participants shared a range of opinions on how doing therapy with sexual violence survivors has affected their lives. Many expressed that they struggled to separate their own emotions from those of their clients or to avoid sharing the burden of their clients' painful experiences. Participant 1 described an early career experience of feeling hypersensitive and overly "tuned into everyone's emotions" followed eventually by a period of numbness: "I kind of went to the other end and was just shut down." Participant 4 reported a tendency to be "overly empathetic" and to "absorb a lot of the emotion and distress and anxiety" that clients present in session. "It can be difficult," the participant stated, "to compartmentalize that and then go home and be a functioning human being." Participant 2 similarly spoke of absorbing clients' affective states: "There would be certain days that people would be in crisis, and I would kind of be in crisis the whole evening." Participant 8 also struggled to leave client material at work:

Some stuff that came up for me was I was having a lot of dreams...not necessarily nightmares at all, but my brain, my mind wouldn't quiet down...It was like I was carrying everyone to bed with me in my head, so I would have dreams about them...it was just my concern for them, it wouldn't shut off. So they were living with me.

Another area where participants experienced changes was in their outlook on life.

Participant 4 addressed the systemic nature of clients' presenting problems and the effect of such deep-rooted issues on the therapists' outlook:

I think particularly with our population, it's not just single incidences of sexual violence, it's usually repeated cycles from childhood throughout adulthood, which is very taxing in the sense that a lot of it's more systemic than the situations where it's this random attack and it can be dealt with and then move forward.

Participant 12 also described how this work can affect the therapist's perspective:

I think it makes you feel like there's a lot more, I don't know, sickness, darkness, bad things, you know, than there really are. Because you spend so much of your time dealing with it, it just gets bigger than it really is in the whole big wide world.

Participant 4 shared a similar opinion:

I think I have become more hyper-vigilant, particularly when we do home visits in neighborhoods or walking through large crowds of men. And not that I didn't have that before but I certainly notice it more since I moved here. In general, I have a pessimistic view already of sort of how problematic our society is, but it's certainly been amplified in dealing with the women we work with who not only are survivors of sexual violence but also are very impoverished, you know, dealing with racial tensions, dealing with other factors that are also a form of, I'd say, social trauma. So I think that's very hard to be around and then go home and live my middle class life.

A number of participants expressed evolving understandings of their own safety, the safety of others, and trust in others as a result of doing this work. Some participants also addressed their heightened concerns regarding the safety of children, either their own or others'. Participant 5 stated, "that part of many people that believes that this couldn't happen to me or it couldn't happen to someone I know...that's gone...because you do see it, you know it happens."

Participant 7 also cited an evolving sense of safety as a result of doing this work:

When I go into bathrooms at gas stations, like on road trips and it's just like a cinderblock building that you have to get a key that's on a hanger or whatever, I'm definitely cautious. I'm looking around outside the bathroom, I'm looking inside the bathroom before I go in. I definitely have a heightened sense of awareness in those situations...With my [partner], I definitely have a heightened sense of awareness too. So

things like 'oh, I'll meet you, I'll walk from our house to this restaurant' and it's like no, can you please just take a taxi?...It's hard to put words to this part, but I'm really sensitive to how someone makes me feel. What is my gut reaction, what is my snap judgment. I don't care if it's mean, I just want to know what it is...I've become much more aware of where I'm at too, so if I'm at a party or a restaurant or on a megabus or a train or whatever, I definitely have a heightened sense of awareness about what energy people are giving off and what environment I am in.

Participant 8 shared a similar experience:

This underlying sense of, I have to be vigilant, I have to be careful, and not just about myself but reminding people that I care about to be careful. Because I've heard a lot of scary things and it makes me more cautious. Not paranoid, but I'm definitely vigilant and you know, paying attention. It has come up over the years since I've done this work when I have nightmares about being chased, someone assaulting me, trying to get to me, things like that.

Some participants acknowledged that doing this work has made them more cautious and safety-conscious, but also expressed that this enhanced awareness can be positive. Participant 9 described how working with sexual violence led to a more cautious, yet engaged, parenting style:

I'm a [parent] of two teenage boys. I was extremely protective of them as children. But I think that it made me a better [parent] because I was very involved. I made sure that I didn't leave them in places and with people that I didn't know very well or even sometimes people that I did know very well. It challenged me to make sure that I spent more time with them so that they didn't have to be with other people very often. They went to day care and all of that, but even searching for the appropriate daycare for them,

that was something that was always in my head and in my mind and so I'm always assessing the possibility, particularly as it relates to children.

Participant 5 described how working with sexual violence has led to an increased awareness of intimate partner violence, even in the context of the participant's own relationship:

A lot of my work with sexual violence and domestic violence have been really connected, just that sexual violence can occur within an intimate relationship, with an intimate partner. And...it comes into your mind. I'm with my partner and if there's a disagreement...nothing could ever come anywhere close to violence in our relationship but there are moments when that comes into your mind, that this would be that moment where somebody could get violent, somebody could get forceful.

Participant 6 shared an anecdote regarding an experienced shift in spiritual understanding and thoughts on whether that evolution was connected to this type of work:

I'm an atheist and one of my friends asked me...I grew up Christian...she thought, 'do you think you're an atheist now because of the work that you do?' It was in grad school that I started to identify as that and she was like 'that's such a coincidence, you're in grad school and...' and I was like first of all...I grew up in a Christian family, I didn't know an atheist. And then I went to [grad school] and everyone is atheist or agnostic. So I think I was in a setting where it was more acceptable for me to come out as that, but I think it's tricky, I think part of it has been influenced...I don't buy 'oh, there's a purpose for it, everything happens for a reason.'...it's in some ways like 'if there's a god, how could I believe in you if this is what we're living in'... but at the same time it's not quite that cynical because there's a lot of beauty and hope.

Many clinicians also revealed how working with survivors has impacted them positively. Two participants described developing a greater complexity in the way that they see others' behaviors and having deeper empathy and kindness for people. Participant 6 spoke to this point:

I think also just recognizing the prevalence of it and having more empathy for people who just walk around and someone's rude and snappy, having more of an understanding for what's beneath all that and trying to be more empathetic and recognizing that people, everyone walks around with a lot of baggage...I think it's made me, I don't know, trying to be kinder in a way. And just recognizing what people are potentially feeling, I mean we don't know, but just seeing how people can have rough, aggressive exteriors and through doing this work, it's just really this protective mechanism. So recognizing that and just trying to be a more kind, gentle person...I think this work has made me want to do that more.

Participant 8 shared a similar experience with enhanced tolerance for others, as well as an increased appreciation for life and personal circumstances:

I think another bit personally has been...I'm already a compassionate and sensitive person, but it's made me more compassionate and empathetic and forgiving, because you hear so much sadness and so much grief and just horror that it reminds me how important it is to acknowledge the good in people and the small things because it's difficult to talk to someone about using strengths-based approaches and affirmations when they can't get out of bed. So it reminds me, not how good I have it, because we all have our trauma history, but that today is a little bit better than so and so, and so that can give me a little more energy or whatever I need to get up or to get through the hour or whatever it is if there's something difficult.

Participant 7 also described how this work has resulted in a new appreciation:

I'm just so thankful. I get that life is really fuckin' hard; I get it. And nobody asks for it and it's nobody's fault...I'm just so thankful for what I have all the time. And that doesn't weigh me down actually, I don't feel necessarily a responsibility with that, I just feel like it's a big gift. So when I hold that perspective out in front more, it's almost scary how vulnerable I can make myself in that generative way. I don't take for granted the moments of eye contact with my partner that are just beautiful or even a nice flower or whatever.

Participants were not asked directly about personal trauma histories or how those histories affect their experience with VT. However, half (six) of the participants in the study volunteered that they have a personal connection to sexual violence and many discussed how that impacts their experience of the work. Four participants specifically cited their survivorship as the factor that motivated them to enter the field of sexual violence. One participant stated, "I think for many people who come into this field, it was a way to sort ourselves out at the same time." Participant 8 described how being a survivor herself enhances her ability to connect with clients and have faith in the techniques she employs:

If you are a trauma survivor and whatever that means to you, it gives you a little more insight to, you know, 'I'm sitting here on the couch.' And I've said that to my clients...'I'm seeing you today but best believe I'm seeing my therapist on a regular basis too. I can't do this work and take care of other people if I don't take care of myself.' And it's not about being hypocritical; it's about taking care of myself. But I think my trauma history has played a role in that and seeing myself as being able to not just practice what I preach, but, you know, I use these things. I know this has worked for me, it's worked for

other people, so that's something that's helpful. I try things myself and know that they've worked.

Participant 9 expressed similarly positive outcomes of conducting sexual violence work as a survivor of sexual violence:

I don't think that it has had a negative impact on me...I am a survivor myself, so I believe that it has been very empowering and it has helped me to I think, on a personal level, it has helped me to be able to understand some of my own personal challenges and then from a professional perspective, I just think that it has been very, very good and important work to do and like I said, I have pretty much figured out a way to integrate it into almost all the work that I do.

Another participant, however, addressed not only the motivating aspects of survivorship as a clinician, but also the potential triggers:

I am a survivor of domestic violence and sexual abuse and so I think that's part of my investment in this kind of work but it's also what makes it difficult in the sense that it can be very triggering to me at times. Not all of the time, this population that I work with now is very different than me and their stories are very different. Previously where I worked, the population was demographically more like me and that was a little more triggering for me.

One participant even reported that doing clinical work with survivors facilitated the process of coming to terms with their own survivorship:

I think there was a period of time in about 2010, 2009, where because of all of the stories and because of just working with trauma survivors everyday, the world definitely seemed a lot less friendly and also very much pushed me to start looking at my own history.

When I initially got into the trauma field, I didn't identify as a survivor...just kind of helping people through this I think made me feel a little more ok in kind of going through it myself.

Protective Factors

Following a discussion of how the work has impacted participants, they were each asked some variation of the questions, "How have you been able to maintain your personal and professional well-being while doing this work?" and "What do you find to be protective for you or do you view as being protective for others who do this work?" As anticipated, participants identified various protective factors. Protective factors identified were sorted into four primary categories: *Coping Skills and Self-Care*, *Professional Factors*, *Personal Qualities*, and *Transformation and Meaning Making*, each of which will be examined in more depth throughout this chapter.

Coping Skills and Self-Care

Many participants discussed the importance of being actively and regularly engaged in self-care practices as a means of protecting their well-being while doing clinical work with survivors of sexual violence. Participant 10 cited the value of being "extra aware of the wear and tear" that working with sexual violence as a specialty can create. Participant 7 discussed the importance of self-care practices from the perspective of modeling healthy living for clients and also understanding clients' perspectives:

If I'm saying it's good for them [clients], why shouldn't I do it too? I'm not a survivor of trauma or sexual assault...but these things work and they're researched and they're evidence based so I use them myself too. So that's just the beginning. And then it also helps me understand where the clients are coming from.

In addition to modeling good self-care practices for clients, various participants spoke of the importance of supervisors and agencies modeling good self care for clinicians and working in an agency where self-care is not merely espoused, but practiced as part of the agency's culture.

Participant 1 addressed the difference between learning about self-care in a theoretical sense and experiencing it as part of the daily experience of working in an agency:

I think here, it's not so much like specific trainings, but for instance, how [my supervisor] conducts the meetings and every meeting, we start with taking deep breaths and checking in where we are so it's like having that implemented in a work day and seeing it has been way more helpful than going to a seminar on self care. Because everyone intellectually knows how important it is, but it takes a while to fully integrate.

Participant 5 spoke to the value of having a supervisor who is intentional in creating an environment of self-care:

The supervisor can really set the pace and the environment for how important self-care is. A lot of organizations and supervisors give a lot of lip service to, 'oh you have to take care of yourself'...but then you get down into the field office and everyone's working 12 hour days and you're like 'You guys are so full of shit, you're not modeling it at all.' So I think...it sets it up really nicely if your supervisor is really serious about...modeling that in their own life.

Participant 4 shared a similar experience:

My supervisor...is certainly helpful in that she pushes us to recognize that we are reaching our limit and tries to enforce self-care, which I think doesn't really happen in a lot of places unfortunately. So I feel fortunate that that's promoted here and taken seriously because burnout is certainly a factor in this kind of work and can happen very

quickly and it leads to turnover...It is about taking care of our clients, but it's also about taking care of ourselves.

Participants cited various self-care practices or coping skills that they believed to be helpful in maintaining their well-being, including exercise and body-oriented techniques, spirituality, support systems, meditation and mindfulness, and boundaries. These will each be discussed in further detail in this section. Many participants mentioned that there is no set of practices that work for everyone; rather, finding the specific activities or practices that work to bring joy, calm, or catharsis to the lives of each clinician individually is the key. Among those specific activities cited by participants were cooking, yoga, dance, going out with friends, comedy, cleaning, being organized, writing, and being pampered. Participant 1 even assembled a self-care folder that can be referred to when needed:

In it, among other things, I wrote down a list of 100 things I love in the world, whether it's finding a parking spot right in front of my house or just a hundred things that make me happy. And after a really hard session or when I feel myself being like, 'Oh, the world sucks,' I can go and I just have little reminders.

Participant 10 described an assembled collection of self-care materials:

I...make sure I get my dose of comedy I like. I keep a stash of DVDs, things like Young Frankenstein, my favorite, Blazing Saddles, a lot of Mel Brooks stuff. The kind of things that let you park your brain at the door and laugh. But I think the key is really you have to find out what works for you and to practice it. Find out what works for you and practice it, that would be my short and sweet answer.

Participants also cited the importance of identifying a variety of self-care activities and practices to choose from based on what one needs in the moment. Participant 7 addressed the importance of having such a toolbox of self-care activities:

I can't just tell myself, 'Oh go play some soccer today and you'll be better.' No, it's not like that. When different things are coming up, different issues, different emotional states are coming up for me, I need to do different things. So having a wide range of things to do helps me.

Participant 11 similarly recognized the importance of paying attention to what is needed in the moment:

Sometimes just doing the things that make me feel good, like 'OK, the house is totally and completely trashed but right now I need to spend time with people I care about' and going out instead of staying home. And the opposite is also true, because I know if my house is totally and completely trashed on a regular basis I'm not very productive either and I just stare at it and say somebody should do this and I'm the only somebody here to do it. I think it has to do with recognizing what it is you need in the moment and having a regular routine that's healthy for you.

Physical Well-being. Participants cited physical well-being as an important element of maintaining overall well-being while doing the work that they do. Five participants specifically mentioned exercise as a core element of their self-care routines and a method of releasing stress. Participant 6, whose work is informed by somatic experiencing and other body-oriented therapies, discussed the importance of physical activity as a means of maintaining well-being:

For me, going to the gym five days out of seven, that really helps. I always mix it up with yoga, but also something that feels like strengths-based training that feels strong or some

sort of cardio, I'll sort of crave one of those and again, kind of listening to my body.

[Somatic Experiencing] training has been so helpful for that. What am I needing? Am I needing a yoga class, am I needing to do a weight lifting class where I can feel really strong and powerful, or do I want to go for a run and just get this energy out, so that's been really helpful just to listen to what I'm needing.

Three participants discussed the importance of diet and healthy eating habits. One participant disclosed that periodic abstinence from alcohol is part of a useful physical self-care routine. Three participants cited utilizing a combination of massage, yoga, and other body-oriented practices to enhance their well-being. Participant 1 described how even sleeping habits can play a role in self-care as a sexual violence therapist:

I definitely sleep way more as a person who works with survivors, than I feel like I would if I did not work with survivors. I feel like I need much more time and space to kind of be recharged... I recognize a need to sleep more than I think I normally would, and will make space for that.

Spirituality. Three participants cited spirituality as a protective factor. They described their spiritual base not only as a source of support and comfort while they do this work, but also as a means of finding purpose in their work. When asked about whether doing work with survivors of sexual violence has had an effect on a personal sense of safety or a sense of the safety of others, participant 11 cited faith as a protective factor:

Not really. That sounds like a really flip answer, but for the most part, that's the part that my faith comes into practice and I guess that's a big part of how I handle what I do...I hold my life very lightly. I don't know if that makes sense or not, but it's not the most important thing to me. I feel like I can put myself in situations and not worry if I'm safe

or not, simply because it's not mine to worry about that, it's in God's hands and what's going to happen is going to happen. And if I'm scared for myself, I can't be helpful to who I really need to be helpful to. I know I've been put in the situations that I've been put in for a reason and I can't back down from that reason just because I might be afraid.

Participant 9 shared a similar belief that this work is part of a spiritual purpose:

I'm very spiritual and I think that that is the foundation for it. I believe that this work that I do is part of my purpose, which is why I think that I never wanted to do therapy -- then I ended up doing it anyway. And it turns out now, I think, to be some of the best work that I've ever done because when I enter into a healthy relationship with a client, I am a very spiritual person in that environment.

Active cultivation of support system. Most participants discussed the important role played by their support systems in mitigating the difficult effects of working with survivors. Friends, family, and pets were cited as crucial sources of support and comfort. Participant 1 addressed the role of animals in providing support while doing this work:

I spend a lot of time with my animals, my two cats. I love them, and that's also, it sounds ridiculous, but that's been super helpful -- if I hear a story about a child who's been really hurt, really abused, I can't do anything for that child, but I can go home and treat my little creatures running around with a lot of respect.

Participant 7 credited involvement in a ... group with providing a vital network of support:

I have an endless number of [folks] that I could call right now and say 'Hey I'm having a problem, I'm feeling upset about this or I'm angry about this or I'm sad about this or I'm sort of feeling like I fucked something up and I've got some shame going on, just I need

you to hear me out or whatever.’ So a lot of really great support around emotional processing, emotional intelligence, emotional mastery.

In addition to relying on support systems for general support, participants described utilizing family and friends and networks to help them process their feelings, decompress after a hard day, and disconnect from work. Participant 2 described how having positive personal relationships can counter some of the effects of VT that may arise as a result of working with sexual violence survivors:

I hear so many really bad stories about things that have happened to people...It’s helpful that my personal relationships are healthy and that kind of reinforces my own sense of safety, in my own environment.

Participants discussed the importance of populating their support systems with individuals and networks that are sensitive to their needs as sexual violence clinicians. Participant 8 described personal efforts to do this:

Some people, I don't have to go into a lot of detail with and those are the people that I really talk to about how it affects me...I try to put those kinds of people in my life so that they are supportive. And if they're not [supportive], they're probably not in my life for that reason.

A number of participants described a double-edged sword phenomenon of friendships and social relationships with coworkers who also work with sexual violence. A tension appears to exist between gaining social support from others who understand what you’re going through and also needing distance from work content and conversation. Participant 2 spoke to this dilemma:

A lot of the people I'm closest with are my coworkers so that can be a blessing and a curse, because we end up talking about work when we're together. But also sharing that we do the same type of work and are going through the same things can be helpful too.

Participant 10, who was a police officer prior to becoming a sexual violence therapist, addressed the process of coming to understand the importance of cultivating non-professional social networks when working in emotionally taxing professions:

I learned early on that hanging with other cops and drinking beer and talking about what a crappy world it is was not good self-care... I didn't realize it right away but there was a point, after I was a police officer for 7 or 8 years, I realized that I had to expand my social networks with non-law enforcement people so that I was hearing happy things and I think counselors have to do the same thing. If you're talking with a therapist, you start discussing cases and how injured some people can be, you're going to watch yourself go to an unpleasant place...I learned that you had to put a lot of variety or balance into your life. That's why some police officers are very cynical. They get that way by hanging out with other cops while they're off.

In addition to selectively and intentionally populating support systems, participants described a process of actively cultivating the quality of relationships within their support systems.

Participant 1 addressed efforts to do this:

I have really learned to ask for what *I* need, especially with friends. If someone wants to talk about something and I can't hear it, I can't hear it, and I'll say that.

Participant 11 addressed similar efforts to meet personal needs through help from a support system: "I spend a lot of time with people who help me laugh or cry, whichever I need."

Participant 6 also addressed coming to understand own needs with regard to a support system

that often needed support as well, noting that it has been necessary to come to a place of “recognizing my limits with family in particular or some friends who are like, ‘Oh, you’re a therapist, let me come to you with this problem or that.’”

Meditation and Mindfulness. Four participants cited mindfulness and meditation as important components of their self-care routines. One participant discussed reliance on breathing exercises, which could be done in the car on the way home, as a way to “get switched over at the end of the day.” Participant 12 addressed using meditation and even EMDR (Eye Movement Desensitization and Reprocessing) techniques as a way to achieve grounding between sessions:

I use some centering and I use EMDR on myself if I get overwhelmed by something or I just feel like something was too much for me. Or if I’m dwelling on something. I sort of stop and meditate sometimes between clients if I have a really intense session. Just sort of clear myself and clear the air so I can be fresh with the next one. So whatever it was that we just talked or discussed or worked with doesn’t stick with me.

Setting and maintaining boundaries. Boundaries were a frequently cited means of protecting participants from vicarious traumatization. Participants described various types of boundaries, including limiting traumatic and work-oriented content in their personal lives, maintaining a separation between their work and personal lives, setting limits on caseload, and navigating empathy and overidentification.

Limiting traumatic and work-oriented content in personal life. A few participants described having made decisions to limit the type of media content they are exposed to outside of work, including television, movies, and print media:

I think for a little while I just started seeing trauma everywhere, just all of my friends, I just kind of assumed everyone had a trauma history. And I would, I just literally lived and

breathed trauma, I read all of these books, I was always watching SVU, just doing a ton of stuff like that...I'm very intentional about what I choose to focus on these days. When I go home, I watch nothing serious. I watch *The Office* and *How I Met Your Mother* and things that are just stupid. Everything I read...when I walk out of this office, I no longer am receiving the serious shit that happens in the world. Which means I also don't read the newspaper, so if something big has happened in the world, I hear it from other people. But that has been extremely important for me. It's important for me to tap into the lighter side of life after working on this extreme... (Participant 1).

It has limited what I can tolerate in the news, is where I notice it a lot. I'm much less able to sit and watch the evening news where it's tragedy after tragedy after tragedy. So I notice that, I just can't sit with it as much... even books that I read, just to be aware, be much more conscious of the choices I'm making outside of work. Movies I watch, what I'm taking in (Participant 6).

Participants also described the importance of having hobbies or interests unrelated to psychotherapy and trauma work. Two participants described having to shift the nature of their volunteer work in order to avoid conducting work with trauma survivors both within and outside of work. Participant 6 addressed the outcome of a decision to stop volunteering with trauma survivors after beginning work with survivors professionally:

If [people are] volunteering or doing things in their free time, I think the people I've found are most protected or do the best work, it's [because their free time is] not related to anything trauma-esque.

Separation between work and personal life. Many participants described a process of learning to maintain a separation between their work and personal lives. For some participants,

this involved communication-related strategies such as turning off their work phone when they leave the office or not giving their personal phone number to clients. For many, it involved not doing work from home. Participant 1 described maintaining a current boundary between professional and personal lives, inspired by a previous job that did not allow the setting of such a boundary:

It was my last job before this one...we had separate work phones...and clients would call at many hours of the day and night. It was kind of impossible to do paperwork at work because you were always on the road and there just wasn't enough time, so I was doing a lot of work at home. So professionally...that just got exhausting and I stopped really respecting who I was as a clinical worker. I just, you know, people just kind of hit a limit...I was starting to skip work a little more, I was sleeping more, I just didn't want to go to work...I noticed the impact it had on my clients...I couldn't feel proud of the kind of work I was doing with my clients... I don't believe I was as effective of a therapist, as effective of a friend...the lines between who I was personally and who I was professionally got super, super blurry. So ... it kind of continued to progress and I have now come to a really strict line between my personal and professional life. I do not do work at home.

Participant 2 also described an evolution in the boundary between work life and personal life:

In the beginning...I'd have to process what's going on at work when I got home which I've gotten much...it's been to my benefit to not do that...I think I've gotten a lot better at being able to kind of justify taking the time that I need for myself. In the beginning, it was just easy to kind of throw everything into this job and feel like I needed to devote all

of my emotional energy towards my caseload and not my personal relationships and things like that.

Another aspect of maintaining a boundary between work and personal lives that emerged during the study involved taking time to disconnect from work content throughout the work day.

Participants mentioned various ways that they do this, from leaving 5 minutes between clients, building regular breaks into the day to focus on themselves, checking email or making a quick phone call, getting out of the office, and regularly taking a lunch break. Participant 8 spoke of efforts to disconnect:

I have learned to take breaks, and not just my hour break and even if I don't eat anything, I call someone, I text someone, I check my email, I return back to [my] life, to my reality, and that's always helpful. Even when I'm in between clients, when I have like 10 minutes or 5 minutes, when I don't have an hour break, I'll call someone and I'll say...and there are only certain people I can call that know the drill...I only have 30 seconds, I just wanted to call and tell you that I love you or what are you doing or I'll be home at this time, where I literally disconnect and it's about focusing on what am I going to do when I leave here.

Participant 6 addressed the importance of another aspect of the boundary between work and personal lives - not allowing one's role as a therapist to define them as an individual:

While being a therapist definitely can influence how you see the world and how you interact with people, at times it's also a piece of me and a part of me. Then, other times, I can be fun and silly and stupid and not at all how I would be in my therapist role.

Limiting caseload. Participants described the protective qualities of limiting their caseload, in terms of both content and quantity. Participant 12 described a process of coming to understand limits with regard to the quantity of work that is tolerable:

One of the things I've done is I don't work as much. I have a sort of limit I've discovered and it's about two and a half to three days a week. More than that, I just start to be overwhelmed, but I'm ok as long as it's two and a half or three days.

Participant 6 also addressed finding balance through limiting clinical hours:

I just think there's no choice but if you're going to be in the field, finding a way that allows you to keep doing it. And for me, that's the inspiration but also balance. Like I work 25 hours a week and that's it. I mean, see clients, clinical hours. But even with that, I probably have, I think I have 25 hours blocked off for clients and each week, maybe see 15-20.

Participant 11 also found recognizing limits to be protective:

You have to be able to understand yourself enough to know when to say enough, right now, today, I've had enough and I can't take any more.

Empathy and overidentification. Various participants mentioned a tendency, particularly early in their careers, to be overly empathetic or to share clients' burdens at the expense of their own well-being. Participant 7 shared an opinion on this difficulty:

It's easy to overidentify and it's easy to give too much sympathy, too much empathy and that bleeds through and I get to be messed up professionally. So once that boundary gets crossed professionally, there's a lot of backpedaling to re-establish it.

Participant 5 addressed the process of trying to balance boundaries with therapeutic connection:

Your greatest strength will be your greatest weakness. Our compassion, which is probably one element that makes us interested in this work, is also what will ultimately burn you out... There's a really fine line, you know, because if you are super boundary-guarded, you will have no connection with people you're trying to work with and it's

really going to limit your therapeutic engagement. But then if you have no boundaries, you will get just taken along with the current and at the end of the day, it's not going to be that helpful for the person you're working with.

Participant 11 also mentioned this delicate balance:

One of the best ones [protective personal qualities] I think is being able to set it aside, let it be close enough to you so that you're empathetic, but not close enough that you don't sleep tonight.

Professional Factors

Professional factors emerged as a fundamental area of protective practices for the participants in this study. The professional factors identified as protective have been grouped into three categories to be discussed in further detail: Supervision and agency support, Specialized training, and Variety in professional roles.

Supervision and agency support. The supervisor's role in modeling self-care practices and creating a culture of self-care has already been discussed as a protective factor that emerged from the interviews. All 12 participants agreed that supervision or agency support is a factor that influences their ability to maintain their well-being while conducting work with sexual violence survivors. Participants had various opinions on the specific elements of the supervisory relationship or the agency environment that are particularly protective. Among those mentioned were building cohesion, listening and processing, providing reassurance and validation, discussing motivations with supervisees, helping to set realistic expectations, reframing, and addressing supervisees' countertransference and red flags. Participant 7 spoke to the protective quality of being in a supportive agency:

What's protective is, first of all, knowing the institution has my back... I wouldn't do this work at an agency I didn't trust.

Participant 1 echoed this emphasis on agency support and described experience with a lack of agency support in the past:

I think that when working with sexual violence, it is imperative that you have a supportive agency...Not receiving the kind of support that I needed to be able to really separate my personal and my work life was...I think just sped up the process of vicarious traumatization.

Participant 3, a veteran clinician and current supervisor of many sexual violence clinicians, spoke to the protective role of supervisors for newer clinicians in particular:

So much of it is brand new to people, in addition to working with a family where there's been intergenerational abuse...there may be drug addiction, there may be homelessness, there may be abusive networks involved or criminal networks. So a young clinician walks into that for the first couple of years, and there's so much coming at [that young person], it's not just about sexual violence, it's about there's this whole world I'm sort of engaging in that's different. And I think helping clinicians sort of have realistic expectations. Things don't change quickly, but that doesn't mean we ever give up. Trying to be a role model in some ways to clinicians or a mentor to sort of say, 'The good thing about sticking with this work is learning and becoming more skilled,' and trying not to ever appear burned out to them. Trying to remind clinicians, 'You're at the beginning of your career and that's a good thing, you should be exploring all sorts of things, you should be trying things out, you're going to make mistakes and that's ok, there are very few mistakes that we can't learn from and go on with.' And sort of giving people, not

making them feel pressure to think, 'OK, I have to come in here and I've got to handle it all and make progress with this client and make sure she's never harmed again' ...it's just not realistic.

Participant 3 also addressed the role of the supervisor in building cohesion and creating an environment of peer support:

I really try to do a lot to build cohesion amongst each other because I think, again I say to people 'This is hard work and you've got to count on each other. Now if you think you're just on your own or out on a limb by yourself with 25 or 28 women who have had all sorts of problems, you're not' ...because that's unrealistic again. You know, something big happens, we go out together. Or you know, someone's really sort of re-traumatized and symptomatic, we share that and try to help each other with that because it's too easy to get sort of saturated and feel disempowered as a clinician when you're really trying to *empower* your client.

Participant 2 also addressed the protective nature of peer support in the work environment:

Sometimes people just need to be reassured, validated that how they're handling it is fine. I think a lot of us struggle with the same issues, especially when you're starting out. So we have some more senior people on the team and newer people who are just dealing with the same kinds of behaviors that are typical to deal with.

Participant 12 expressed a similar opinion:

[Peer feedback is] very, very useful. Otherwise, you're just out there, you can get way out in left field sometimes... Just feeling, getting respect and support from the clinicians that you work with, and your boss, that's very useful. If they seem to feel like you're doing something worthwhile, it helps a lot.

Many clinicians who've been practicing for many years reported finding supervision, whether individual or peer-based, to still be helpful. Participant 6 addressed the role that individual or peer supervision can play in providing an impartial, external opinion on your work with clients even after years of clinical work:

Even though I'm fully licensed, I still get supervision, and I think that's a key piece ... a lot of clinicians are like 'Oh, I'm independently licensed, I don't need supervision anymore.' But I don't see a time in my life when I wouldn't want supervision, even if it's peer supervision, because I think it keeps us in check to make sure, 'Is that their stuff coming up or is that really yours?'

Participant 5 described an experience of walking into an initial team meeting at work where the discussion topic was motivation, why the clinicians in the room do the work they do. She further described how having those types of discussions in the workplace can be helpful for clinicians who are struggling to process their work:

I think discussion of...motivation and how we understand the purpose of our work, what that means to us in our own personal lives and that we'll relate to everyone differently...how that is connected to how we see the world and how we see the purpose of our lives here...I think those are really important discussions to have in this type of work. I think that that's a very appropriate discussion to have in the workplace...To me, that 100% relates to how you will kind of metabolize what you're doing.

Participant 10 addressed the supervisor's role in sensing and reading their supervisees and being willing to ask the questions that need to be asked:

Every two weeks we would meet with our clinical supervisor who was a psychologist and we would spend about half the time talking about our clients, but he was a real wise

man...he was very good at sensing what was going on with you in terms of transference and countertransference with you and your client. I remember when I first started working there, I was still thinking more like a cop than a therapist and he said to me, and it was a very valid question, he said “ Do you need to rescue this client?” Just based on how I presented her and he hit the nail on the head. He was always an excellent instructor in that he would always use an anecdotal story about himself kind of experiencing the same thing.

Participant 10 asserted that the supervisor’s role also involves paying attention to signs that their supervisees may be experiencing hardship and a willingness to express those concerns:

If you see telltale things like maybe their marriage is in trouble, maybe they come to work with alcohol on their breath, or if there are signs of substance abuse or if they look exhausted all the time or if they're angry or they don't talk as much as they used to or they never laugh...there are so many things, you just have to be aware of what's going on with your folks and if you're concerned, I always found the best way is to have a sit down with them and let them know that you are concerned.

Specialized Training. A number of participants mentioned the protective qualities associated with specialized training, particularly in body-oriented trauma therapies. Participants reported feeling a greater sense of agency, confidence, and effectiveness when they had specialized training. Participant 7, who has completed training in EMDR, discussed the unique importance of developing technical skill sets as a trauma therapist:

I had to adopt a theory base to treat trauma quickly, because you can’t just fly by the seat of your pants with that...I feel like you have to have some real technical skills, technical know-how and some coaching on that generally in terms of trauma, whereas in general

sort of emotional change behavior that people might want that's not trauma related, I feel like there's more wiggle room. Because there's no chance of re-traumatizing, there's no chance of flashbacks, there's no chance of nightmares, of significant emotional regression and of course even suicide.

When asked about the role that this specialized training plays in the ability to protect oneself from VT, Participant 7 responded:

I think it's huge. It gives me some really solid approach to trauma. So I can just sort of rest in that approach, that it's been tested for years, there are a lot of people out there who know it better than I do...and there's a lot of support. And that it's purposeful, it's structured, so it helps me interpret if I've made a mistake and how big the mistake really is. It helps me just sort of orient my thinking around how to approach this person and how to approach their issues in a way that I wouldn't get if I was making it up a little bit more...I guess another theory would do the same, but I chose EMDR because it really links in the body. The other thing is that when I'm patient with the technique and I follow the protocols, it works, it's worked so far. So seeing that change is huge, a huge protective factor: it means that I'm making a difference, I'm doing something, I'm relieving this person's distress or facilitating that process for them. That's huge, that's the whole point. So it helps me know whether or not I'm doing that, it helps me know how I'm doing that, how I could do that better, faster, slower. It also just gives me that sense that this is what I'm doing and this is what the person's asked me to do, I can do it...so there's competency based in there too and that's a huge protective factor for me. I definitely roll my eyes when I go into meetings of people who want to talk about trauma

and they don't know what they're talking about. I feel sorry for whoever they're working with, really.

Likewise, Participant 6, who has had specialized training in somatic experiencing and other body-oriented therapies, addressed the ability of training to increase confidence and motivation:

Doing trainings...is another big thing. When you feel more confident...it's like 'Oh, I get how to deal with this better' and that motivates me. I'll come back from training and there are a couple of clients who have more awareness, so they'll be like 'Did you just go to training or something? This is new.' And yes, I'm like 'I think this is going to work; can we try this out?' And just to get sort of excited about it and I encourage my clients to approach healing with curiosity and with some sense of, you have to be careful how you approach it, but with fun. Seeing it as an opportunity to explore themselves and get to know themselves better...I think just being able to respect the seriousness of it but also using it as 'It's ok, things will change, things will get better.' Whether that's good interventions and what's this wacky way of looking at your body, just sort of having fun with it, I've found to be healing for me and for clients.

Participant 2 credited training in a trauma-informed group curriculum with increased confidence and feelings of effectiveness with individual clients. This participant also addressed the role that specialized training plays in an ability to understand the root and motivation for frustrating or exhausting client behavior:

I think it always just helps to have a better understanding...we deal with a lot of really difficult behavior and just to understand it and understand where it's coming from and just work on finding empathy through that and not to just be reactive. I think that's been

some of the more challenging part of this job is dealing with difficult people... when you get some better understanding it makes perfect sense why we see the things that we do.

Participant 12 described the role that training in body-oriented trauma techniques played in an ability to re-enter the profession after a significant burnout:

I worked in a very busy clinical setting for the first seven years, the first three being only with children, so the next four being with adults and having a lot of survivors of trauma. And I basically got so burned out that I quit. I quit my job and did nothing for a year. It felt to me at that time that I didn't really know what to do, wasn't really doing a very good job, people weren't really getting better. And I had some horrible stories, I just bumped into some horrible stories. So I quit. But I also went for EMDR therapy training and when I was there, the trainers kind of quickly decided that I was burned out and needed EMDR so they worked with me on some of the things that were just stuck in my brain and helped me to clear a lot of that out, and also gave me great tools to work with people. So I am a whole lot more effective and get a whole lot more accomplished than I used to in talk therapy... I think someone should know how to, well, I think you need some tools for it. You need either EMDR or EFT or meditation, some kind of real tools to help clear trauma.

Variety in professional roles. Some participants described as an important protective factor having variety in their jobs, both in terms of the types of cases they work with and having a combination of clinical and non-clinical work in their jobs. The participants who found this to be protective described finding it helpful to utilize creativity, to have involvement in macro level work, and to have balance. Participant 1 addressed the importance for her of conducting macro

level work within the agency she works for and having the opportunity to utilize skills and talents:

Another thing that I think has been really protective is, especially in this job, being able to work on a more macro level, as well as doing the individual work. I am working on helping to make this agency a more trans-inclusive agency, so being able to try to do big picture changing stuff has been super, super, super helpful...I'm fairly creative and I like making things and developing plans and things like that. So whether it's here at work, developing new initiatives or creating random stuff at home, it's helpful to be able to work on things in that way too.

Other participants addressed the protective nature of having a varied caseload that combines more emotionally demanding and less emotionally demanding clients, as well as clients who allow the clinician to utilize varied approaches and techniques:

[My clients] all share trauma as a theme, that's why they've been assigned to the team I work on, the women's trauma team. But otherwise there's a huge range of people's abilities, so I think that helps balance the work. Sometimes, especially [for] the more therapy oriented people, it can be very mentally draining, emotionally draining. So the other clients can balance it out when you're just figuring out how much money they need for the week or whatever (Participant 2).

When I was working full time and it was a very busy, full time job, I kept children, some children and did some play therapy, and I did like having that in the mix (Participant 12).

Still other participants described finding specific areas of non-clinical work to be more of a risk factor or to be more emotionally taxing. Participant 9 described an experience of feeling drained by responsibilities as an administrator:

It [psychotherapy] actually is the most soothing if you will, work that I've actually done. The other work that I do is much harder in terms of maintaining my sanity. The administrative work that I do, [is] being in charge of our Master's program at my university. Well teaching is not so hard, but definitely being an administrator, any administrative challenges that I've ever had and had to supervise people and problem-solve with staff. Problem solving with staff and getting staff to do what they're supposed to do is harder than doing therapy with people who need help. So I find doing therapy, it is very soothing and very relaxing.

Another participant, Participant 5, described feeling significantly more overwhelmed and frustrated by prevention and macro-oriented sexual violence work than clinical work with survivors:

I think that the times that it's been the most frustrating are the times when I've been not involved not only in sexual violence response, so caring for survivors, but also then working on prevention. And for me personally, the prevention is what burns me out because I'm so overwhelmed by these huge social norms that allow this type of violence to continue to take place.... We're working on trying to stop a violence that has been occurring since the dawn of time...think how recently it was, and even in some pockets of this country now, I mean, that's something that you keep quiet. You don't talk about women being raped, you don't talk about that. And I find that so frustrating. Whereas working one on one with someone, that I understand. It's so much more tangible to me and I can't solve it, I can't make it not have happened but I can provide some small support to this person.

Personal Qualities

Participants were asked if there are any personal qualities or personality factors that they believe can help prevent or mitigate VT when working with sexual violence survivors. Specific qualities such as patience, humor, curiosity, rigor, discipline, and empathy were all cited. Three primary themes of protective personal qualities emerged, however: *Self Awareness and Realization*, *Doing your own work*, and *Openness to vulnerability*.

Self awareness and realization. Nearly all (11 of 12) participants cited self-awareness as a key protective personal quality, though different aspects of self-awareness were mentioned. Some focused on the importance of understanding and acknowledging one's skills, talents, and interests. Some cited understanding how one's own history and schemas affect how one experiences the work, as well as one's own sources of resiliency and coping. Others discussed the importance of having a strong sense of self or a "tough skin." Still others discussed the importance of acknowledging the heaviness of the work and its effects on the clinician, some emphasizing the utility of using the body in order to do this. What united each of the participants' opinions on self-awareness as a personal factor was the sense that the experience of working with survivors of sexual violence is personal and understanding *how* it is personal is incredibly important.

Participant 3, a veteran supervisor of sexual violence clinicians, expressed the belief that self-awareness and reflection are critically important protective measures:

When they are starting to burn out or when they are starting to feel the weight, I really ask them about their resiliency. I always liken it to immunity; how are you keeping yourself healthy from getting the flu? How do we fortify your immunity so that you can be the healthiest you can be? And I think resiliency looks at that: for many clinicians we

all come to this work with our own fabric. We all have varying degrees of resiliency and what we bring to that, our own coping skills, our own schemas, our own sort of what do we need to do in life to be healthy. And I really try to get folks to look at that. Is it about perspective, is it about a spiritual base for you, is it about separating things, is it about making sure that the balance in your life is such that you're addressing the things you need to, to better fortify yourself when you're working here? And there's no perfect pitch or harmony there, I think it's so different for everybody based on what they bring to it. If you experienced loss at a very young age, that's a part of your fabric when you walk in here as a clinician, so you see the world in a different way. Fine, I mean that's expected, so what do you then have to do for yourself that helps you appreciate your view of the world knowing [your] loss at an early age that still helps you do this work everyday instead of walking in here everyday and thinking, "It doesn't matter because things go away and I can't help it and it's out of my control."

Participant 6 spoke to the body's role in the clinicians' ability to track how they are faring with the work:

And I think, the toll on the body...I'll notice after a session, how do I feel? Do I feel completely drained? And I'll take the time to really notice that and that for me has made me more self aware and then, once I have the awareness that that was completely draining or overwhelming, then I can do something about it. I'm not sure I always had that awareness...I definitely find noticing my body and being able to recognize when I'm feeling overwhelmed or upset and not being critical of it. Allowing myself to feel human and feel affected by something and sort of to recognize that and let myself feel it but not get stuck in it. Which is sometimes hard and I think that's a balance that is so personal

and you sort of have to figure out your limits, but so basically not to deny that you're going to be affected by it, but not to let yourself get stuck there.

A number of participants addressed the protective nature of honestly assessing one's skills, talents, and interests and honestly reflecting on strengths and weaknesses:

I started out working for Child Protective Services and that was awful and that's just not me, I can't do it. And I think it's really important -- and trying to support kids immediately after that type of abuse is such important work -- but I hated it and I felt like a cop and it was terrible. And so that was a very difficult time, so I think removing myself from that situation, reevaluating, again allowing the fact that it was not a good fit, that I have a set of skills and interests and talents and I have to try to find the right fit for them. And if it's not the right fit, then that's fine, I'll move on (Participant 5).

I think maybe sometimes people, they don't really process what it is they're good at doing and what it is they're not good at. So they have their good stuff and their bad stuff all intermingled together and one of the things I try to do is I try to do less of the stuff I know I'm not good at so I can have the time and energy to do the things that I am good at. So perhaps it is because people get too over involved and then they start doing things that they're really not good at and it feels like work. And I think anytime you have to do something as much as we have to work but then it also feels like work, I think that is a real issue (Participant 9).

I'm not involved in legislation for child abuse, because I don't really feel like that's something that I can do well and I think I would get burned out doing that, but working with clients one at a time doesn't seem to be something too big for me. The other thing is constantly keeping myself as knowledgeable and as good a therapist as I know how to be

and recognizing that some days I'm not going to be that total and complete, wonderful therapist but other days I am going to be. And more days than not, I am. So I guess that's how I work with it. Not getting so lost in the big picture that I lose sight of the individual and not trying to tackle something that I know is too big for me (Participant 11).

Participant 1 addressed an additional area where self-reflection can be protective in mitigating VT with regard to sexual and emotional intimacy:

When working with sexual violence, you also go through a period of examining your own sexuality and sexual relationships with whoever you're in a relationship with if you're in one. And so that can, that needs to be negotiated. And I think either conversations with a partner or just kind of being more sensitive to things that, if you've heard super horrifying stories, to just be aware of that and so I think that's something else that has, you know, as a result of working with survivors has been something to just contend with I guess (Participant 1).

Doing your own work. A number of participants cited the clinician's own therapeutic process as an important protective factor in preventing and mitigating VT while working with survivors. Seeking one's own therapy was referenced as a way to understand how client material may trigger and/or impact the clinician and to provide a venue to process both personal and professional content. Acknowledging that this is a field in which the professional role requires the worker to be fully engaged with the client's emotions and experience and often to share in their burden, participants noted the importance of having a space that is "just for me" and where "my therapist has to be 100% present for me." One participant also cited involvement in a 12-step program as a means of ongoing self-care and self-reflection. Participant 1 expressed an opinion on the importance of the clinician's own therapy:

I'm in therapy and I recommend all therapists to be in therapy, not only to deal with your own stuff, but to make sure you're figuring out how is this work impacting you, hoping to not experience a similar burnout to what I experienced a few years ago and I think if I had really been looking at the signs and really talking about that in therapy, it would really have gotten to that level of feeling like the world was horrible.

Participant 3, a supervisor, responded to a question regarding which personal qualities have aided those clinicians who have fared well doing this work: "I think people who've done their own therapy before they come into this work and sort of have more of a handle on, again, the colors in their fabric that sort of bring them here." Participant 6 acknowledged that therapy is one important element of modeling the healthy behaviors therapists encourage for their clients:

I just got to a point where I was like, if I'm working with this much Big T trauma, I need to make sure that I'm taking care of myself if I'm going to be helping and supporting other people. So I restarted my own therapy. So I think overall it's made me healthier myself and more aware of my own triggers and my own...what's grounding for me and 'resourcing' my own needs and stuff like that, because I make myself do my own work if I'm asking my clients to do it. Which I think a lot of therapists don't do.

Openness to vulnerability. Many participants mentioned the protective quality of a willingness to be vulnerable with clients and colleagues, to seek help, to be humble, and to remain open to learning.

I think my willingness to seek help and ask for help when I come up against a wall when I felt like I just don't really know where to go from here. I really love doing my own little research...it's helpful to me to go and seek out written knowledge and what's been done and what's been tried. And I try as much as possible to stay open and teachable, like I

know I'm never going to learn everything there is to know about anything. So being willing to learn from other people even if it feels like they don't have as much experience or whatever, I have tried to come to a place where I see every experience as a way to further my understanding of trauma and my ability to be an effective clinician (Participant 1).

I think that an openness, and ability to be vulnerable at times and it's ok, instead of defending against that... Often this team attracts very intelligent, perfectionistic women, which is not unusual and they want to do a good job, they want to seem competent, they want to succeed. And I think getting them to a point where they understand that sometimes to express or show vulnerability to their client is a good thing, it makes them more human. Yeah, a client needs you to be knowledgeable and know what you're doing and competent in a way, but they also need to see that you're another woman who experiences the world and is not perfect and isn't immune to things and would rather walk hand in hand with you rather than be instructive or authoritarian or sort of idealized in a way that is not that helpful. So being ok [that] things don't always work right and it's not because I'm stupid or ignorant or incompetent,' and being able to say that (Participant 3).

I do think that one's ability to make themselves vulnerable in a generative way is really at the center. If you can sort of jump into the fire with these people and open your heart, I think that's really where it begins versus fear or power or something like that (Participant 7).

So being humble enough to know that I'm always learning and that it's a two way street is really important and I say that to a lot of my clients too, especially to my older clients

because I present as youthful and it's this, 'Well can you teach me?' And when I was an intern and I was younger, I was like 'I don't know! What can I teach you?' I was scared as hell. So you know, I'm much more confident to answer those questions, to address their needs, and again reminding myself that I'm competent enough to be in this position and this is how I can help. And yeah, you may teach me some things along the way too, and then we both get something out of it. So I think being humble is important. And being forgiving, you know you don't always do everything right. Being able to acknowledge that and being apologetic. And being able to be flexible moving forward (Participant 8).

Transformation and Meaning Making

All participants in the study had been practicing for at least two years at the time of the interview, half of them for seven years or longer. Many participants described a transformative process associated with their years as trauma therapists, noting that they fare better than they did at the beginning of their careers and are better able to maintain their well-being than they were as new therapists working with sexual violence. Many described a period of burnout or being overwhelmed at some point in their careers and an early inability to manage the intensity of doing therapy with sexual violence survivors. They also described having changed and shifted in various ways over time and becoming more equipped to protect themselves, as well as a greater ability to find meaning and a sense of purpose in their work. Participant 3 reflected on this change that occurs over time and with years of experience, as observed in supervision with young clinicians:

I think that when clinicians start doing this kind of work, it's sort of an acute response that gets, sort of this heightened sense of "It's a cruel world, you can't trust," that kind of thing. I think the nice thing about continuing to do this work and helping women heal or

seeing them make connections with others that they couldn't make previously because of violation, sort of restores that, so it sort of...comes around. This is hard work and it's hard for anybody to stick with for any extended period of time, but I think it's a good thing if you can...it would be very easy [if] doing this for a year or two, to walk away from it and to think there's nothing good in the world, it's cruel, people got dealt a bad hand. And I think sticking with it...it's a very long road to recovery, but being able to do that actually sort of puts the pieces back together, not only for the client or the survivor, but also for the clinician to see that there is health, there is balance, there is a world that people can live in and keep themselves safe.

Other participants spoke to their own processes of learning to manage the work, sometimes after experiencing a significant disruption:

I think that in the beginning I just felt overwhelmed, like people were bringing all kinds of situations to me and I didn't really know how to manage it other than to just take it on myself, take their emotions...bring them home, and now I feel like I can kind of understand where they're coming from and I know better how to manage that (Participant 2).

I feel like if you don't change, then you burn out and leave. I don't think it's possible to do this work and not be changed. And I think that as a person, you're affected by hearing these things that other people go through, and being connected and empathic and present will take its toll because you're hearing these things. So it wouldn't be possible to be in this job the way I was when I first started working in trauma, it just would not be possible because I was just so open, so receptive, took the work home with me all the time, just in terms of thinking about clients and I've seen people who don't change and they leave,

they leave the field. Or they just become completely, almost catatonic as they move through the day...I absolutely think that's a process every trauma therapist goes through...everyone grows (Participant 1).

When I was first doing this work, I definitely went through a period of not feeling safe, of feeling scared a lot...I kind of had divided the world up into survivor-perpetrator. So that's how I was conceptualizing the world. And in order to continue this work, you have to kind of make sense of things...I personally can only handle so much ambiguity before I need to come to some sort of way of making it make sense...the longer that I stay in this field, the more positive stories I hear. I see people as more resilient than I did when I first started working here. So just seeing that has helped to reverse some of the mentality of everyone is either a perpetrator or a survivor (Participant 1).

I'm very good at self care. And I think that that lesson of the importance of that was learned over many years and through a couple of significant burnouts (Participant 5).

I basically got so burned out that I quit, I quit my job, and did nothing for a year. It felt to me at that time that I didn't really know what to do, wasn't really doing a very good job, people weren't really getting better (Participant 12).

Participant 6, a therapist trained in body-oriented techniques, described what it was like to practice prior to developing a routine of tracking emotional reactions to sessions by paying attention to the body:

I think it was a lot harder...well, it's tricky. I think in some ways it was easier, because you could just stuff stuff aside, it was just total denial. It was like 'Oh this isn't affecting me, I'm going on with my own life.' But I think clearly it got to a point where it caught up with me...So in some ways it might have been easier, but with any client that comes

in, you reach this point where you can't tolerate it anymore. And fortunately I didn't quite get there...it was like I *could* get there so it was time to go back to my own work.

Based on participant descriptions of the transformative processes they have undergone over time as sexual violence clinicians, two primary areas of transformation seem to have taken place: 1) a shift toward active optimism and 2) an adjustment of expectations and reframing of success.

Active Optimism. Harrison and Westwood (2009) described active optimism as “an overarching positive orientation, conveyed in terms of an ability to maintain faith and trust in: (a) self as good enough; (b) the therapeutic change process; and (c) the world as a place of beauty and potential (despite and in addition to pain and suffering)” (p. 211). In line with and expanding about this definition, I use active optimism to refer to actively noticing the positive aspects of the work rather than dwelling on the negative, focusing on resiliency, concentrating on survivorship as opposed to victimhood, and maintaining the belief that clients have the innate ability to heal.

Participant 1 described a personal transformation toward active optimism:

I have begun to frame this work in a more positive way instead of kind of looking at Oh, the tragedy,' and all that stuff, which there absolutely is, but there is also how awesome it is that somebody took a step to break from that silence and shame...if I'm doing what I'm doing I have to believe that healing is always possible. So really holding onto that and picking out after every session, I pick out a couple of super positive things, which has really impacted the way I feel about the profession...And just really understanding that, 'Yes, you survived something, you survived something horrible' and when you think about it that way instead of every horrible little thing that is doomed forever...they are very different ways of looking at people. And so, kind of the more I got out of 'I have to help people, I have to save people' ...but I'm going to facilitate a co-creation and

recreating somebody's empowerment, and they're able to do it. It's just a different way of looking at things. So it's changed who I am, it's changed how I see the world, but I have gotten to a place where it's not the negative, scary place that it was a few years ago...

The more I go through this, the more I see it's kind of like...'Oh my god, it's amazing that I get to be here'... being able to refocus my mind onto picking up and taking the positives home rather than the play by plays and all of that stuff of what happened.

A number of other participants also described their efforts to focus on the positive and the protective qualities associated with doing so:

Working with women everyday who have been victimized as children and as adults makes you at times question humanity, to really think how can one human be as cruel to another human being. But it also I think reaffirms that when you connect to a woman who has been violated and can help her heal from that, sort of restores that faith in humanity. So because of that, I think it makes me feel always hopeful, it makes me feel there's always more to do to help people (Participant 3).

We deal with a lot of really negative things, so just in general having a perspective that change is possible. It may not be immediate or it may not necessarily look the way you expect it to, but hope in the fact that things can change and people can change and grow is important in not having a nihilistic view that things will never go away. Otherwise, I think it's really hard to get out of bed and come here (Participant 4).

It would be easy to be disheartened by the way people are treated by other people. But the other side of that, and it depends on how you look at life...the other side of that was the courage that I saw and the resiliency and the tenacity to continue to try to heal themselves and make their quality of life better in spite of what they experienced. That was always, I

found, to give me strength. One of the things you're looking at, how can we protect ourselves, and sometimes just stepping back and looking at the courage of the client is what helps me (Participant 10).

I took a break two weeks at a time in 2001 and I worked as a contractor for the justice department...we were doing a lot of kind of seed planting in terms of women's rights. So one of the things we had to talk about in a global sense was some of the things that had taken place in Africa and Bosnia and Kosovo where they had actually had rape battalions and the things that they did to use rape as a weapon against the other side by destroying the society, by humiliating the women and under their kind of archaic views, once a woman was dishonored by assault, she was no longer welcome in that family. They would practice gang rapes so the individual would have a high possibility of becoming pregnant and that child of mixed background, the woman would be rejected and the child would be rejected. So it was used as a weapon to destroy their culture, so to speak. I look at that and I just think boy, if I was from another planet and I came down here, I'd paint a big sign on the back of the moon saying 'Stay away, there's no intelligent life here.' But with all of that, again I go back to the courage and the example that some of the people who've experienced those things, just seeking help, I never took for granted how much courage that simple act took. And especially ..., trusting [a male therapist] enough even just to tell their story (Participant 10).

Adjusting expectations and reframing success. Many participants indicated that they had gone through a process over time of recognizing the limits of their role in clients' healing, adjusting expectations, and re-evaluation of what success looks like in the context of therapeutic relationships with survivor clients:

Growing as a clinician to recognize what are my limits, what are within clients' abilities and not to try to force things beyond what is the natural progression. So just kind of finding a balance and being able to be at acceptance with where the person's at in the moment and not to feel like it has to be my responsibility to take on more than that (Participant 2).

Releasing this idea that I have to reach everyone in pain...that's something that when I first started in social work school, it's like 'I'm going to save the world' and that's not possible, not my job. So really just accepting what is, accepting...all right, this is the reality of the world right now, this stuff happens, what can I do to make a small contribution and how can I protect myself so that I am still able to continue making that contribution and enjoy the rest of life, because life is not supposed to be one big trauma...[My supervisor] was good at kind of adjusting expectations and reframing what a success is. Not in a way that's like 'Oh, we really need to have low expectations,' but I was working with one woman who was addicted to crack and I swear it was just so overwhelming to watch her go in and out and in and out. She was tricking on the street and just could not stay clean. So I was talking to [my supervisor] about this and said I feel like I'm not really doing anything and she'd be like, 'One, she's continuing to come so you have become part of that routine where that wasn't there before and something in her realizes that she's worth continuing to come and continuing to try to stay clean and you are providing an alternate narrative to how her story could go. Whereas this woman could be dying, prostituting on the street, she might end up dying with more dignity, whether or not success looks like what you think success looks like.' So really redefining what success looks like...I really use that, especially when people come in and they're

hopeless, it's like 'Well, you're here, one side of you may be saying I want to die, but there's some part of you that doesn't want that because you are here and you're telling me, so let me hear from that part of you.' So I feel like it's really given me access to another part of who people are and another way to look at how to do this work (Participant 1).

I think we all came in, in different ways, but probably with some element of we're going to help people, we're going to fix something, we're going to save someone, and hopefully with time and practice and maturity and probably with some burnout and some tears, you realize you can't really save or fix anything. You can come along side someone, you can certainly contribute your skills and interests, but the weight of that responsibility is not actually on you (Participant 5).

Two of the veteran clinician participants, Participant 9 and Participant 10, who have been practicing for 29 years and 14 years respectively, shared their views on recognizing one's own limits while doing this work:

I enter into therapy or whatever work that I do as a partnership. So I don't take on more responsibility than I should. I challenge my clients to take on the responsibility that they should. And it really is a dual kind of dynamic if you will. So I just really see myself as a facilitator I guess, in that process. I don't overthink it, I don't overdo, I don't over anything. I just help the person as much as I can to get to the place that they're trying to get to (Participant 9).

I looked at each one of my clients kind of like a book. Each one had their own story and your job was helping them just in the particular chapters they were working on at that time and you did whatever you could to hope for a good outcome at the end... I said to

the director, I said to her one time...’How do you keep on going, how do you not get discouraged?’ and she told me an analogy and a metaphor that has always stuck with me and I’ve always used that to remind myself if I’m having a bad time because of what happened to one of my clients. She said, ‘If I look at myself like a ferry boat captain...I pick them up on one shore and they get on my boat and I do whatever I can for them while they’re on my boat and then I know we’re going to get to the other side and they’re going to get off. I hope that I’ve helped them and I’ve equipped them in a certain way to deal with whatever they’re experiencing, but I’m here for them and if they get on the ferry again, I’ll do the same thing over again.’ And I just thought that was a great analogy about how you have to realize that you can only do what you can do at the time (Participant 10).

Capacity to find meaning and purpose. Most participants described feeling a deep sense of purpose in their work. Feeling that the work they do is meaningful was a prevalent protective factor for participants in this study. Some participants mentioned the importance of the support they have personally received in the past and the significance of “paying it forward.” Others cited a sense of personal gratification from this work and feeling a personal calling to work with gender-based violence. One participant even referred to this work being directly related to a personal mission statement that informs meaning in the participant’s life. There was a prominent trend among participants of having made an intentional choice to do this type of work that is difficult and emotionally demanding because it feels meaningful and because from doing so, they derive a deep sense of purpose:

Every social worker I’ve ever met has had some experience with a very deep pain which enables them to connect with other people who are experiencing that pain. When I was

experiencing whatever kind of pain, there were people there who helped me get out of that. And so in a way, it's kind of like, pay it forward kind of thing... It feels, right now, like this is where I'm supposed to be (Participant 1).

As stressful as it can be, there's probably nothing else that I would want to be doing in the sense that I sort of have always felt called to address issues of gender violence and sexual violence and the ways that we as a society have created systems that both perpetuate and sustain those kinds of relationships and perspectives about women and women's bodies. So that's the gratifying side for me is being able to work with someone and have them kind of work toward empowerment, whatever that looks like for them. It's not always an easy process, but I think that's the reason why I continue to do this work (Participant 4).

I would say at the core of everything is a choice that I made to go into it because I believe that I have a larger purpose on the planet than to make money and live my life. And so, that's sort of the foundation, that larger purpose. I've been changing that statement, but it's basically something to the effect of "creating deep connections through generative vulnerability." And when I kind of come back to that statement, it scares the shit out of me and then it's like, yeah this is what I want to do with my life. So having a really focused mission statement or whatever you want to call that, purpose or whatever. So that's like the foundational core and building on that, so the question is 'Am I doing that?' And with the trauma therapy, it's absolutely, I want to be in places...to fulfill that mission I need to be with people who are having crises of meaning in extraordinary circumstances and trauma is that (Participant 7).

Finding meaning in their work involved, for many participants, feeling effective, feeling as though their work is making a difference, and being acknowledged:

I want to help another [client] that walks in here and says ‘Nobody’s ever told me that all I experienced was trauma or that life could look differently than the way I grew up or that I can have a different life.’ I never get tired of thinking that. How do you not want to help someone like that? Even with hearing horrible, horrible stories, and knowing that that badness exists in the world...you only need proof of one person that you see every so often to say “Hey, it’s good to see you again, here’s what I’m doing” (Participant 3).

Seeing people just blossom. And then seeing people continue to come back like I said. To empower them, for them to reach out even when you're terminated to say, like I got a call a couple of weeks ago, from a client that she didn't even finish her sessions here and she just called and said, 'I just wanted to let you know this is what's going on.' She was still strugglin with some of the same issues, but 'I just wanted to tell you'...she said she loved me all the time and she said 'I love you and I'm wishing you and your family great things' and I've never said anything to this woman about my family but she was just so sweet and so open, she gave me a call. One of my other clients who didn't finish but she's in group here, she sent me a happy new year email. So those are the things that keep me coming back and really remind me that I'm doing some kind of good... And it does something for me too, I feel like it makes me, I feel like a better person, I feel like I'm giving back to the world in some way doing this work. I don't have to be in this profession and I don't have to work with this group of people. I've made a conscious decision that I want to do this work and it makes me feel good (Participant 8).

One of the major things about me and how I feel about life is I have a real need to make sure that the world is a better place when I leave than it was when I came. And I don't want to ever stop. I think, so many people, especially my age, talk about retirement. I don't plan on ever retiring...maybe changing my focus, changing the way I do things, changing the environment I do it in, but I don't want to ever stop. It's just so much of who and what I am that I even know how to think about not doing it. I don't know how to think about not doing it (Participant 11).

I don't think you can do it very long if you don't feel like you're getting anywhere. And even, actually, from day to day I notice if my people come in and they're backsliding, feeling suicidal, threatening to kill themselves, sometimes if I have too many of those, I'll just go 'Oh, why am I doing this, I don't know.' And then the next day I might have people come in and they had a breakthrough, they suddenly are feeling differently about something that we've been working on and it's very uplifting. So for me, it very much depends on whether I feel as though I'm accomplishing anything (Participant 12).

I think if I didn't see people getting better, I just could not do this. But the great thing is they do and that feels really, really good...And not just healing from the assault, but seeing, 'Oh they're more open to new experiences, they're more trusting, they're more outgoing, they are picking up interests that they had lost interest in' -- seeing all of that is really helpful (Participant 6).

Connection to a larger social movement. Various participants mentioned that they find meaning in feeling connected to the larger issues of sexual violence and empowerment. For some, doing this work has strengthened their resolve to fight for the empowerment of women and created an increased appreciation and understanding of feminism and the context in which

sexual violence occurs. Participants described this greater connection to the macro issues of sexual violence and to a social movement as motivating and grounding. Participant 3 described how having a connection to the a larger social movement has led to a greater appreciation for the work that they do:

I do think also having a strong commitment to women's services helps. Sort of appreciating from a feminist perspective that it's not just someone that's been raped but that there's a whole kind of context in which violence and sexual violence happens and is permitted...an appreciation for that helps.

CHAPTER 5

Discussion

This study aimed to explore which protective factors clinicians who work with sexual violence survivors identify as being helpful in preventing or mitigating Vicarious Traumatization (VT). While significant research has looked at how working with trauma may affect clinicians, this study intended to address the gap in current research regarding how clinicians are able to maintain their well-being in a field where VT is a reality they face. This study adds to the body of knowledge on protective factors for VT, particularly among therapists who work primarily with survivors of sexual violence. The study's results are valuable, not only in confirming that findings of previous research on protective factors for VT are applicable to this population of therapists, but also in yielding new hypotheses and areas for future research.

Demographics

Twelve psychotherapists participated in this study. Inclusion criteria included being English-speaking, having worked for a minimum of the previous 12 months with clients who are survivors of sexual violence, having a current caseload consisting primarily (at least 50% of caseload) of clients affected by sexual violence or childhood sexual abuse, and practicing in the United States. Eleven of the participants clearly met all inclusion criteria. One male participant, however, had been working primarily with a type of trauma other than sexual violence for three years, coupled with sexual violence work for the six months prior to being interviewed. While

this participant did not meet the criterion of having worked with sexual violence survivors for 12 months, having significant prior experience with trauma and unique understanding of sexual violence work as distinct from that individual's other work seemed to warrant inclusion. Further, his involvement adds a male perspective to what would otherwise have been an N of 1 in the male gender category. In an effort to disguise confidential and potentially identifying information, I omitted gender pronouns and disguised all references to gender except in this instance.

While the study's convenience, snowball sampling method was not a way to ensure a diverse sample, participants covered a variety of demographics. Participants ranged in age from 26-69 and represented clinicians at various stages of their careers, including veteran trauma clinicians, therapists only a couple of years out of graduate school, and career-changers who became therapists following significant life and professional experience in other fields. Racially, nine participants identified as white, two as African American, and one as mixed race.

Effects and Symptoms

The findings of this study confirmed those of earlier researchers that trauma therapists are indeed affected by a wide array of VT symptoms, including cynicism or detachment from client experiences (VanDeusen & Way, 2006), anxiety (Cunningham, 2003), and emotional states and imagery related to client traumatic material (McCann & Pearlman, 1990). As Pistorius et al. (2008) found among the sexual abuse therapists in their study, many therapists in the current study described a tendency to adopt the emotional states of their clients, including sadness, and having difficulty setting boundaries. Like those in Pistorius et al.'s study, the participants in this study have tended to "bear an immense burden of the trauma for their clients" (Pistorius et al., 2008, p.186).

Theoretical Implications

Using Constructivist Self-Development Theory (CSDT) to frame the study proved to be fruitful. While symptoms of VT were not assessed using a quantitative tool such as the Traumatic Stress Institute Belief Scale, cognitive schema areas known to be affected by vicarious traumatization were utilized to develop interview questions and inform data analysis. Further, participants in this study referenced pervasive and cumulative effects of their work with sexual violence survivors on various cognitive schema areas known to be affected by VT (Hesse, 2002; McCann & Pearlman, 1990). Among those referenced most prevalently were sense of self and the world and sense of safety and trust. Interestingly, while participants did describe changes in these schema areas to be pervasive and cumulative, as described in the VT literature (Trippany, Kress, & Wilcoxon, 2004), many also described a transformative process of coming to better manage their well-being in this work over time and with more experience. The implications of this transformative experience will be discussed in further detail later in this chapter.

This study lends credence to Dunkley and Whelan's (2006) criticism of CSDT, that it does not properly allow space for the possibility that cognition can change and awareness of cognitive schema areas can be heightened without that heightened awareness translating to a cognitive schema disturbance or distortion. Many participants in this study reported heightened concerns about their safety and the safety of others and a more discriminating sense of trust. While some described these cognitive changes as troublesome, others described them merely as shifts in their realities. Some even described these heightened states of awareness as positive, particularly concerning their awareness in their roles as parents or romantic partners.

This study also sheds light on some previous authors' (Dunkley & Whelan, 2006; Calhoun & Tedeschi, 1998) suggestions that CSDT does not adequately address the vicarious

post-traumatic growth that can occur as a result of working clinically with trauma survivors. Participants in this study reported gaining a deeper empathy and increased tolerance for others and an enhanced appreciation for their own relationships, circumstances, and privileges as a result of working with survivors of sexual trauma.

Protective Factors

Coping Skills and Self Care. This study confirmed the findings of previous research that coping skills and self-care practices are vital protective factors for VT. Harrison & Westwood (2009) reported that some clinicians in their study “think of self-care in terms of practicing what they teach, or ‘walking my talk’” (p. 211), which was also reported by participants in the current study. This study confirmed the findings of previous research that exercise and sleep (Killian, 2008; Pistorius et al., 2008), spirituality (Killian, 2008; Harrison & Westwood, 2009), mindfulness (Harrison & Westwood, 2009), and spending time with one’s support system (Killian, 2008; Pistorius et al., 2008) are helpful in maintaining clinicians’ well-being. An interesting finding of the current study was that not only is having and utilizing one’s support system an important protective factor among the participants interviewed, but participants specifically cited being intentional and particular about the individuals who make up their support systems and the quality of those relationships -- both in sometimes choosing, and sometimes avoiding, those who do the same work.

The participants in this study confirmed the findings of Harrison & Westwood (2009) that maintaining clear boundaries is an important protective factor in mitigating VT. Many reported doing what Harrison & Westwood referred to as “consciously setting temporal and spatial limits between professional and personal realms” (p. 212), in the form of limiting trauma-related content in the media they consume, the hobbies they participate in, and the volunteer

work they do, and not doing work from home. Further, this study confirmed the findings of various studies (Harrison & Westwood, 2009; Phelps et al., 2009), which found that clinicians who are well protected are able to navigate the difficult balance of being emotionally and professionally engaged with clients without taking the burden of trauma on as one's own.

Speaking of clinicians who are well protected against VT, Harrison & Westwood state,

While remaining highly attuned to clients, they do not engage in emotional fusion or otherwise confuse clients' feelings or experiences with their own. Instead, they maintain firm interpersonal boundaries that are sufficiently permeable to allow them to experience intimate connection within the context of a present-oriented professional relationship 'with the person here and now', without losing personal perspective (p. 212).

Another important boundary that emerged in the previous research (Schauben & Frazier, 1995; Killian, 2008) and was confirmed by this study as a protective factor is limiting the volume of one's caseload. One participant in the current study realized over time that there exists a maximum number of days per week that they can conduct this work while maintaining well-being. Another has learned to limit the number of clinical hours worked.

Professional Factors. The participants in this study confirmed Trippany, Kress, & Wilcoxon's (2004) assertion that being aware of VT and cognitive schema changes in oneself can aid the therapist in mitigating VT symptoms. Many therapists in the current study referenced the importance of not only their own awareness of their well-being, but also the supervisor's awareness of the well-being of their supervisees. They noted the importance of having supervisors who facilitate a culture of self-care within the workplace. Myriad previous studies have identified quality supervision as a crucial protective factor in preventing and mitigating VT among trauma clinicians (Pearlman & McIan, 1995; Sommer & Cox, 2005; Killian, 2008;

Pistorius et al, 2008). Participants in the current study affirmed these findings and pointed to a number of aspects of supervision that they find to be particularly protective. In addition to creating an atmosphere of self-care in the workplace, the findings of the current study suggest that supervisors should model good self-care in their own lives in order to encourage self-care among their supervisees. Participants confirmed the findings of Sommer and Cox (2005) that supervisors who acknowledge and validate the effects of VT and provide proper support in managing those effects are protective for clinicians.

Harrison & Westwood's (2009) study included only participants who identified as "managing well" in this work, none of whom ended up being clinicians who work exclusively with one type of trauma. This led the authors to hypothesize that those who work with only one type of trauma "are not managing as well as those who have greater balance in professional responsibility or diversity of clientele" (p. 215). The current study supports this hypothesis. This study's participants all worked primarily with one particularly pervasive type of trauma, sexual violence, and therefore did not typically have a great deal of variety within their caseload. Many participants were, however, able to find variety within their roles and cited this as a factor that affects their ability to protect their well-being. For the clinicians in this study, variety that is protective takes the form of variation in caseload, work on macro-oriented or larger agency initiatives, using creativity and non-clinical skills, and working with clients at varying stages of healing, including some who are working primarily on activities of daily living rather than in-depth trauma processing. Therefore, even for these clinicians who work primarily with one type of trauma, finding ways to diversify their work and to make room for other activities is protective.

A professional protective factor that was not identified in the literature reviewed for this study but presented prominently in the current study was specialized training. Numerous participants in this study cited the important role that training in trauma-specific and body-oriented therapies, including EMDR and somatic experiencing, play in their ability to help clients, feel confident and effective in their work, and therefore, protect their well-being. One participant even pointed to personal use of body-oriented trauma techniques, including EMDR and EFT, as part of the participant's own efforts at self-protection while doing this work.

Personal Qualities. A number of previous studies identified personal qualities or personality factors, such as a sense of humor (Pistorius et al., 2008), as protective factors or suggested that future research more closely examine personal qualities as possible protective factors (VanDeusen & Way, 2006). Participants in this study were asked if there are any personal qualities or personality factors that they possess or that they've seen in others that they believe protect their well-being while doing this work. The three themes that emerged from responses to this question are supported, to varying degrees, by previous research.

Nearly every participant cited self-awareness as an important protective personal quality. Self awareness, to the participants in the study, meant having an understanding of one's own skills and talents, having a "thick skin," acknowledging rather than denying the personal effects of working with sexual violence survivors, and understanding how one's own history and schemas affect coping and resiliency. As a veteran trauma clinician and supervisor explained, understanding "the colors in their fabric" is protective.

This study also supports the assertion of previous research (Hunter & Schofield, 2006; Pistorius et al., 2008) that clinicians' engagement in their own therapy or similar introspective work can be protective in preventing or mitigating the effects of VT. Finally, this study found

that an ability to remain open to learning and accepting of one's own vulnerability is an important protective factor. Pack (2011) called this a "critical-reflective stance," noting that this stance supports clinicians' ability to feel effective and connected to their profession.

Transformation and Meaning-Making. Some of the more notable findings relate to participants' reports of transformation over time and meaning making. The importance of clinicians' abilities to derive meaning from their work has been well documented (Harrison & Westwood, 2009; Trippany et al., 2004; Phelps et al., 2009), often alongside a discussion of spirituality as a protective factor. While some participants in this study did associate their spiritual grounding with their ability to derive meaning from their work, many cited their capacity to find meaning and purpose in their work as protective independent of any spiritual beliefs. Some participants reported feeling that sexual violence work is a "calling," or "what I'm meant to do." Others found meaning in the work in light of their own personal sexual violence or other trauma history. Still others described finding a personal sense of gratification associated with helping survivors heal and a connection to a larger social movement to be meaningful. Regardless of the source of a clinician's ability to find meaning in the work, all found it to be protective.

Previous studies have cited years of experience (Pearlman & MacIan, 1995; Van Deusen & Way, 2006) as a protective factor for VT and the participants in this study confirmed this finding. The findings suggest a marked trend in the way that the well-being of therapists who work with sexual violence survivors changes over time. Based on participant descriptions, the possibility exists that there is a plateau phenomenon of sorts in which clinicians frequently experience difficulty adjusting to clinical work with sexual violence survivors and eventually

reach a point where they either leave the trauma field because they are experiencing significant VT, or they grow, change and develop new insights that allow them to continue to do this work.

As discussed in the previous chapter, those who are able to go on with this type of work appear to possess the capacity to approach the work with active optimism, a term coined by Harrison & Westwood (2009) whose study also identified active optimism as a protective personal quality. Clinicians who continue as sexual violence therapists also seem to make a transition in the way that they view their work with clients, their role as clinicians, and their definitions of success. This is also in line with Harrison & Westwood's findings. Speaking of clinicians who are well-protected against VT and manage well in this type of work, they state, "[They] hold realistic expectations of self, other, and the world, and do not confuse the ideal with the actual or the likely. They recognize that change unfolds slowly, in small increments, and that larger scale change is a community rather than an individual responsibility" (Harrison & Westwood, 2009, p. 212).

Limitations

A number of limitations were present in this study. First, the study relied on participants' subjective understandings of VT, their interpretations of well-being (both their own and other clinicians'), and participants' memories of their experiences with well-being over time. I chose to explore the concept of VT rather than burnout or secondary trauma given its apt description of the pervasive effects of working with trauma on the clinician and specifically, the cognitive schema changes that occur as a result. However, the qualitative nature of this study did not allow for any objective measure of whether participants were experiencing symptoms of VT. The self-reported nature of symptoms and exploration of clinician experiences in managing the work over time still proved to be useful in framing the discussion of protective measures, particularly as

they have differed even for my small number of participants throughout the course of their careers.

As expected, the small sample size in this study limited the equitable representation of various demographics. Additionally, various protective factors identified in previous research, such as age (Way, VanDeusen, & Cottrell, 2007) and personal trauma history (Pearlman & MacIain, 1995) could not be adequately explored given the nature of this study. While older participants did appear to be better protected from VT, those participants were also veteran trauma clinicians; it is difficult to isolate age as a specific factor separate from years of experience conducting trauma work. In order to avoid intrusiveness or potential discomfort for participants, they were not asked about personal trauma history.

Implications for Practice and Future Research

Protection from Vicarious Traumatization appears to involve neither a set of concrete practices and circumstances nor a specific combination of innate or environmental factors. Rather, it seems to be a process, one that is both individual and collective, involving, among other factors: intentional self-care practices on the part of the therapist, an ability to be self-aware and open to vulnerability, a supportive system of individuals and networks, and a work environment and in particular, a supervisor, that encourages a culture of self care. Further, it is a process that seems to occur over time. Clinicians learn what they need to take care of themselves, what brings them joy and peace, how to balance empathy with emotional boundaries, and many other techniques for maintaining well-being. Additionally, over time, clinicians are able to witness the healing process and understand the impact of their work; time, in effect, “puts the pieces back together” (Participant 3).

Supervisors and employers. The study's findings, and their grounding in previous research, suggest a number of important implications for agencies and supervisors in particular. Kyle Killian (2008) explained that the agency, not the worker alone, has a responsibility for protecting trauma clinicians:

Agencies and organizations could begin to move from focusing on individual workers and their coping strategies, because this focus implies that helping professionals who are hurting are somehow at fault—they are not balancing work and life (i.e., “Just take some leisure time”), or, they are failing to make use of their opportunities for supervision, or educational seminars that focus on individual coping responses. Instead, organizations could proactively take on the task of figuring out ways of distributing workload so that traumatic exposure of any one worker can be limited (p. 42).

Ensuring that employees who work with sexual violence are as protected as possible from VT and are supported to manage the symptoms they experience can not only help agencies to reduce staff turnover, but also to improve the well-being of their employees, the overall work environment, and the quality of the work that takes place with clients. Among the steps that agencies and supervisors can take are creating a culture of self care within the agency, which includes supervisors modeling healthy self-care practices; actively acknowledging VT and its effects; paying attention to employees' well-being and noticing and acknowledging signs of VT; making space to discuss motivations for doing this work; respecting and encouraging boundaries and supporting clinicians in taking time for themselves throughout the day; facilitating collaboration and cohesion among employees; encouraging employees to leave work at the office; supporting clinicians in seeking specialized training in trauma-specific and body-oriented

techniques; validating and reassuring, particularly with young clinicians; and helping to reframe expectations and redefine success.

Future research. A clinician's own history of trauma has been identified previously as a risk factor for VT. While many participants in the current study did volunteer that they were survivors of sexual violence, it was not clear from the information volunteered by participants whether survivorship is itself a protective or risk factor. There did, however, appear to be a connection between survivorship and motivation and meaning-making. It would be worthwhile to further explore this connection. Further, future research should explore whether career changers - clinicians who are older and have significant life and professional experience, but are new to the field of clinical trauma work - are able to protect themselves from VT more easily than younger clinicians in a similarly early stage in their clinical careers.

A limitation of this study involved a reliance on clinicians' subjective interpretations of VT symptoms and protective factors. A mixed methods study among sexual violence therapists could utilize a quantitative portion to assess VT and a qualitative portion to discuss how those symptoms have changed over time and how participants are able to protect themselves. This type of study could also test a number of the findings from the current study among larger sample sizes.

Finally, future research should explore the possibility that there is a natural plateau effect involved in becoming a trauma clinician or sexual violence clinician in particular. Is there a common progression for the sexual violence therapist wherein newer sexual violence clinicians are deeply and empathically engaged, arrive at a point where they are affected by VT and burnout, and then either leave the field or "get over the hump" so to speak and learn to protect themselves? If so, further research on how clinicians are able to do this would be warranted. Is it,

in fact, that clinicians are able to reframe their expectations and definition of success while also actively viewing the work and the healing process more optimistically? Or is it purely time and experience that allows clinicians to continue doing the work? Additional research might specifically target a sample of clinicians who have gone through this process.

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Appendix A

Human Subjects Review Committee Approval Level



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

December 3, 2012

Aasta Heasley

Dear Aasta,

Thank you for making the requested changes. You did a very careful, thoughtful and professional job. Your project is now approved by the Human Subjects Review Committee.

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.

Nice job and good luck with your study!

Sincerely,

A handwritten signature in black ink, appearing to read 'David L. Burton', with a long horizontal flourish extending to the right.

David L. Burton, M.S.W., Ph.D.
Chair, Human Subjects Review Committee

CC: Gael McCarthy, Research Advisor

Appendix B

Screening Questions and Informed Consent Form

Screening Questions

1. Are you currently practicing psychotherapy in the United States?
2. Are you licensed to practice within your field of practice?
3. Would you say that a majority of your caseload is comprised of survivors of sexual violence?
 4. How long have you been working with survivors of sexual violence?

Informed Consent for Research Study

Dear Participant,

My name is Aasta Heasley and I am an MSW student at the Smith College School for Social Work in Northampton, MA. I am currently conducting research for my thesis, which explores protective factors that may prevent or mitigate the effects of vicarious traumatization among clinicians who work with survivors of sexual violence. The Smith College Human Subjects Review Committee has approved this study, which will be prepared as a thesis and used for possible presentation or publication.

Participation in this study will involve a 45-minute interview, which can be conducted in person if convenient or via telephone or skype. With your permission, interviews will be recorded. During the interview, I will ask you to answer some basic demographic questions and to provide general information on your work setting and caseload so that I may accurately describe my overall sample in the thesis report. I will then ask you to describe how working with survivors of sexual violence has affected your life and how you maintain your personal and professional well-being while doing this work. To participate in the study, you must be an English-speaking psychotherapist, licensed within your field of practice, working in the United States, who has spent a minimum of the previous 12 months working primarily with clients who are survivors of sexual violence (at least 50% of caseload). Therefore, excluded from the proposed study are non-English speaking or non-licensed clinicians, those working outside of the US, clinicians who have had only minimal exposure to traumatized clients, and those who do not work primarily with survivors of sexual violence.

Participation in this study involves some risk of emotional discomfort related to discussing how working with survivors has affected your life and work. Benefits of participation, however, include the opportunity to reflect critically on the ways that your work impacts you personally and professionally, as well as to contribute to a body of knowledge that needs to be explored further in order to benefit clinicians' own well-being and longevity in the field, their work with clients, and the psychotherapy profession as a whole. Unfortunately, financial compensation will not be provided for participation.

Your identity and all data collected from the interview, including audio recordings or transcripts, will be kept confidential. My research advisor will have access to the data collected from our interview, but only after your name has been replaced with a pseudonym. Likewise, in publications or presentations, if illustrative quotes or vignettes are included, they will be thoroughly disguised. All data collected from the interview, including data stored electronically, will be kept in a secure location for three years as mandated by federal guidelines. Should data be needed beyond this three year period, it will continue to be kept securely and will be destroyed when no longer needed. I know that you are familiar with confidentiality requirements and will refrain from providing client-identifying information during the interview; if you should inadvertently mention names or other potentially revealing information, I will carefully remove it before the report is written.

Participation in this study is voluntary. You may refuse to answer any question during the interview process and may withdraw from the study until February 15, 2013. Should you choose to withdraw from the study, you will need to notify me by telephone or email, at which point all materials pertaining to you will be immediately destroyed. Should you have any questions or concerns about your rights or any aspect of this study, please contact me by phone [] or email at []. You can also contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at 413-585-7974.

I encourage you to keep a copy of this informed consent form for your records. Please return a signed copy to me by mail at the address listed below or a scanned copy by email.

Thank you for your time and interest in this study.
Warm wishes,
Aasta Heasley

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.

Participant Signature

Date

Participant Printed Name

Researcher Signature

Date

Aasta Heasley

Appendix C

Interview Guide

Demographic and Standardized:

1. Age
2. Gender
3. Race/Ethnicity
4. How many years have you been practicing as a therapist?
5. How long have you been working with trauma?
6. How long have you been working with survivors of sexual violence?
7. What percentage of your caseload in sexual violence survivors?

Open-Ended:

1. How has working with survivors of sexual violence affected you, personally and professionally?
 - a. Relationships with friends and family
 - b. Professional satisfaction and identity
 - c. Sense of personal wellness
 - d. Beliefs about the world or society / Outlook on Life
 - e. Sense of safety or trust
2. How do you maintain your personal and professional well-being while doing this work?
 - a. Personal and professional support systems
 - b. Role of supervision
 - c. Role of training and theoretical grounding
 - d. Variety in professional responsibilities
 - e. Self care
 - f. Personal qualities or personality characteristics
3. If you can imagine someone else who works in this field who you believe fares particularly well while doing this work, are there any practices they engage in or factors about them that are unique that you believe contribute to their well-being?
4. What keeps you motivated to continue doing this work?