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Vicarious traumatization and vicarious resilience : an exploration of therapists' experiences conducting individual therapy of refugee clients : a project based upon an investigation at Family Health Center of Worcester, Worcester, Massachusetts

Megan C. Welsh

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(Family Health Center of
Worcester, Worcester, MA),
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ABSTRACT

The purpose of this qualitative, descriptive study was to explore clinicians' experience of vicarious traumatization and/or vicarious resilience in working with refugee clients in order to gain a better understanding of vicarious trauma and the ways in which clinicians are effected by vicarious trauma. A second purpose of this study was to determine whether or not clinicians experience vicarious resilience in working with this client population, and what, if any, impact the vicarious resilience has on the clinician's treatment modalities, practice style, and personal life.

Twelve face-to-face interviews were conducted at Family Health Center of Worcester with clinicians who had worked with refugee trauma survivors within the past 5 years. Narrative data was gathered that focused on the challenging personal and professional aspects of working with refugee clients, emotional and somatic effects of trauma, changes in personal and professional life, and experiences of overcoming adversity.

One major finding had to do with the mutual experience of being emotionally triggered by their client's reported trauma and undergoing personal and professional changes in response to trauma. Another important finding was that all participants were able to identify intentional

and successful ways of coping with the impact of trauma that ultimately may have allowed them to experience vicarious resilience.

Overall, this study supports previous research, with the findings showing that clinicians may experience both vicarious trauma and vicarious resilience. With a widespread experience of vicarious growth and resilience across participants, this study calls attention to resiliency and the power it may hold in recovery and prevention of clinician burn out. It seems clear from this current study as well as within the reviewed literature that clinicians view refugees as strong, resilient, and able to overcome adversity. Previous research has focused on vicarious traumatization, which seems insufficient in explaining why many clinicians continue to work with this population. This study suggests that focusing on resilience and vicarious resilience can neutralize the arduous experiences of vicarious traumatization, as well as increase experiences of inspiration and motivation.

VICARIOUS TRAUMATIZATION AND VICARIOUS RESILIENCE:

AN EXPLORATION OF THERAPISTS' EXPERIENCES CONDUCTING INDIVIDUAL THERAPY OF REFUGEE CLIENTS

A project based upon an investigation at Family Health Center of Worcester, Worcester, Massachusetts, submitted in partial fulfillment of the requirements for the degree of Master of Social Work.

Megan C. Welsh

Smith College School for Social Work
Northampton, Massachusetts 01063

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CHAPTER I

Introduction

The United States has historically provided a home for those fleeing persecution, but refugees officially began moving to the United States after World War II (United Nations High Commissioner for Refugees, 2014). Since that time, the number of individuals forced to live outside of their country of origin has risen exponentially due to issues of globalization, political conflict, and persecution due to religious beliefs and sexual orientation (Ruiz & Bhugra, 2010). Increased political conflict including Operation Iraqi Freedom, Operation Enduring Freedom, and the Syrian Crisis, contributed to the largest number of refugee and displaced individuals in over 20 years: 41.5 million people (The Guardian, 2014). The United States is a host nation for many refugee individuals and this influx of people brings an influx of trauma. Typically, refugee clients present for medical care with somatic concerns, but after medical attention does not produce symptom resolution, refugees are referred to mental health. Other clients seek therapy when overwhelmed by symptoms of anxiety, depression, and post-traumatic stress.

Refugees present unique concerns to mental health professionals. Not only have most clients been exposed to war time trauma, many refugee clients also worry about family members left behind in danger, struggle with a language barrier, and must adapt to the idea that they will probably never return home (Couch, 2005). Most refugees experience a shattering of the human life experience when subjected to war crimes and torture, causing them to question the meaning of life, and subsequently subjecting their

clinicians to vicarious traumatization (Basham, 2008; Blackwell, 2009; World Health Organization, 1996).

Due to the recent and ongoing influx of refugees, clinicians may experience an increase in refugee clients on their caseloads. In order to provide adequate care, it is important to minimize the effects of vicarious traumatization. One way to do so is to build vicarious resilience. Trauma theories state that resiliency is an aspect of traumatization, suggesting that resiliency could be experienced vicariously, similar to the experience of vicarious trauma (Basham, 2006). This study was an examination of the effects of both vicarious trauma and vicarious resilience on clinicians who worked with refugee clients. A second objective of this study was to explore the impacts of vicarious resilience on clinicians' treatment modalities, practice styles, and personal lives.

Much of the recent literature in this area has focused on the challenges of the refugee population and the impact of vicarious traumatization on clinicians working with trauma survivors. Research specific to working with refugee clients has mainly focused on the potential for vicarious post traumatic growth, with most research conducted outside of the United States (Cohen & Collens, 2012; Guhan & Liebling-Kalifani, 2011). Vicarious resilience is a relatively new concept, so little research exists in this area. Only two studies examined the potential for vicarious resilience in clinicians working with trauma survivors, one of which focused on the refugee population (Barrington & Shakespeare-Finch, 2013; Hernandez, Gangsei, & Engstrom, 2007).

I conducted the study by interviewing 12 clinicians at Family Health Center of Worcester in Worcester, Massachusetts. This sample included LICSW, LCSW, MSW, PhD., and LMHC clinicians and interns who have worked with refugee clients in

outpatient individual, family and/or couples therapy. All participants must have worked with refugees within the past five years to determine if they have experienced vicarious traumatization and vicarious post traumatic growth, and to assess how these experiences might impact their clinical practice and personal lives. I used convenience, nonprobability sampling by emailing clinicians and hanging recruitment flyers in the staff kitchen and lounge. I reintroduced myself as an intern from Smith College School for Social Work and explain the purpose of my study, and ask my colleagues if they are interested in participating in my study. I used an interview guide I have designed to collect data.

Due to the lack of research in this area, the intent of this study is to gain a better understanding of the ways in which vicarious trauma and resilience affect the clinicians that work directly with refugee clients. The results of this study may have the potential to expand the knowledge base for prevention of clinician burn out and other potential negative aspects of vicarious trauma, and may enrich clinical practice by building upon vicarious resilience.

CHAPTER TWO

Literature Review

Trauma theory informs the exploration of the impact of vicarious traumatization and/or vicarious resilience on clinicians who work with refugee clients. Basham (2008) explains that *trauma* is an event or experience that involves the infliction of extreme, everlasting stress. Refugee clients often experience this long-term stress due to exposure to violence present in wartime and political violence (Basham, 2008). The continuous threat to survival referred to as Type III Trauma, impacts refugee clients in a unique way due to the specific needs of this population (Basham, 2008). Not only does trauma impact the client, but traumatic stories also have the potential to vicariously traumatize clinicians (Basham, 2008). According to trauma theories, all clinicians are vulnerable to vicarious traumatization, which shatters belief systems of clients and clinicians alike (Basham, 2008). Trauma theories suggest that resiliency is an aspect of traumatization, and as traumatization can affect clinicians vicariously, this research seeks to discover whether resilience may also vicariously affect a clinician (Basham, 2008).

This literature review first describes the needs and characteristics of refugee clients. Next, vicarious traumatization is discussed in terms of working with survivors of trauma and torture, exploring the ways in which a client's trauma stories may affect his/her clinician. Although little research has been conducted in the field on vicarious resilience, this concept is explored at the end of this chapter. The chapter concludes with a rationale for the current exploratory research study.

Refugee Clients

As previously stated, refugee clients have distinct characteristics and complex needs (Couch, 2005). *Refugees* are individuals forced to live outside of their country of origin, or country of citizenship, and are unable to live with safety and security within that country, and unable to return home (Couch, 2005). Refugees are not war criminals, but are often targets of war crimes due to differences in religious beliefs, political beliefs, or sexual orientation (Ruiz & Bhugra, 2010). Political conflict arises out of globalization, and pushes individuals to relocate (Ruiz & Bhugra, 2010). Typically, refugees experience or witness traumatic events that ignite fear, and drives them to flee their countries to escape further trauma or persecution (Couch, 2005).

Refugee migration process

The forced migration process is another series of traumatic events unique to refugees. Ruiz and Bhugra (2010) described the involuntary transition, beginning when the refugee client first arrives and attempts to integrate with the majority population of the host country. The attempted assimilation into the majority population frequently triggers acculturative stress, which then typically causes refugees to resent and reject the majority population. The majority population marginalizes the refugees, and the subsequent stress, combined with their traumatic experiences, motivates refugees to present as clients in therapy (Ruiz & Bhugra, 2010). As clinicians are typically not refugees and are generally from the dominant population, those who work with refugees must be aware of their cultural and racial differences.

Refugee mental health

Several studies highlight the mental health needs specific to refugee clients (Blackwell, 2009; Couch, 2005; Jamil, Hakim-Larson, Farrag, Kafaji, Duqum, & Jamil, 2002; and World Health Organization, 1996). Refugees enter protective countries from places in which their humanity has been diminished (Blackwell, 2009; Couch, 2005). Loss and death is constant, the meaning of life is minimized, and their relationship to the world changes (Blackwell, 2009).

Jamil, Hakim-Larson, Farrag, Kafaji, Duqum, and Jamil (2002) conducted a study to assess the mental health needs of Iraqi immigrants arriving to the United States after the Persian Gulf War. The researchers reviewed the medical charts of 375 Arabs at a clinic that served both refugee clients and Arab immigrants and found that Iraqi born refugees demonstrated different psychiatric and medical needs than other patients. The rates of post traumatic stress disorder were significantly higher in refugee clients than in other Arab immigrants. Refugees also had significantly higher rates of somatic concerns, depression, anxiety, and substance abuse, which were also corroborated by several other studies (Blackwell, 2009; Couch, 2005; Jamil, Hakim-Larson, Farrag, Kafaji, Duqum, & Jamil, 2002; and World Health Organization, 1996). Substance abuse was virtually absent in other Arab immigrants (Jamil, et al, 2002). Although this study was conducted during the Persian Gulf War and may be similar to current wartime refugees, the research is over 20 years old. Conflict has changed, and it may be that the refugee experience has changed as well. This study is limited to Iraqi and Arab Americans, and may not be representative of the experience of all refugee clients.

Challenges of refugee clients

It can be assumed that refugees experience profound violations of human rights (Couch, 2005). The violations may include multiple inhumane relocations, resettlement in unsanitary camps, witness of killings and torture, and long-term exposure to direct and indirect traumas (Jamiel et al, 2002).

Refugees have multifaceted needs that lead to gaps in services, yet their need of services is often dire (Couch, 2005). Unexpected displacements leave refugee clients to wonder about the wellbeing and whereabouts of relatives. Refugees also experience mixed emotions about resettlement in the receiving countries due to anxiety regarding those left behind, language differences, and adapting to the idea that they will probably never go home (Couch, 2005). Several factors prevent refugee clients from pursuing mental health services. The World Health Organization (1996) noted that cultural factors often prevent refugees from seeking assistance. Due to small population sizes, refugee clients may worry about privacy and confidentiality. Refugee clients often come from cultures that attach a stigma to the outreach for mental health care, preventing them from receiving treatment until symptoms become unbearable (World Health Organization, 1996).

As previously stated, the human life experience has become devalued and often meaningless for refugee clients, as the refugee experience demolishes a sense of self (Blackwell, 2009; World Health Organization, 1996). Refugees may witness lives taken and abused nonchalantly, demonstrating that they and their families are worth less than the ones committing the atrocities. For this reason, clients may struggle to define the meaning of life, what it means to be human, and what it means to survive such torture

(Blackwell, 2009). The shattering of the human experience is the aspect of working with refugee clients that most impacts the clinician and leads to vicarious traumatization (Basham, 2008; Blackwell, 2009).

Vicarious Traumatization

Vicarious traumatization is a potentially negative effect on clinicians who work with trauma survivors (Barrington & Shakespeare-Finch, 2013; Cohen & Collens, 2012; Guhan & Liebling-Kalifani, 2011; Robinson, 2013). Clients' trauma stories may cause disruptive psychological effects on their clinician, evoking strong emotional reactions, intrusive images, and a disruption of established beliefs (Barrington & Shakespeare-Finch, 2013; Cohen & Collens, 2012; Guhan & Liebling-Kalifani, 2011; Robinson, 2013). Clinicians become vulnerable to vicarious traumatization after an empathic engagement with their clients, and as the therapeutic connection is one of the first treatment goals, most clinicians are susceptible to the trauma (Barrington & Shakespeare-Finch, 2013).

Psychological effects of vicarious traumatization

Clinicians who experience vicarious traumatization share a shattering of beliefs, specifically the global belief that bad experiences do not happen to good people, similar to their clients (Barrington & Shakespeare-Finch, 2013; Cohen & Collens, 2012; Robinson, 2013). Cohen and Collens (2012) conducted a study that examines the impact that trauma work has on clinicians who work with trauma survivors. This study consists of a metasynthesis of 20 published articles and utilizes constructivist self-development theory which states that individuals base their perceptions of reality on the experiences of others (Cohen & Collens, 2012). The findings of this study showed that when clinicians

experience vicarious traumatization, their thoughts become negatively altered, heightening emotional and somatic reactions to clients' trauma (Cohen & Collens, 2012).

Similar results were found in a more recent study not included in Cohen and Collens' (2012) metasynthesis study. Robinson (2013) analyzed the effects of ongoing exposure to trauma on clinicians working with refugee clients, interviewing 30 frontline mental health care workers in Australia and the United Kingdom. The sample included social workers, doctors, psychiatrists and nurses and found that all reported high trauma caseloads due to staff shortages. Almost all participants described a negative impact due to little time to cope, leading to high rates of burnout and vicarious traumatization. All participants struggled with feelings of powerlessness in relation to meeting emotional demands and feeling overwhelmingly responsible for the future safety of their clients.

The importance of supervision

Several studies noted the importance of supervision for the prevention of vicarious traumatization (Guhan & Leibling-Kalifani, 2011; Robinson, 2013). The majority of participants in Robinson's (2013) study of mental health workers did not receive any type of supervision and reported feeling alone in their work. Guhan and Leibling-Kalifani (2011) conducted a study in which 12 mental health staff who worked with refugees and asylum seekers in the United Kingdom, were interviewed using the Professional Quality of Life Scale to examine the positive and negative effects of working with this population. The results showed that although most staff members reported a moderate to good level of satisfaction from their work, 25% were at risk for burn out, and 45% displayed symptoms of compassion fatigue due, in part, to limited access to supervision (Guhan & Liebling-Kalifani, 2011). Cohen and Collens (2012)

found other factors that can make a client susceptible to vicarious traumatization. These factors include the clinician's self-care strategies, personal stress, and percentage of trauma cases in his/her caseload, all of which could be processed in supervision.

Robinson (2013) and Guhan and Liebling-Kalifani (2011), emphasize the critical importance of supervision, especially when working with refugee clients who experience high levels of trauma, for surveillance and support. Supervision is important for meaning making of traumatic experiences. Lack of appropriate supervision can account for high turnover rates (Robinson, 2013; Guhan & Liebling-Kalifani, 2011). Robinson (2013) also found other critical needs including access to evidence based practices specific to refugee clients, trainings, and specialists for consultation, though these may be unreachable due to minimal resources.

Vicarious Post Traumatic Growth

Although many people report challenges in working with this population, a spectrum of negative and positive feelings seem to occur simultaneously (Cohen & Collens, 2012; Guhan & Liebling-Kalifani, 2011). These feelings may include anger, frustration and demoralization, as well as satisfaction, gratitude, and compassion (Guhan & Liebling-Kalifani, 2011). Guhan and Liebling-Kalifani (2011) found that most participants in their study mentioned that their clinical work reflects their moral beliefs, leading to personal and professional development, and subsequently feel rewarded by their work (Guhan & Liebling-Kalifani, 2011). Since there were ample positive effects of trauma work with refugee clients, the research team suggests that the concept of vicarious trauma is insufficient for realizing the full effects of trauma work. Meaning

making in supervision and positive experiences, such as work through narrative therapies, allow for a full range of positive and negative effects (Guhan & Liebling-Kalifani, 2011).

Cohen and Collens (2012) found that clinicians who intentionally developed ways to cope with the emotional impact of hearing their clients' trauma stories are less likely to experience long term vicarious traumatization. When clinicians actively work through vicarious trauma, they lower their chance of developing clinician burn out, and have a higher chance of experiencing positive effects (Cohen & Collens, 2012). The results of a few studies showed that positive schematic changes can occur when a clinician focuses on resilience and amazement of experience, and may therefore increase his/her capacity for compassion (Cohen & Collens, 2012; Guhan & Liebling-Kalifani, 2011). Clinicians who find value in watching clients grow in therapy are likely to experience their own personal growth as well (Cohen & Collens, 2012).

As vicarious traumatization occurs through empathic engagement, the aim of the current study is to determine whether vicarious resilience may also occur in a clinical setting. Vicarious resilience appears to be a relatively new concept to the field of social work, and further studies should include an exploration of the potential positive effects of trauma work on clinicians.

Vicarious resilience

Vicarious resilience is defined as the potential positive effects of engaging with a client's traumatic experience in a therapeutic setting on clinicians working with trauma survivors (Hernandez, Gangsei, & Engstrom, 2007). Through vicarious resilience, a clinician may strengthen his or her work by learning to cope with adversity, reflecting on a client's capacity to make meaning of the trauma and heal, developing tolerance to

frustration, and finding motivation and strength for working with trauma survivors (Hernandez, Gangsei, & Engstrom, 2007) Although clinicians may experience vicarious trauma, several studies suggest that vicarious post traumatic growth my lead to vicarious resilience (Barrington & Shakespeare-Finch, 2013; Hernandez, Gangsei, & Engstrom, 2007).

Meaning making

Mann (2005) studied the experience of therapists working with trauma survivors, specifically in the field of child sexual abuse, utilizing the meaning-making model of narrative therapy. Mann explains that when clinicians employ double listening techniques, they gain the opportunity to develop post traumatic growth. Instead of listening to trauma stories alone, narrative theories suggest that clinicians listen for stories of hopes, dreams, and survival (Mann, 2005). Expanding upon stories of strength, such as resisting trauma and attempts to protect loved ones, leads to both client and clinician resiliency (Mann, 2005).

Barrington and Shakespeare-Finch (2013) conducted a study of clinicians working with refugee survivors of torture and trauma, focusing on the meaning making process that clinicians experience when exposed to trauma stories heard in therapy sessions. The goal of this study was to explore whether positive effects could co-occur with negative effects for clinicians working with refugee clients (Barrington & Shakespeare-Finch, 2013). Although clinicians may experience fear, hopelessness, and helplessness, clinicians may also undergo a post traumatic growth process. Barrington & Shakespeare-Finch, (2013) found that it is impossible for a trauma worker to experience traumatic growth without first feeling the effects of vicarious traumatization (Barrington

& Shakespeare-Finch, 2013). As noted by previous research, exposure to trauma stories may initiate a destruction of existing beliefs (Barrington & Shakespeare-Finch, 2013; Cohen & Collens, 2012; Robinson, 2013). Barrington and Shakespeare-Finch (2013) found that all interviewed clinicians who attempted to adjust their existing beliefs found positive changes in life philosophy, relationships, and self-perception. Further research should be conducted to determine whether this post traumatic growth with clients can lead clinicians to experience vicarious resiliency similarly to the vicarious traumatization that occurs through empathic engagement.

Power of Resiliency

Hernandez, Gangsei, and Engstrom (2011) first contrived the term "vicarious resilience" after conducting a qualitative research study evaluating the experience of therapists who work with trauma survivors and their families. Several of the sampled psychotherapists discussed the inspiration and strength they earned from working with trauma survivors, leading the research team to examine whether clinicians can learn to overcome personal adversity through their clinical work (Hernandez, Gangsei, & Engstrom, 2011). Findings of this study showed that working with trauma survivors can have a positive effect on clinicians, especially when attention is brought to the resiliency and expanded upon (Hernandez, Gangsei, & Engstrom, 2011). The elements that make possible vicarious resilience include: witnessing and processing clients' healing capacities, reassessing personal challenges, incorporating spirituality or religion into personal life, developing personal and professional political beliefs, goals and hopes, developing professional boundaries, coping with frustrations and challenges, and

developing a use of self in therapy (Hernandez, Gangsei, & Engstrom, 2011). When these occur, the possibility to develop vicarious resilience emerges.

In order for a clinician to experience vicarious resilience, the client must first develop his/her own resilience within the therapeutic session. *Resilience* is defined as the process of adjusting when presented with trauma, adversity, tragedy, or other sources of extreme stress (Yehuda, Flory, Southwick, & Charney, 2006). Even further, *psychological resilience* is one's ability to recover from a traumatic experience by flexible adaptation (Yehuda, Flory, Southwick, & Charney, 2006). Yehuda and colleagues (2006) found that there are two types of resiliency: 1) resistance, lack of post traumatic symptoms and 2) recovery, an individual's ability to adapt to and cope with psychological injury, which may be taught in therapy. The psychological constructs associated with recovery resiliency include optimism, ability to employ positive reframe, use of coping skills to regulate negative emotions, and mastery, the client's belief that he/she can manage stress (Yehuda, Flory, Southwick, & Charney, 2006). The discovery that resiliency is a learned processes suggests that clients and clinicians could learn the process together. The client learns to adopt resiliency in response to trauma, and during a simultaneous process, the clinician may learn such vicariously. The process of vicarious resilience is an area for further exploration in the current study.

Rationale for Current Study

The examination of the effects of trauma work with refugees on clinicians is becoming increasingly important. Political and military conflicts arise out of globalization, causing an exchange of world views, ideas, and cultures, but also displacing millions of refugees (Ruiz & Bhugra, 2010). Community mental health

centers are now receiving an increasing number of refugee clients with extensive trauma histories, overloading and overwhelming the scare resources and limited clinicians. It is important to protect clinicians working with this population. For that reason, the effects of vicarious resiliency should be further examined to better understand clinician professional satisfaction and to prevent clinical burnout.

CHAPTER III

Methodology

The over-arching research question was: What is the impact of vicarious traumatization and/or vicarious resilience on clinicians who work with refugee clients? The purpose of this study was to gain a better understanding of vicarious trauma and the ways in which vicarious trauma effects clinicians that work directly with refugee clients. A second purpose of this study was to determine whether or not clinicians experience vicarious resilience in working with this client population, and what, if any, impact the vicarious resilience has on the clinician's treatment modalities, practice style, and personal life. This exploration and assessment has the potential to prevent clinician burn out, as well as to enrich clinical practice with refugee clients who have experienced trauma.

Research Design

A review of the literature on vicarious traumatization briefly introduced an emergent topic: vicarious resilience. Vicarious resilience is a relatively new concept, and little research has been done in this area but suggests that if built upon, could minimize clinician burn out. Community mental health centers, specifically the one examined in this study, are receiving an influx of refugee clients. These refugee clients tend to arrive with extensive trauma histories, overloading and overwhelming the scare resources and limited clinicians. It is important to protect clinicians working with this population. For that reason, the effects of vicarious resiliency are further examined in this qualitative, exploratory study.

A qualitative method was used to gather narrative information, so as to capture the lived experience of each clinician interviewed and to gain a deeper understanding of the effects of vicarious traumatization and vicarious resilience. Open-ended questions were used to collect a full reflection of the perspectives of each participant (Rubin & Babbie, 2011).

Sample

Recruitment for this study included clinicians at Family Health Center in Worcester, Massachusetts, who have worked directly with refugee clients within the past five years. This sample includes LICSW, LCSW, MSW, PhD, and LMHC clinicians who have treated this client population in outpatient individual, family, and/or couples therapy. The sample also includes MSW, PsyD, and MA in Psychoanalysis interns working with refugee clients at the time of the interview.

The clinicians at Family Health Center are diverse in race, ethnicity, gender, sexuality and socioeconomic status, and the researcher aimed to include all clinicians and interns in this study. Burn out, as well as symptoms of vicarious traumatization were recurrent topics of group clinical supervision, relating most specifically to work with refugee clients, and have been mentioned by most clinicians. Twelve participants were interviewed in total.

Recruitment

Before recruitment began, the researcher first obtained approval from the Human Subjects Review at Smith School for Social Work (Appendix A). This study used convenience, nonprobability sampling to obtain participants. The director of social services at Family Health Center was contacted to obtain permission to recruit clinicians

(Appendix B). A preliminary email was sent to re-introduce the researcher as an intern from Smith College School for Social Work and to explain the purpose of this research study (Appendix C). The email included an attachment of a recruitment flyer, which was also placed in the staff lounge, staff kitchen, and in each clinician's mailbox (Appendix D). The flyer asked that the participants contact the researcher via phone or email. When contacted by participants, the researcher determined whether or not they met eligibility requirements using a list of screening questions (Appendix E).

Ethics and Safeguards

Protecting confidentiality

Participation has been kept confidential, and neither the fact of his/her participation (or nonparticipation), nor any information provided was disclosed to anyone else at Family Health Center. To ensure privacy, the researcher met participants in a private office in the social service department at Family Health Center. The tapes and transcripts of this study are kept in a secure, locked location separate from the signed consent forms and will remain there for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. Only the researcher, had access to the audio recordings of each interview. The identity of each participant was deleted and each transcript was assigned a numerical code.

Risks and benefits

Participation in this study had the potential to evoke discomfort or distress. Discussing experiencing of vicarious traumatization may be triggering for participants. Participants were reminded at the time of informed consent that they could chose not to

answer particular questions, and that they could stop the interview at any time. At the end of the interview, time was allowed to discuss the interview process. The researcher provided information regarding the Employee Assistance Program at Family Health Center when necessary.

Benefits to the participants included the opportunity to discuss, process, and reflect upon their work. Other benefits included the opportunity to gain more insight to the effects of vicarious traumatization, as well as vicarious resilience. Participants had the potential to learn more about vicarious resilience and how this process may enrich his/her practice.

Presently, there is an influx of refugee clients presenting for therapy at Family Health Center, impacting the caseloads of all clinicians. This exploratory study sought to examine the impact, both positive and negative, on the clinicians hearing the trauma stories. This research may provide insight into the effects of vicarious traumatization and vicarious resilience in working with refugee clients. This insight may inform future practice with refugee clients. This study also holds the potential to enhance understanding and prevention of clinician burn out. The discussion of vicarious resilience, a relatively new phenomenon, also has the potential to strengthen practice in relation to working with refugee clients.

Data Collection

Participants initially contacted the researcher from the email or flyer. From the initial contact, participants were asked purposive, Yes/No, screening questions to determine eligibility (Appendix D). The questions included whether he/she was currently working with refugee clients, or if he/she worked with refugee clients within the past five

years. After the screening occurred, the researcher discussed the interview process, and explained that the interview would last about 45 minutes, occurring in a private office at Family Health Center. The researcher then collaborated with the participants to establish a date and time for the interview. Participants were asked to meet with the researcher for 45 minutes for a guided, in-person interview. Upon meeting for the first time, participants were asked to read and sign the informed consent (Appendix E).

Instrument

Participants were asked to honestly describe their experiences with vicarious traumatization and vicarious resilience as seen in their personal practice using an interview guide (Appendix F). The set of interview questions was created by the researcher, inspired by a similar study conducted by Hernandez, Gangsei, and Engstrom (2007), and expanded upon after a review of the literature. The questions were open-ended and designed for an individual, face-to-face, structured interview format.

Each interview was audio recorded and later transcribed by the researcher. Examples of interview questions included: "What are the most challenging professional aspects of working with refugee trauma survivors? Please describe a time in which you felt emotionally triggered by trauma expressed by a refugee client. How do you cope with the emotional impact of trauma? Please describe an experience in which working with trauma survivors has sparked a change in your personal outlook, or behaviors in your personal life?" and "How has listening to stories of refugee clients who have overcome adversity changed the way you practice clinically?" The questions were grouped under the following categories: clinical background, challenges of working with refugee clients, emotional impact of trauma, personal and professional changes, and overcoming

adversity and vicarious resilience. The questions were designed to explore clinicians' experiences with vicarious traumatization and vicarious resilience, and how working with clients who have experienced trauma impact both their professional and personal lives.

Data Analysis

The method of analyzing the narrative data was content theme analysis (Rubin & Babbie, 2011). The researcher used note taking and tape recording to collect and organize data throughout the interviews. The interviews were transcribed by the researcher and then condensed and organized by question. Responses were then analyzed for each question by reading, and rereading for similar and different categories. Recurring patterns and emergent themes were identified and compared across each transcript. Then, the themes and patterns were documented according to frequency and commonality. Outliers were also identified, as the open-ended nature of the questions allows for an exploration of both commonalities and differences.

In most cases, responses to questions included several different themes. When this happened, more than one theme was recorded. For example, one of the open-ended interview questions asked interviewees about the most challenging personal aspects of working with refugee trauma survivors. Most participants acknowledged multiple challenging aspects of working with refugee trauma survivors and all responses were grouped together and reported. Several patterns were noted among participants who shared common characteristics. For example, many clinicians spoke about their personal experiences with trauma, and these clinicians were more likely to be emotionally triggered by the trauma stories of their refugee clients. Further interpretations of these findings are noted in the discussion chapter.

CHAPTER IV

Findings

Introduction

This chapter contains the findings from interviews conducted with 12 mental health clinicians at Family Health Center of Worcester located in Worcester, Massachusetts. Each participant worked directly with refugee clients, providing individual outpatient psychotherapy, within five years of the interview. The sample included full time, master's level staff clinicians, clinical doctorate of psychology candidates, as well as master's level clinical interns. The interview questions were designed to extract information regarding experiences of vicarious traumatization and vicarious resilience in order to determine whether these phenomena may impact a clinician's treatment modalities, practice style, and personal life.

All participants reported experiencing challenges, personally and professionally in working with refugee clients. Everyone reported the need to develop ways to cope with the emotional impact of trauma, as well as restructuring clinical practice in response to working with this population. Most interviewees reported positive clinical and personal changes after working with this population, and all but two participants explicitly stated his/her belief in the power of vicarious resilience.

The findings are presented according to the order of the interview questions, broken down into five sections (Appendix F). The sections are as follows: clinical background, challenges of working with refugee clients, emotional impact of trauma, personal and professional changes, and overcoming adversity and vicarious resilience.

Clinical Background

Please describe your clinical background and training. This study was comprised of 12 clinical psychotherapists: 10 women and two men. All participants worked clinically with refugee clients within the past five years, but each participant had varying levels of experience and education levels. Three participants were clinical doctorate of psychology candidates. Five interviewees were master level interns; one in psychoanalytic psychotherapy, one in counseling psychology, and three in clinical social work. Three participants were full time, masters level clinical social workers; one MSW and to LICSW. Nine out of 12 participants identified as psychodynamically trained and focused, while the other three participants did not disclose that information. Years of experience varied from two to 20 years.

Challenges of Working with Refugee Clients

This section pertains to the clinicians' responses to questions regarding the difficulties working with refugee clients. The data are presented in two sub-sections: professional and personal challenges.

What are the most challenging professional aspects of working with refugee trauma survivors? Participants responded to the above question under three different identified themes: challenges pertaining to forming a therapeutic alliance with refugee clients, feelings of inadequacy, and the weight of the trauma.

Eight of the 12 participants identified forming a therapeutic alliance as a challenge when working with refugee clients. Half of these clinicians reported that the language and cultural barrier impedes the ability to form a strong therapeutic alliance.

Three participants mentioned difficulty communicating empathy to clients because they could not conceptualize the trauma, exemplified by one clinician's statement, "The biggest challenge professionally is finding a way to empathize with their trauma because a lot of what they have experienced is something I could never even comprehend happening to me, especially in the United States." Other interviewees mentioned difficulty in establishing a sense of trust and an environment in which the clients could allow the vulnerability necessary to process trauma.

Six of the respondents reported that feelings of inadequacy were major professional challenges of working with this client population. Clinicians reported feeling "helpless in the face of such severe trauma" and the challenges that come with that had to do with no direct training of how to work with this specific group of clients. All six of these respondents reported feelings of anxiety and helplessness, one clinician stated, "I think there's a sense of helplessness as a clinician because you can't really work with and take away that pain, because it's very real…there's no ifs ands or buts about how to get rid of it."

The depth of the trauma was cited by six of the 12 participants as a major professional challenge of working with refugees. All six of these respondents reported that the trauma is too complex to be able to conceptualize or relate to, two respondents mentioning running out of typical coping skills and techniques while trying to help refugee clients cope with trauma.

What are the most challenging personal aspects of working with refugee trauma survivors? The responses to the preceding question are grouped under five themes: the most challenging personal aspects of working with refugee clients are

reported feelings of hopelessness, difficulty remaining professional, vicariously experiencing trauma, trouble forming an alliance, and challenging worldviews and beliefs.

Half of the participants reported feelings of hopelessness and inadequacy when asked about the most challenging personal aspects of working with refugees. One clinician disclosed, "Personally, I feel like I can't do enough. There's a sense of hopelessness and your heart breaks because you can't save these people." Most of these participants revealed that they feel limited in their clinical abilities to help and often felt like something was missing due to cultural and language barriers, which then led to questioning talent and skill.

Four of the twelve clinicians discussed difficulties remaining professional while in the room with refugee clients. These participants felt internal conflict when they became visibly emotional during a session with clients and they had strong desire to reach out and embrace clients. Participants who mentioned these challenges also stated that this struggle with professional boundaries stemmed from growing emotionally attached to clients, as well as feeling unable to verbally connect due to language barriers.

One third of the interviewees stated that they have experienced symptoms of traumatization after working with refugee clients, and that this experience has negatively impacted their personal lives. One clinician explained, "When you have clients that do start to talk about their trauma, you start to sit with a level of trauma, and then you start to have an image in your head of all of the awful things that happened." These clinicians reported that they think about their clients long after sessions have ended and tend to take the trauma home with them, impacting relationships with others.

Five clinicians felt frustrated when unable to form a therapeutic bond with refugee clients. All five mentioned a language and cultural barrier that interfered with the formation of an alliance. Some of these frustrations included, "…wanting to connect but not being sure now" and "having to have another person in the room for interpretation."

Another important personal challenge reported by one third of interviewees was the phenomenon that occurs when fundamental beliefs about the world become challenged when bearing witness to refugee trauma. One participant disclosed, "It challenges your beliefs on a personal level and it makes you kind of jaded to the horrible things that happen in the world. It's hard to keep the overall picture and that there is still hope, despite all of this really horrible stuff happening to people." Other participants report that they now question the nature of human beings and personal beliefs about their worldviews. Most of these clients also report feelings of "disgust" with human beings in general.

Emotional Impact of Trauma

This section addresses the clinicians' responses to questions that inquire about the emotional impact of working with refugee trauma survivors. The data is presented in two sub-sections: emotional response to trauma and coping with the effects of trauma.

Please describe a time in which you felt emotionally triggered by trauma expressed by a refugee client. What was your emotional response? What was your somatic response? Do these feelings ever linger on after session? All 12 participants identified a time in which they felt emotionally triggered by a refugee client. Each participant was also able to identify an emotional response, as well as a somatic response.

All but one interviewee experienced emotional and/or somatic feelings lingering on after a session.

The clinicians recalled a wide array of emotional reactions to trauma. Seven of the 12 expressed feelings of helplessness. Four participants expressed sadness, with another four articulating anxiousness. Guilt was conveyed by several participants, as well as despair. Other emotional responses include curiosity, anger and stress.

In addition to emotional reactions, there were also many somatic responses reported by all clinicians. The most prevalent somatic states include tightness in chest, knots in stomach, and overall heaviness in the body. Other bodily sensations included tension in shoulders, anxiety in body, crying, elevated heart rate, headaches, and "warm anger inside the body." One clinician stated, "I do get some physical pains, but usually it just nails me in the sleep. It never lets me go."

As stated above, all but one participant recalled emotional and/or somatic responses lingering after the end of a session with refugee clients, though the three staff clinicians all agreed that this happens less than when they were first beginning to work with refugees. Nine participants explicitly mentioned thinking about their clients' trauma for prolonged periods of time. One clinician stated, "What keeps with me are the memories, the trauma and the sadness that comes with hearing the stories…and the wish that no one could have experienced such horrible things" which was supported by several other clinicians. Another interviewee revealed, "As a clinician I am not letting myself have the emotional reaction in the moment, but if I see it in a movie, that's when I realize my response might be disproportionate because I might be carrying all of this stuff that I thought I put to the side."

When asked to describe a time when emotionally triggered by a refugee client, five respondents described experiences of strong empathic emotional attunement. One participant related several experiences in which she felt her clients needed her to "cry and experience emotions" for them. Other participants mentioned feeling "all of the feelings clients were feeling" as a sense of mirroring, with the most profound vicarious feeling being that of guilt and responsibility.

Five clinicians reported feeling emotionally triggered when they were able to identify a connection to the trauma being expressed by the client. Two clients disclosed personal characteristics of themselves that were similar to character traits for which their clients were targeted. Both of these disclosed experiences came with feelings of guilt, stating "It was difficult to conceive that this could have happened to me if I was born in a different country."

Several participants offered insight into factors that contribute to heightened emotional reactions to refugee trauma. As stated above, five participants revealed that they have a stronger reaction when there is a personal connection to the trauma. One participant mentioned that sexual trauma is especially difficult due to her own experience with sexual boundary violations. Another interviewee mentioned that as a mother, she has a stronger emotional response when hearing about trauma that happened to children and women. Four other clinicians felt limited in ways to empathize due to language barriers heightens their emotional reactions. Witnessing intense affect from clients, how recently the trauma took place, and helplessness were other factors listed that may contribute to why participants react so strongly to refugee trauma.

How do you cope with the emotional impact of trauma? All participants identified ways in which they cope with the emotional impact of trauma. The responses are grouped under three major themes: externalizing trauma, engaging in self-care, and conducting rituals. One outlier stated that she relies on confidence alone explaining, "I deal with the emotional impact by knowing they feel safe here. I have felt like somehow I was effective in transmitting my own empathy and giving them something, even if it's just a listening ear for an hour."

More than half of the participants acknowledged externalizing and processing of trauma as a means of coping with the emotional impact of trauma. Three participants stated that they talk about the trauma with spouses who are also in the mental health field, and an additional three stated they use peers and friends in the field to process cases. Several participants discussed cases with a strong supervisor and processed especially disturbing case material in therapy.

Half of the subjects mentioned self-care as a tool for dealing with the emotional impact of trauma, almost all did physical exercise. One participant stated, "I feel like I have better emotional armor on when I can go to the gym and work out." Another interviewee described the importance of scheduling time for self.

One third of clinicians described ritualistic techniques they have established for themselves to cope with trauma. One person stated, "When I get in my car, I slam my door, consciously leaving everything outside, and I leave with that imagery of 'Okay I'm done'." Another clinician conducts a similar ritual stating, "When I cross the door I take a huge breath and say, 'It's on.' sort of turning on my clinical self, and then when I leave,

I take a big breath as I'm about to walk through the door, and release as I walk out and say, 'Day is done'."

Personal and Professional Changes

This section addresses the personal and professional challenges met by each of the participants. The data is presented in two sections: changes in personal outlook and/or behaviors and changes in clinical practice.

Please describe an experience in which working with trauma survivors has sparked a change in your personal outlook or behaviors in your personal life. When asked about this question, all participants were able to identify at least one way in which working with refugee clients have impacted their personal lives. Responses to this question are organized under four groups: negative experiences, altered worldviews/beliefs, change in self-perception, and inspiration.

Two clinicians report having had negative experiences while working with refugee clients. These experiences include developing a sense of paranoia and feeling the desire to change career paths. One clinician recalled, "I'm paranoid around sexual abuse and had dreams about being in a parking lot and being held hostage, being raped" and explained that these dreams seem to develop from stories he/she hears from her refugee clients. This clinician stated that he/she feels, while sleeping, the helplessness expressed by refugee clients. Another clinician reports that his/her passion was in working with refugees but that the hopelessness and language barrier led him/her to pull away from working with this population.

Half of the participants stated that their worldviews have changed since working with refugees. Several interviewees mentioned that they are now more aware of "awful

things that are happening," leading to questions about the nature of humanity, "How can such bad things happen to good people?" Other participants mentioned that they now place higher value on relationships and treasuring moments with family and friends. One clinician stated, "It makes me realize that having a larger community and social circle of supports is invaluable. It's made me think about what emotionally intimate relationships do for people in terms of health, longevity, and blood pressure…I think all of those things are affected."

Six of the interviewees mentioned that their self-perception has changed. One clinician stated that he/she is more passionate about working with this population. Almost all of these participants stated that they now engage in reflective practices that allow them to be mindful of their privilege, relationships with others, and personal challenges. Another clinician mentioned that he/she has developed a hard outer shell, stating, "I've become tougher than I wish I've had to be" when dealing with difficult material from clients.

Almost half of the participants reported that they felt inspired by working with refugee clients. One clinician disclosed, "I think I became stronger…there's nothing like being with the patient to really transform you." Other interviewees stated that they are inspired by the hope, love, and kindness witnessed in so many refugees, despite the atrocities they have endured. Another participant mentioned developing a new meaning for resilience, as refugees face tremendous adversity, yet never seem to give up.

How has working with refugee trauma survivors changed your clinical practice? Clinicians responded to the above question under four different identified themes: mindfulness, communication style, shifts in focus of the work, and enhanced ability to work with trauma.

Almost half of the clinicians interviewed mentioned that they have become more mindful when working with refugee clients. Each of these participants mentioned the importance of remaining present and focused on the client when conducting therapy with refugees. Several participants explained that because their trauma is so unique, it is important to stay as close to the client as possible, often taking more energy than other sessions with non-refugees. One person mentioned, "You have to be listening so close to the client because you don't have those sort of questions in your mind that are circulating, you really have to think, 'I'm going to be present and try to figure out how to follow and how to inquire'." Several other clinicians stated that they are increasingly mindful of the impact of culture when working with refugee clients.

One quarter of the participants mentioned that learning to effectively communicate with refugees has been the biggest change to their clinical practice. A clinician stated, "You can't fall back on words, so you have to think about how to be therapeutic as a whole person." Another therapist stated that he/she encouraged clients to speak in their native language without being interrupted by an interpreter, in order to feel the emotion of the spoken room. Most of these clinicians mentioned having to sit differently in the room with refugee clients because of the "third party" interpreter.

More than half of the interviewees described a shift in the focus of their practice as a result of working with refugee clients. Two clinicians report that they have a more

positive, strengths based approach since working with refugees, one therapist elaborated that, "I look at clients differently, because so many of the clients come in with all of this weight on them, and that's what I was looking at before, but it's helped me to look at what's keeping them here, what are they holding onto, and the strengths they have." Another interviewee stated that he/she no longer holds expectations for following a specific framework or treatment modality but instead focuses on responding to the individual needs of each client. Several other therapists mentioned that they consciously let go of assumptions based on common experiences of trauma, culture, or pain and suffering.

Seven of the 12 respondents reported that working with refugee trauma survivors has enhanced their ability to work with other trauma survivors, whether refugee or non-refugee. Several clinicians mentioned that their capacity to sit with traumatic material has increased. One clinician stated that, "It strengthens your personal capacity for dealing with [trauma], carrying it with you or not carrying it with you." Three other clinicians elaborated on this idea, stating they have learned to "let go" of the trauma once the refugee client leaves the room and developed "an emotional ability to sit with anything." Another respondent stated he/she has reconsidered how to measure success, as refugees "demonstrate progress differently" than non-refugee clients.

Overcoming Adversity and Vicarious Resilience

This section examines the participants' responses to questions regarding witnessing clients overcome adversity and experiencing vicarious resilience. The data is presented in three subsections: the emotional impact of trauma, the effects on clinical

practice of bearing witness to clients overcoming adversity, and personal thoughts regarding the idea of vicarious resilience.

Describe a case that made a strong emotional impact on you in relation to your client overcoming adversity. Do you think emotional impact has positively changed the way you practice clinically? How has this story positively impacted your personal life? Ten of the 12 interviewees answered this question, and two participants expressed that they had not experienced an emotional impact of clients overcoming adversity. Three themes emerged when participants were asked to discuss how the emotional impact of watching a client overcome adversity has influenced the way they practice clinically: an increase in hope, a change in clinical expectations, and a confirmation of beliefs.

Four of the 10 respondents disclosed that they experienced an increase in hope for their clients after watching refugee clients overcome adversity. One interviewee stated, "I now have the hope that everyone can find resiliency, and that everyone has the potential to change." Another clinician stated that prior to witnessing a client overcoming adversity, he felt pessimistic, especially working with refugee clients due to the level of trauma they have experienced. Several participants mentioned that they have increased hope for other clients.

More than half of the participants felt that there has been a change in clinical expectations of their clients since watching refugee clients overcome adversity. Several therapists described an increased awareness to help clients set realistic goals while not having "lofty expectations" of how progress may look. Another clinician elaborated on this idea stating that she struggled to identify a positive outcome for this question because

what may seem like a small accomplishment for one client could be great progress for another.

One of the participants mentioned that working with clients who have overcome adversity has confirmed her desire to work with the refugee population. As an intern, this participant mentioned that witnessing powerful transformations in this vulnerable population inspired her to continue working with this group of people who typically do not have access to care.

When examining the second part of the question regarding an impact in their personal lives, three themes emerged: an enhanced self of appreciation, developing a realistic perception of self, and an increase in feeling good overall.

Four of the therapists stated that working with refugee clients who have demonstrated resilience has made them feel more appreciative of their lives. One interviewee stated, "I am more thankful for what I have, and I put less focus on what I don't have. I'm more thankful for my opportunities." Another participant mentioned that she is more aware of and thankful for her freedoms.

Several interviewees mentioned that witnessing this phenomenon has helped them to develop a realistic sense of self. Those participants that mentioned the clinical change in expectations, also stated that their expectations for themselves have changed. One person described no longer allowing herself to have limiting self-beliefs after witnessing clients overcome adversity. Another clinician mentioned that he consciously sets realistic expectations and goals for himself, knowing that lofty expectations may set up a person for failure.

A group of participants mentioned feeling good overall in response to witnessing refugee clients overcome adversity. One clinician elaborated that she feels happy in her personal life when observing her clients experience resiliency. Another mentioned that on top of feeling good, she feels she is able to feel through her clients, "If they can handle everything, and still tell jokes and have a life, it just makes me feel like I can do a lot of things" and continues to say that when her clients feel strong "I'm able to feel stronger now too."

How has listening to stories of refugee clients who have overcome adversity changed the way you practice clinically? Four themes were identified within the respondents' interviews: increased awareness of overcoming adversity, change in expectations of the therapeutic process, shift in perspective, and alterations in the way the therapist prepares for therapy. All but one of the interviewees reported a clear shift in the way they practice clinically after working with refugees who have overcome adversity; with one respondent stating this question did not apply to his/her experience with refugee clients.

One quarter of the respondents stated that working with a refugee client who had overcome adversity had made them more aware of "…day to day things that you would not really consider to be adversity." One participant explained that he/she attempts to reflect on all of the experiences of watching clients overcome adversity in hopes of pinpointing the characteristics and factors make some people more capable of working through adversity than others. Several other clinicians stated that it is has been helpful to watch refugee clients overcome adversity because it gives hope and encouragement to the clinicians to continue working with this client population, in spite of the heavy trauma.

Two clinicians reported a change of therapeutic expectations after watching refugee clients overcome adversity. Both of these clinicians acknowledged the importance of making smaller goals with refugee clients. One of the clinicians mentioned that he/she has to let go of expectations entirely. This psychodynamically oriented respondent explained, "My refugee clients don't necessarily do, in my mind…what I define as therapy, but [working with refugees] has made me very clear that it's not like someone has to have this big insight moment in therapy to have a positive chain of events happen. There are so many other things that influence a person."

More than half of the participants who responded to this question identified a change in their clinical perspective. Two of these clinicians mentioned developing increased hope, stemming from clients overcoming adversity that the clinician initially felt was impossible from which to recover. Another therapist mentioned that he/she has changed her approach to knowing that he/she will never be able to understand or comprehend the life experiences of refugee clients. Additionally, several other respondents emphasized that they learned not to sit with refugee clients as if they need to be repaired. One clinician stated, "There's always the lesson to not sit with them like they are broken. People could look and say, 'Look at her suffering and how scarred she is' but there's the flip of the coin, it's just unbelievable what people can endure and keep plugging along." Another respondent articulated a similar change in perspective and added that his/her focus in working with refugees has developed into looking for and building upon the positive aspects that keep them moving forward.

Many of the participants also mentioned that working with refugee clients has altered the way they prepare for sessions with their clients, most specifically with refugee

clients. One therapist explained that he/she reminds him/herself that although they may come from different cultures, countries of origin, and life experiences, humanity is the common denominator between client and therapist and that all people can find commonalities regardless of the barriers. Another participant described his/her attempt to locate the inherent characteristics in resilient clients, in order to help all clients identify such characteristics to ultimately work towards healing. Several other interviewees emphasized a conscious "mental preparation for the experience" of hearing the traumatic stories of refugee clients, "…to change my practice is to prepare myself better to hear them, to find my strength to listen because I never know what is going to be discussed."

Just as vicarious traumatization often occurs in working with refugee clients, vicarious resilience is the idea that clinicians can take on the sense of resiliency witnessed in their clients. What are you thoughts on this concept? The interviewees identified two major themes regarding vicarious resilience: affirming the possibility of the existence of vicarious resilience and the transformative power of working with resilient clients.

All of the interviewees felt that working with refugee clients to assist them in overcoming adversity has a powerful, transformative capacity. One interviewee disclosed, "We become frightened when we realize that other human beings can affect us in negative ways, and we become empowered when we see what people can do in a positive way. It's a sense of 'Wow if they can go through that and still enjoy life, there's a lot that we can get through'." Another respondent stated that he is sure that overcoming adversity with a client is powerful, but he is unsure whether it is the client or the therapist that is responsible for initiating the resiliency. He stated, "If they sit across from you,

and who knows where it begins, my side or their side…but if there is a belief on both sides that I can be helpful to them, there will be a positive outcome. As far as resilience, I don't know who starts that."

Ten of the twelve participants explicitly stated that they believe that vicarious resilience can occur when working with refugee clients. One participant stated,

> I would take incidents with my clients and would be in awe about how much they overcame, how brave they are, and their ability to adapt to a new environment…this would be something I would admire, and I would remind myself in practice and in my personal life that, one client overcame this, and one client could adjust, and I felt empowered myself.

Other interviewees affirmed this, stating that they remind themselves of the strength of their clients and use that strength to propel themselves through difficult situations. Another therapist stated that since watching clients overcome adversity, he/she is able to look at difficult situations with more hope, believing now that there is no such thing as "an impossible dream." The remaining two participants acknowledged that they are unsure if vicarious resilience is an adequate term, but that transformative experiences certainly occur that strengthen them both personally and professionally.

CHAPTER V

Discussion

Introduction

The intent of this study was to explore the impact of vicarious traumatization and vicarious resilience on clinicians who work with refugee clients. As a whole, the findings showed that clinicians experience both phenomena. It seems that clinicians who face symptoms of vicarious traumatization respond by modifying aspects of both professional and personal lives, thus leading to vicarious resilience. This finding is similar to that of Hernandez, Gangsei, and Engstrom (2011), when they found that clinicians could learn to overcome personal adversity through their clinical work. Overall, findings from this study support the previous research.

This chapter discusses the findings in the following order: key findings in comparison with previous literature, implications for social work practice and theory, strengths and limitations of the study, as well as recommendations for future research.

Key Findings: Comparison with the Previous Literature

The qualitative research is discussed sequentially according to the sections presented in the findings chapter, beginning with the reported professional and personal challenges of working with refugee clients. The next section discusses emotional impact of trauma, including responses regarding the clinicians' emotional reaction to trauma and ways of coping with the effects of trauma. The third section addresses potential changes in personal outlooks and/or behaviors, as well as professional changes in clinical practice. The subsequent section addresses clinician's responses to witnessing clients overcoming adversity and experiences of vicarious resilience.

Professional and personal challenges of working with refugee clients. The emerging themes of the professional challenges of working with refugee clients include forming the therapeutic alliance, feelings of inadequacy, and holding the weight of the trauma. Overall, these findings were supported by the literature. The World Health Organization (1996) found that cultural factors including fears regarding breaches of confidentiality as well as the stigma attached to receiving mental health treatment often prevent refugees from seeking assistance. The cultural reluctance towards treatment may contribute to the difficulty in helping a refugee client to engage in the treatment process. The reported feelings of inadequacy were also supported by other studies (Barrington & Shakespeare-Finch, 2013; Cohen & Colleens, 2012; Hernandez, Gangsei, & Engstrom, 2011; Robinson, 2013). Research shows that refugees have often witnessed the devaluing of human lives, thus losing a sense of self, which may contribute to this study's reported challenge of holding the weight of trauma (Basham, 2008; Blackwell, 2009; World Health Organization, 1996). Other studies also found that clinicians may experience feelings of helplessness and inadequacy in relation to their clinical work when working with survivors of immense trauma (Basham, 2008; Blackwell, 2009).

The findings of this study showed that the five major themes surrounding the personal challenges of working with refugee trauma survivors include feelings of hopelessness, difficulty remaining professional, vicariously experiencing trauma, trouble forming an alliance, and challenging worldviews and beliefs. The literature displayed similar findings. Several studies discussed the negative personal impacts of working with this client population, noting that clinicians typically have strong emotional reactions, cope with intrusive images, and face a disruption of beliefs about humanity (Barrington

& Shakespeare-Finch, 2013; Cohen & Collens, 2012; Robinson, 2013). Another study mentioned heightened somatic responses, which is what several respondents to this study identified as a difficulty remaining professional in session (Cohen & Collens, 2013). It is unclear if the participants of this study experienced heightened emotional and somatic responses in their personal lives, which could be explored further in future research (Cohen & Collens, 2012). None of the previous studies mentioned trouble forming an alliance, though several respondents in this study identified that as a personal challenge. Perhaps other studies determined this phenomenon to be a professional challenge, but the researcher felt it was important to acknowledge the challenge as personal when the interviewees reported as such.

Emotional impact of trauma. The findings of this study seem to substantiate previous literature. As Guhan and Liebling-Kalifani (2011) found, a wide range of emotions were also reported by respondents. Clinicians reported helplessness, sadness, guilt, curiosity, anger and anxiousness. Guilt seems to be an outlier, not mentioned in the reviewed literature, and appears to be expressed by those who disclosed traumatic experiences of their own. Though previous research mentioned heightened somatic responses, none of the reviewed literature explored the types of somatic concerns or the extent to which they are experienced (Cohen & Collens, 2013). All but one participant in this study were able to identify lingering emotional and somatic responses, which may be due to experiences of secondary trauma that may ultimately lead to vicarious traumatization.

All participants were able to identify ways in which they cope with the emotional impact of trauma whether through a process of externalization of the trauma, engaging in

self-care, or conducting symbolic rituals around putting the trauma away at the end of the day. A review of the literature could not find a link between coping with trauma and the development of vicarious resilience. This study suggests that perhaps there is a connection as all participants articulated successful ways of coping and their belief that working with refugee clients to assist them in overcoming adversity has had a powerful and positive transformative experience on practice and personal lives.

Personal and professional changes. Barrington and Shakespeare-Finch (2013) acknowledged that clinicians may experience co-occurring positive and negative effects of working with refugee trauma survivors, which was supported by this study. The participants discussed positive effects, such as seeing themselves differently and becoming inspired to further their work, and negative effects such as symptoms of re-experiencing the trauma and a shattering of worldviews and beliefs. Previous research suggests that exposure to traumatic stories may initiate a destruction of existing beliefs, and that this must occur in order for positive effects to occur (Barrington & Shakespeare-Finch, 2013; Cohen & Collens, 2012; Robinson, 2013). Although half of the participants of this study report a similar destruction of existing beliefs, all 12 participants appear to have experienced resiliency with their clients.

The sample in this study did not reflect the high burn out rates that were found in much of the literature (Cohen & Collens, 2012; Guhan & Liebling-Kalifani, 2011; Robinson, 2013). Clinicians in this study reported changes in increased mindfulness, communication style, shifts in focus of the work, and an enhanced ability to work with the trauma. Perhaps this difference is related to all participants being able to identify effective ways to cope with trauma. The previous literature suggests that adequate,

supportive supervision is critically important with those who work with refugee trauma survivors for surveillance and support (Guhan & Liebling-Kalifani, 2011; Robinson, 2013). With all participants of this study working in the same agency, it can be assumed that supervision may have been similar for all participants. The effect of supervision on this sample was not examined, but further exploration could be done in the future to determine if similar experiences with supervision may lead to similar experiences of vicarious traumatization and vicarious resilience.

Overcoming adversity and experiences of vicarious resilience. Hernandez, Gangsei, and Engstrom (2007) found that by working with refugee trauma survivors, clinicians have the capacity for vicarious post traumatic growth including learning to cope with adversity, making meaning of trauma and healing, developing tolerance to frustration, and finding motivation and strength for working with trauma survivors. This study supported these findings with reports of enhanced hope, a change in clinical expectations, and a confirmation of personal values. The ample positive effects on clinical practice and person lives suggest that although participants may have experienced vicarious or secondary trauma, this growth may lead to experiences of vicarious resilience (Barrington & Shakespeare-Finch, 2013; Hernandez, Gangsei, & Engstrom, 2007).

All but one participant in this study reported changes in clinical practice in response to working with refugees. According to previous findings, this phenomenon makes clinicians susceptible to the experience of vicarious resilience, as the process of adjusting existing beliefs may open a clinician up to positive changes in life philosophy relationships, and self-perception (Barrington & Shakespeare-Finch, 2013). All

participants were also able to identify areas of resiliency in their refugee clients. These two experiences have been found to lead a clinician to experience vicarious resilience, in which all participants reported belief and experience.

The widespread experience of vicarious growth and resilience may help to explain this sample's low experience of burnout. Perhaps asking questions focusing on overcoming adversity, growth, and resilience alone had the power to minimize the participants' perceived levels of frustration, trauma, and burn out. This suggests that calling attention to resiliency and further developing it in practice may be a powerful tool for recovery and prevention of burnout.

Implications for Social Work Practice

Trauma theory was used as the theoretical framework for this study. Although this theory suggests that resilience is an aspect of trauma, the possibility of vicarious resilience is not mentioned (Basham, 2008). Findings of this study suggest that although clinicians may experience vicarious traumatization, this phenomenon may not be sufficient in describing the full experience of working with trauma survivors, as clinicians continue to work with this population, citing feelings of hope and strength from working with clients to help overcome adversity. Results from this study propose an expansion of existing trauma theories to include an exploration of potential vicarious resilience when resilience is experienced in clients.

The researcher believes that developing and using vicarious resilience in practice has the power to further heal the lives of clients while simultaneously enhancing the practice experience of the therapists conducting the therapy. Learning more about this new approach to working with refugee trauma survivors may reduce high levels of

burnout. It seems clear from this current study as well as within the reviewed literature that clinicians view this client population as strong, resilient, and able to overcome adversity. Previous research has focused on vicarious traumatization, which seems insufficient in explaining why many clinicians continue to work with this population. Perhaps focusing on resilience and vicarious resilience can neutralize the arduous experiences of vicarious traumatization, as well as increase experiences of inspiration and motivation.

Strengths and Limitations

There are several strengths as well as limitations for this study. One of the major strengths of this study was the qualitative research, exploratory design that allowed participants to open up in detail about their experiences. This approach allowed participants to talk freely about their experiences with trauma, vicarious traumatization, resilience, and vicarious resilience, without limitation or restriction. Another strength of the study was the use of purposive sampling to include differing levels of experience and degrees to be representative of the clinicians studied in the community health center.

Considering the small scale, there are several limitations to this study. Although participants had a varying degree of experience, only 12 participants were used in this study. The participants were also all from the same agency, Family Health Center of Worcester. These two factors limit the generalizability of the study. Additionally, research was conducted as intimate, face-to-face interviews within Family Health Center. Private rooms were utilized, but participants may have felt inhibited to disclose uncomfortable information in an intimate setting in their work environment.

Recommendations for Future Research

This study proposed several areas for further research. In order to address the limitations, the research could be expanded to include clinicians in other agencies that work with refugee trauma survivors. Expansion could enhance generalizability to ensure that these findings are not unique to Family Health Center of Worcester. The impact of supervision on the levels of vicarious traumatization and the potential experience of vicarious resilience should be further explored as well. The participants that discussed their supervision experiences disclosed that supervision has been helpful to feel supported, which may explain the low rates of burnout and the high rates of resilience. Future research may focus on the specific qualities of supervision that lead to the development of vicarious resilience. Similarly, as all participants reported effective coping skills, further research could be conducted to examine what seems to be the connection between successful coping skills and the development of vicarious resilience.

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Appendix A

HSR Approval Letter

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

November 18, 2013

Megan Welsh

Dear Megan,

You did a very nice job on your revisions. 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).

Congratulations and our best wishes on your interesting study.

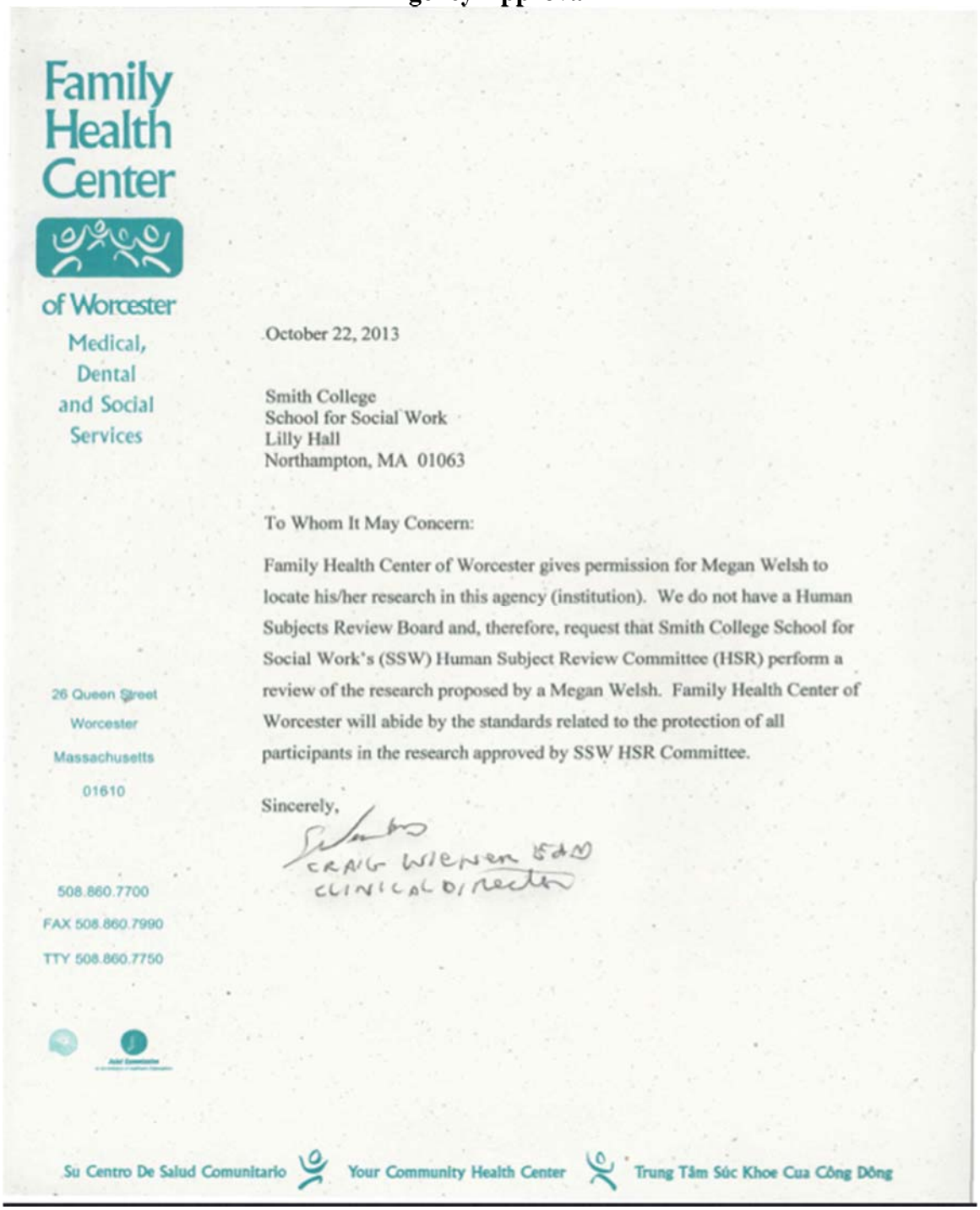
Sincerely,

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Jean LaTerz, Research Advisor

Appendix B

Agency Approval



Family Health Center of Worcester
Medical, Dental and Social Services

October 22, 2013

Smith College
School for Social Work
Lilly Hall
Northampton, MA 01063

To Whom It May Concern:

Family Health Center of Worcester gives permission for Megan Welsh to locate his/her research in this agency (institution). We do not have a Human Subjects Review Board and, therefore, request that Smith College School for Social Work's (SSW) Human Subject Review Committee (HSR) perform a review of the research proposed by a Megan Welsh. Family Health Center of Worcester will abide by the standards related to the protection of all participants in the research approved by SSW HSR Committee.

Sincerely,

CRAIG WIENER MD
CLINICAL DIRECTOR

26 Queen Street
Worcester
Massachusetts
01610

508.860.7700
FAX 508.860.7990
TTY 508.860.7750

Su Centro De Salud Comunitario | Your Community Health Center | Trung Tâm Sức Khoe Cua Công Dông

Appendix C

Recruiting Email

Date: October 24, 2013

Subject: Thesis Research Recruiting

Dear Colleagues,

I have recently begun my research for my thesis that fulfills a requirement for my Masters in Social Work at Smith College School for Social Work. As this research pertains to our direct work with refugee clients at Family Health Center, I am reaching out to you for your help.

The purpose of my research is to study the effects of vicarious traumatization and vicarious resilience on clinicians who work with refugee clients. I am looking to interview clinicians from Family Health Center, and asking for your participation in my study. If you chose to participate, your participation will include a 45-minute guided interview with a personal refection on your experience.

If you are interested, please respond to this email, or you can contact me by phone at XXX-XXX-XXXX. Thank you in advance for your consideration.

Respectfully,

Megan Welsh
MSW Intern

Appendix D

Recruiting Flyer

Research Participants Needed!

Do you work with refugee clients?

Megan Welsh is conducting a research study for a thesis that fulfills a requirement for her Masters of Social Work at Smith College School for Social Work.

The purpose of this study is to gain insight into the effects of vicarious traumatization and vicarious resilience on clinicians who work with refugee clients.

Participation Includes:

- 45 minute interview
- A personal reflection on your experience with vicarious trauma
- Discussion about your experience with client resiliency

If interested please contact
Megan Welsh by email
mwelsh@smith.edu or phone at XXX-XXX-XXXX

Appendix E

Eligibility Questions

1. Are you a clinician or social services intern at Family Health Center?
2. What are your credentials?
3. Are you currently working with refugee clients?
4. Have you worked with refugee clients over the past 5 years?

Appendix F

Informed Consent

Consent to Participate in a Research Study
Smith College School for Social Work ● Northampton, MA

……..

Title of Study: What are the effects of vicarious traumatization and vicarious resilience on clinicians who work with refugee clients?

Investigator(s): Megan Welsh, MSW Intern, Smith College School for Social Work, XXX-XXX-XXXX

……..

You are being asked to be in a research study of the effects of vicarious traumatization and vicarious resilience and clinical practice and personal development. You were selected as a possible participant because of your experience working with refugee clients. I ask that you read this form and ask any questions that you may have before agreeing to be in the study.

The purpose of the study is to better understand vicarious traumatization and the ways in which vicarious trauma effects clinicians that work directly with refugee clients. This study also aims to determine whether or not clinicians experience vicarious resilience in working with this client population, and what, if any, impact the vicarious resilience has on the clinician's treatment modalities, practice style, and personal life. This study is being conducted as a research requirement for my master's in social work degree at Smith College School for Social Work. Ultimately, this research may be published or presented at professional conferences.

If you agree to be in this study, you will be asked to meet with me for 45 minutes for a guided interview to discuss your experiences with vicarious traumatization and vicarious resilience in practice. Our interview will be audio recorded and the researcher will take written notes.

Participation in this study has the following risks. First, discussing vicarious traumatization has the potential to trigger an uncomfortable or difficult emotional response. This risk is unlikely as the research aims to discuss responses to vicarious trauma, and the research will take care not to ask about specific experiences. In the event that the interview leaves you feeling uncomfortable or distressed, the researcher will provide time after the interview to process your experience with the study. If further support is needed, a referral list for post interview follow up support will be provided.

A benefit of participation includes the opportunity to gain more insight to the effects of vicarious traumatization, as well as vicarious resilience. You might learn more about vicarious resilience, and how this process may enrich your practice. . By sharing your experience, the field of social work may gain further knowledge into the effects of vicarious traumatization that can be utilized to examine and help prevent clinician burnout. Also, discussing vicarious resilience has the potential to improve practice in relation to working with refugee clients.

Your participation will be kept confidential. To ensure your privacy, I will meet you in a private office in the social service department at Family Health Center. The tapes and transcripts of this study will be kept in a secure, locked location separate from the signed consent forms for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. Only I, and a volunteer transcriber, will have access to the audio recordings of your interview. Your identity will be deleted and each transcript will be assigned a numerical code.

You will not receive any financial payment for your participation.

The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* (up to the date noted below) without affecting your relationship with the researcher of this study or Smith College. Your decision to withdraw from the study will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely up to the point noted below. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by April 15, 2014. After that date, your information will be part of the thesis, dissertation or final report.

You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Megan Welsh at mwelsh@smith.edu or by telephone at XXX-XXX-XXXX. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep. You will also be given a list of referrals and access information if you experience emotional issues related to your participation in this study.

……..

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

……..

1. I agree to be [audio or video] **taped for this interview:**

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

2. I agree to be interviewed, but I do not want the interview to be taped:

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

Appendix G

Interview Questions

The Effects of Vicarious Traumatization and Vicarious Resilience on Clinicians who Work with Refugee Clients

1. Please describe your clinical background and training.
2. What are the most challenging professional aspects of working with refugee trauma survivors?
3. What are the most challenging personal aspects of working with refugee trauma survivors?
4. Please describe a time in which you felt emotionally triggered by trauma expressed by a refugee client.
    a. Did what was your emotional response?
    b. What was your somatic response?
    c. Do these feelings ever linger on after session?
5. How do you cope with the emotional impact of trauma?
6. Please describe an experience in which working with trauma survivors has sparked a change in your personal outlook, or behaviors in your personal life.
7. How has working with refugee trauma survivors changed your clinical practice?
8. Describe a case that made a strong emotional impact on you in relation to your client overcoming adversity.
    a. Do you think emotional impact has positively changed the way you practice clinically? How?
    b. How has this story positively impacted your personal life?
9. How has listening to stories of refugee clients who have overcome adversity changed the way you practice clinically?
10. Just as vicarious traumatization often occurs in working with refugee clients, vicarious resilience is the idea that clinicians can take on the sense of resiliency witnessed in their clients. What are your thoughts on this concept?

Appendix H

Employee Assistance Program

The following resource is available to you as an employee/intern at Family Health Center.

Employee Assistance Program
University of Massachusetts Medical School
382 Plantation Street
Worcester, MA 01605
eap@umassmed.edu
(508) 856-1327
(800) 322-5327