THE EFFECTS OF INDIRECT TRAUMATIZATION ON THERAPIST

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Effects of Indirect Traumatization on Therapist Relationships

ABSTRACT

The current qualitative study investigates the nature of indirect trauma, or the ways in which therapists are negatively affected by working with trauma survivors. This study provides an in-depth exploration into the experiences of indirectly traumatized therapists, paying particular attention to the effects on their relational lives. Imprecise use of the terms vicarious trauma, secondary traumatic stress and compassion fatigue has contributed to inconsistent evidence regarding mechanisms of development, risk and protective factors, and implications for the support and protection of mental health workers. The present study utilizes the term indirect trauma as an umbrella construct incorporating the other three terms as distinct manifestations. This study aims to increase clarity in the empirical and conceptual literature in the field while providing a new focus on how therapists' relational lives are affected by working with trauma. Semi-structured interviews were conducted with eight therapists self-identifying as having experienced negative effects of treating trauma survivors. A modified grounded theory (Corbin & Strauss, 1990; McCracken, 1988) was used to analyze the data. Three primary effects on the therapists' relational lives were found: 1) Therapists experienced a drained or exhausted emotional state, which reduced their capacity to provide support to others and resulted in a renegotiating of their relational boundaries. 2) Therapists experienced distressing beliefs and affects that led to an increased need for emotional support and understanding from others. 3) Therapists both anticipated and experienced misunderstanding and invalidation from others, which contributed to increased isolation. The discussion features directions for future research as well as recommendations for individuals and organizations aimed at supporting therapists in this challenging, yet rewarding work. Key recommendations include: increasing dissemination of indirect trauma information in both academic institutions and clinical organizations, and encouraging trauma therapists to participate in routine interpersonal dialogue, including the discussion of indirect trauma symptoms, with other trauma-informed clinicians via supervision or consultation.

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CHAPTER I: INTRODUCTION

Statement of the Problem

Therapists working with survivors of trauma open themselves to the painful stories, emotional distress, physical discomfort, and social difficulties faced by their patients. Through empathizing with these survivors, therapists may experience deep personal transformation that often mimics the post-traumatic experiences of the survivors themselves (McCann & Pearlman, 1990). Trauma therapists are at risk for experiencing post-traumatic symptoms ranging from hyperarousal and hypervigilance, to avoidance, to the intrusion of traumatic thoughts and images tied to their clients' trauma (Figley, 1995, p. 7). In addition to facing post-traumatic symptoms, trauma therapists may experience a transformation in their schema related to sense of self, others and the world. Researchers investigating the effects of therapists' indirect exposure to trauma believe that these effects are not only possible, but inevitable for those who regularly engage with trauma survivors (Adams et al., 2006; Figley, 1995; McCann & Pearlman, 1990).

McCann and Pearlman (1990) describe that the impacts on therapists working with trauma survivors are cumulative, "in that each client's story can reinforce the therapist's gradually changing schemas," pervasive, "affecting all realms of the therapist's life," and "likely permanent." Dr. Laurie Pearlman, in *Vicarious Traumatization: The Cost of Empathy* (1995) notes that these effects are "not limited to what goes on in the therapy session or even in the work setting. We carry our vicarious trauma (VT) with us outside our therapy relationships into our personal relationships." She describes that VT affects therapists' self-capacities, including their ability to tolerate and moderate strong emotions, object constancy or inner sense of connection to others

and belief that others care about them, and positive and effective sense of self. Given the powerful personal effects associated with trauma work, and the intimately interpersonal nature of the therapy setting, it would reasonably follow that these therapists' relationships would also be affected. However, the effects that indirect exposure to trauma has on therapists' relational lives has only been afforded peripheral attention in the research to date.

The present exploratory study aimed to capture the experience of indirectly traumatized therapists and how their relational systems have been altered by their work. To do so, eight licensed therapists self-identifying as having experienced indirect trauma were asked open ended questions about their experience. These questions were aimed at highlighting how indirect traumatization impacts the quality of therapists' personal, therapeutic and romantic relationships, as well as the way they experience themselves and others in said relationships.

CHAPTER II: REVIEW OF THE LITERATURE

Historical Context

Post-Traumatic Stress Disorder (PTSD) was established as a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III) in 1980 and, in the process, illuminated how common traumatic experiences really were (Kessler et al., 1995). In a study examining the prevalence of exposure to traumatic events and PTSD development in the United States, (Kilpatrick et al., 2014) found that "traumatic event exposure using *DSM-5* criteria was high (89.7%), and exposure to multiple traumatic event types was the norm." While most survivors of traumatic events will not go on to develop PTSD, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) reports that the lifetime prevalence of PTSD within the United States is 8.7%. Given the prevalence of PTSD and traumatic event exposure, it seems fairly likely that any given therapist will eventually work with a trauma survivor. Add to this the fact that "individuals with PTSD are 80% more likely than those without PTSD to have symptoms that meet diagnostic criteria for at least one other mental disorder" (American Psychiatric Association, 2013), and the prospect of treating a survivor of trauma seems nearly inevitable.

In the fields of psychology and psychiatry, research into post-traumatic stress and its treatment is booming, but remains relatively new. The study of how *the treaters* of these disorders are affected by the process is even more novel. While Carl Jung described the negative effects that may arise in therapists treating general mental illness in 1966, Haley (1974) was one of the first to do so in a trauma-specific context when she described the intense emotions that therapists could feel when exposed to the atrocities

described by Vietnam War veterans. At the time, the phenomenon was discussed as just

one type of reaction that therapists might have towards or about their clients - their

countertransference. For some time, this was the best term available to describe the

therapist experience. Nearly ten years later, Charles Figley used the term secondary

victimization to describe the way in which family members and caregivers of trauma

survivors may suffer from similar signs and symptoms (McCann & Pearlman, 1990).

Since that time, the study of this phenomenon has progressed and the terminology

associated with it has continued to evolve.

Definition of Terms

Since the 1990's research specific to the negative effects therapists experience

while working with trauma survivors has gained traction. However, the imprecise use of

multiple closely related terms regarding this phenomenon has become a persisting

problem in the empirical and conceptual literature. Vicarious Trauma (VT), Secondary

Traumatic Stress (STS), and Compassion Fatigue (CF) are currently the three most

popular terms and are often used interchangeably to describe the effects of treating the

traumatized. Despite the imprecise usage "theory and research increasingly reveal that

these terms refer to three very specific—and different—sets of symptoms and reactions"

(Knight, 2013). In order to discuss the complete experience of trauma therapists, the more

recently established term "Indirect Trauma" (IT) was chosen for this study to act as an

umbrella term incorporating all negative effects resulting from empathizing with trauma

survivors. To maintain conceptual clarity, the trauma-related terms of vicarious

traumatization, secondary traumatic stress, and compassion fatigue are considered

specific manifestations of indirect trauma, and are used in accordance with their narrower

definitions. The often-associated terms of burnout and countertransference are also discussed below.

1. *Vicarious Traumatization (VT)*

McCann and Pearlman (1990) were the first to apply this term to therapists working with traumatized clients. The definition utilized in their theoretical framework described a process in which "persons who work with victims may experience profound psychological effects, effects that can be disruptive and painful for the helper and can persist for months or years after work with traumatized persons." The "profound psychological effects" that they describe primarily revolve around disturbances to therapists' *cognitive schemas* in the areas of safety, dependency/trust, power, esteem, intimacy, independence, and frame of reference. The construct of VT stems from McCann and Pearlman's Constructivist Self-Development theory, which suggests that individuals construct their own realities through their schema and core beliefs about themselves, others and the world. Vicarious traumatization is a term used predominantly to discuss the effects on professionals working to help trauma survivors heal. It is a cumulative process "through which the therapist's inner experience is negatively transformed through empathic engagement with clients' trauma material" (Pearlman & Saakvitne, 1995a, p. 40).

2. *Secondary Traumatic Stress (STS)*

In their study comparing the constructs of STS and VT, Baird and Kracen (2006) differentiated the two, in part by stating that "The focus [of STS] is not specifically on cognitive phenomenon (as in case of VT), but on a wider syndrome of experiences quite directly linked to the symptoms of PTSD." The symptoms of avoidance, re-experiencing

and hyperarousal found in STS stem from exposure to the details of the trauma of another person. In order to differentiate trauma therapists' post-traumatic experiences from PTSD, Charles Figley (1995, p. 7) first defined secondary traumatic stress as "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other—the stress resulting from helping or wanting to help a traumatized or suffering person." He described it as an experience affecting anyone trying to help or care for a traumatized individual where the helper develops PTSD-like symptoms.

3. *Compassion Fatigue (CF)*

Also coined by Charles Figley (1995), compassion fatigue originated as a term more-or-less synonymous with secondary traumatic stress. Figley desired a less stigmatizing name for what he described as a "normal occupational hazard of working with traumatized people." Compassion fatigue and secondary traumatic stress have both been used in the literature as terms that focus "on the symptoms and emotional responses resulting from work with trauma survivors but do not take into account the specific cognitive changes that vicarious trauma definitions emphasize" (Sabin-Farrell & Turpin, 2003). While the term compassion fatigue was created primarily to destigmatize the experience, "the construct of compassion fatigue has been conceptualized differently from trauma symptoms and may include changes in work behaviors, attitudes and perceptions" (Sprang & Craig, 2015). More recently, Ludick and Figley (2017) reported that "compassion fatigue is the term favored for helping professions whereas STS is used across diverse populations." In addition to the experience of symptoms associated with PTSD, compassion fatigue includes the negative aspects of caregiving and being

overwhelmed by the work. This aspect has led to some conceptual overlap between compassion fatigue and burnout, which is a term used to describe negative reactions to general work stressors.

4. Burnout

Burnout is a concept similar to compassion fatigue in many ways. It is a result of stressful working conditions and can lead to emotional challenges and negative views of oneself and one's work. Maslach et al. (2001) conceptualize burnout as:

> "A psychological syndrome in response to chronic interpersonal stressors on the job. The three key dimensions of this response are an overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and lack of accomplishment."

While these symptoms can certainly occur as a result of indirect trauma, they represent only one aspect of the phenomenon. Where indirect trauma has been tied to hearing, and empathizing with, survivor-client's stories of traumatic experience, burnout results from stressful occupational conditions such as long hours, overwhelming workload and poor organizational support. It is not necessarily linked to direct or indirect exposure to traumatic material, and burnout is not solely the result of exposure to clients' traumatic experiences (Maslach et al., 2001).

5. Countertransference

When theorists and researchers first began to investigate the ways that therapists were affected by treating trauma survivors, they discussed the effects as a particular type of countertransference. Countertransference typically refers to practitioners' (often unconscious) reactions to their clients, and incorporates the ways that the practitioners'

history impacts the working relationship. Countertransference reactions generally do not

persist outside the therapeutic relationships in which they develop and they are not

limited to work with trauma survivors. "Countertransference and indirect trauma are two

distinct phenomena; yet, they are interrelated and can be self-reinforcing" (Knight, 2013).

Another way of describing this distinction is provided by Boulanger (2018):

> "Being vicariously traumatized does not amount to identification with the
>
> patient's relationship to her internal objects, but rather with the patient's
>
> overwhelming affect and confused cognitive state during a particular event."

While countertransference can include painful feelings and emotional avoidance similarly

to indirect trauma, it does not necessarily stem from working with survivors and does not

include changes in schema or PTSD-like symptoms.

6. *Indirect Trauma (IT)*

The International Society for Traumatic Stress Studies (ISTSS) frames indirect

trauma as an inevitable reaction to working with trauma survivors. It is a cumulative

response with some signs and symptoms resembling those of direct trauma. Therapists

working with trauma survivors may experience intrusive thoughts and images, difficulties

regulating emotion, hypervigilance, anxiety, and avoidance. Additionally, indirect trauma

can lead to changes in therapists' cognition, world-view, spirituality, and personal

identity. The ISTSS describes that indirect trauma can affect therapists' professional

relationships with clients and colleagues as well as their personal relationships (ISTSS,

2000). The ISTSS discusses indirect trauma as interchangeable with the terms vicarious

trauma and compassion fatigue. For purposes of this study, however, indirect trauma is

used as an umbrella term encompassing all negative effects that therapists experience as a

result of empathizing with trauma survivors. The terms VT, STS and CF will be considered separate, specific manifestations of indirect trauma.

Risk Factors for Indirect Trauma

A number of elements have been identified as potential risk factors for the development of indirect trauma. Generally speaking, these factors are associated with personal characteristics of the therapist, characteristics of the clients, and aspects of the work environment. Some of the factors contributing to indirect trauma development are: therapist history of personal trauma, coping style and defenses, trauma-focused therapy training, number of traumatized clients on caseload, experience conducting therapy, experience conducting trauma-focused therapy, age, gender, organizational setting, and supervision (Baird & Kracen, 2006; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995).

Pearlman and Mac Ian (1995), in their questionnaire completed by 188 self-identified trauma therapists, examined what factors had the *greatest* impact on the development of vicarious trauma. They found that therapists' personal trauma history was by far the most powerful variable affecting VT development and intensity. Therapists who had personally experienced trauma reported greater overall disruption in schema and higher levels of general distress than those without a trauma history, especially if they were newer to the work. However, for those therapists who were personally traumatized, the longer they conducted trauma therapy, the less distress they reported. While it is possible that the most distressed therapists left the field, the researchers hypothesized that survivor-therapists may experience personal healing by sharing in their clients' growth and change. It seems that, just as trauma survivors are able to experience post-traumatic

growth, vicariously traumatized therapists can gain a deeper sense of personal understanding, an increased feeling of connection to others, and a stronger appreciation for human resiliency through their work.

While certain features of the therapist, the work environment, and the clients have been suggested to predict the development of indirect trauma, there has not been overarching consensus in this area. In fact, Baird and Kracen (2006), in their epidemiological synthesis of prior research, found that different factors were involved in predicting the development of vicarious trauma and secondary traumatic stress. For VT, personal trauma history was found to be the biggest contributing factor, with perceived coping style and supervision experiences also impacting symptom development. STS, on the other hand, was most closely tied to the amount of exposure to clients' traumatic material, with personal trauma history found to be the second largest contributing factor. It is clear that more research and further definitional clarity of related constructs would help to further agreement in this area.

Implications for the Present Study

There now exists considerable research linking indirect trauma with disruptions in cognitions about self, others, and the world, and with symptoms of PTSD. However, the research only peripherally or conceptually describes how indirectly traumatized therapists' relationships are affected. While evidence suggesting that trauma therapists' lives are profoundly altered is available, the question remains: how are these therapists' relationships affected by their work?

For therapists who had not personally experienced interpersonal trauma, working with traumatized clients was found to cause greater disruptions in "other esteem," or the

belief that others are valuable, over time. However, therapists who had personally experienced trauma experienced the opposite effect. The longer they treated traumatized clients, the more highly they regarded others. Pearlman and Mac Ian (1995) hypothesized that personally traumatized therapists already had relatively negative views of others when they began the work, so remaining in the field longer did not lead to conflict between their preexisting beliefs and the stories of human suffering they heard. While a therapist's negative view of others would not *necessarily* impact their personal relationships, it can be assumed that disruptions in "other esteem" are likely to have negative interpersonal results.

McCann and Pearlman (1990), in their theoretical framework of VT, hint at some of the ways in which indirect trauma may negatively impact therapists' personal and professional relationships. They describe that, just as trauma survivors experience stigma and isolation, their therapists may also feel stigmatized and distanced from family, friends, and co-workers. Trauma therapists may feel alienated by colleagues' assumptions and judgements about why they decide to work with this population. Additionally, the requirements of confidentiality prevent trauma therapists from discussing their experiences with others as a means of support, leading to increased isolation and potential disconnect between these therapists and the people they are closest to.

More recently, Sabin-Farrell and Turpin (2003) conducted a review of the literature on the implications of VT for mental health workers and found:

"Fewer studies have specifically investigated effects on interpersonal relationships and occupational functioning… There is a need for further research to assess the potential effects on these areas of functioning."

Their review of both quantitative and qualitative studies provided some feedback about relational effects such as: therapists feeling more vulnerable in personal relationships, increased emotional exhaustion related to intimacy and power, isolation from others, and loss of faith in others. The results included in this review, however, were mixed. The qualitative research investigated appeared to be more likely than quantitative research to identify disruptions to therapists' personal lives and relationships. The mixed results relating to both the extent of IT's effect on therapists' relationships and the manifestations of that effect even include quantitative results from Knight (1997) stating:

> "Reactions which reflected disruptions in therapists' personal lives were not particularly common among the respondents in this study. Few of the clinicians who participated in this research reported that their work hindered their ability to be emotionally or sexually intimate or intensified problems they already had."

The present exploratory study sought to benefit trauma therapists by providing a primary focus on how the phenomenon of indirect traumatization impacts therapists' relationships. Existing literature paints a cautionary tale for trauma therapists, describing that they should be prepared to experience symptoms of PTSD and profound changes in their worldview by working intimately with human suffering. Descriptions by trauma therapists, however, also describe the positive effects of a deeper sense of connection to others and increased appreciation for human resiliency. By providing indirectly traumatized therapists an opportunity to share their deeply personal stories and to describe how their work altered the way they relate to others, this study aimed to enhance the knowledge of this powerful phenomenon. Establishing an improved understanding of indirect trauma will benefit future generations of trauma therapists.

CHAPTER III: METHODS

Rationale

The purpose of this study was to deepen the understanding of the ways in which empathizing with trauma patients affects trauma therapists and their interpersonal relationships. The study utilized a qualitative research approach. According to Kazdin (2003):

> "Qualitative research looks at phenomena in ways that are intended to reveal many of those facets of human experience that the quantitative tradition has been designed to circumvent—the human experience, subjective views, and how people represent (perceive, feel), and hence react to, their situations in context" (p. 329).

This approach was selected in hopes that it would elicit a richer, more complete picture of the therapists' subjective experience than is currently available in the literature. The qualitative nature of the study was also intended to help circumvent the current challenge in the literature that multiple distinct, yet overlapping, terms are used interchangeably to describe and study this complex phenomenon.

Participants

Selection Criteria

In order to be considered eligible for this study, participants had to meet the following inclusion criteria: A) Must have completed the necessary requirements to obtain a license to provide psychotherapy services. Licensure in any of a number of therapy-related fields including psychology, psychiatry, clinical social work, mental health counseling, and marriage and family therapy will meet this inclusion criterion. B)

Participants must have conducted therapy with at least three clients who have survived an interpersonally caused traumatic experience. C) Participants must identify as having experienced indirect trauma according to the definition above as a result of providing psychotherapy to trauma survivors. In addition to meeting the inclusion criteria for the study, potential participants will not be interviewed if they meet the following exclusion criterion: A) Participants must not have experienced direct traumatization in the course of their therapeutic work (such as experiencing psychological trauma as a result of being assaulted at work or as a direct result of their work).

Recruitment

Participants were initially recruited through a recruitment email (Appendix A) posted to the following professional listservs: Graduate School of Applied and Professional Psychology Alumni Network, New Jersey Psychological Association, New York State Psychological Association, and International Society for the Study of Trauma and Dissociation. The remaining participants were recruited via word-of-mouth sampling by the investigator.

Measures

Demographic Questionnaire

Participants were asked demographic questions (Appendix E) at the beginning of the interview session, which gathered information about participants' age, gender, relationship status, trauma-focused therapy experience, and personal experience of psychological traumatization.

Semi-Structured Interview

The current study employed a semi-structured interview (Appendix F), which comprised open-ended, phenomenological questions about how trauma therapists experience the effects of working with trauma survivors. The protocol followed the long interview procedure outlined by McCracken (1988) in order to explore the following qualitative research domains: how therapists subjectively experienced indirect trauma; how their romantic, personal, and professional relationships were affected by their indirect trauma; how their perceptions and feelings about their relationships were affected; and what lasting effects they experienced as a result of working with trauma survivors. The questions were developed by the principal investigator based on the literature review. They were designed as an organizing guide to the interview that would allow participants to offer rich, personal information without being overly restricting. The investigator piloted the interview questions with a fellow doctoral candidate to test the interview length and observe the types of responses evoked by the questions.

Procedures

Interested participants were instructed to contact the principal investigator for a phone screening (Appendix B), which was then utilized to ensure prospective participants met selection criteria and to inform participants about the purpose of the research and what participation entailed. Individuals deemed ineligible were provided with an explanation as to why and were thanked for their time and interest. For those who were interested and eligible for participation, an in-person interview was arranged at a location of the participant's choosing to ensure comfort and convenience.

Five interviews were conducted at participants' places of work, two were conducted in participants' homes, and one interview was conducted remotely via secure video-conferencing. At the beginning of each interview, participants' written informed consent for participation in the study (Appendix C) and audio-recording (Appendix D) were obtained (these consents were obtained prior to the remote interview). All participants were interviewed using the semi-structured interview protocol (Appendix F) and all interviews were audio-recorded. Each interview lasted between 60-90 minutes.

Treatment of Data

All participants were assigned a case number and pseudonym that were attached to their data. The document pairing participants to their assigned case number and pseudonym was kept in a locked file cabinet, and was only accessed by the principal investigator. All paper data and the audio recorder were kept in a separate locked bag only accessed by the principal investigator. The audio recordings were deleted from the recorder after being uploaded to a password-protected file on a password-protected computer.

The principal investigator manually transcribed the audio recordings into written transcripts stored in password-protected documents on a password-protected computer. During the transcription process, the investigator changed all identifying information. For example, dates, ages, locations, and institutions were all changed to maintain participant confidentiality. Only the principal investigator and the two dissertation committee members had access to the complete transcriptions. All audio files were deleted following transcription. All transcriptions and identifying information securely stored during the study will be destroyed and/or deleted three years after the completion of the study.

Data Analysis

Data was analyzed using a modified grounded theory approach (Corbin & Strauss, 2014). Using grounded theory, data analysis consisted of three phases of coding: open coding, axial coding, and selective coding. In open coding, the data obtained from the interview transcriptions was broken into smaller categories by grouping and labeling similar concepts, phrases, words, and patterns together. The data being obtained was continuously compared to the developing categories in order to determine reliability in coding. The process continued until no more emerging categories could be identified. This was accomplished by repeatedly reading and re-reading the transcripts, which allowed for both the emergence of subcategories and for a more refined organization of the data (Corbin & Strauss, 1990). Data was analyzed as it was created and helped to guide later data collection. Once the data was grouped and labeled through open coding, the analysis proceeded to the second phase, axial coding. This phase consisted of identifying relationships between the categories previously identified via open coding and involved considering the conditions, contexts and consequences that govern the different categories. The final phase, selective coding, involved combining the categories and relationships into core categories by attempting to create a narrative that provided a sufficient and adequate description of those core categories. This phase involved relating the core categories to one another in order to portray the central phenomena elicited from the data (Corbin & Strauss, 1990).

About the Researcher

In qualitative research, the researcher is the main instrument of data collection and analysis (Glaser & Strauss, 1967). As such, it is necessary for the qualitative

researcher to be aware of the impact that their identity, subjectivity, bias, and attitudes have on data collection and analysis. As the principle investigator, I have attempted to remain aware of my background, motivations and hopes for conducting this research, as well as the ways in which these factors may impact the research process.

I am the eldest child of a single mother who survived childhood trauma. My father died of cancer when I was six years old. From an early age, I developed a strong attunement to my mother's emotional experience. Though none of my family members have conducted psychotherapy, nor did I know much about therapists or therapy growing up, studying psychology and eventually pursuing a doctorate in clinical psychology felt like a natural calling. In retrospect, and through my own therapy, I have realized that a major motivation in pursing clinical psychology was a desire to better handle the emotional stress of caring for a caretaker. During my first clinical experience, I learned that treating others' trauma came intuitively to me. In the relatively short period of time I have been working in this field, I have been presented with the opportunity for incredible self-exploration and growth.

The idea for this study came from that same personal search for self-understanding. Knowing that I was interested in working with trauma survivors, and hearing the terms various trauma and secondary traumatic stress, I worried what effect this work might have on me in the future. My interest in relational psychodynamic therapy, and my belief that interpersonal connection is key to mental and emotional wellbeing, led me to focus further on the relational impacts of indirect traumatization.

Towards the end of the data collection phase of this study, before beginning the data analysis and writing, I started my psychology internship at a Veterans Affairs

Medical Center. The vast majority of my patients suffered from psychological trauma. Over the course of my internship year, I experienced firsthand the toll that this work can take on the clinician and related personally to the challenges my participants described. The anxiety, anger, and traumatic material that my patients shared with me left an impression. Near the mid-point of my internship year, I made a concerted effort to acknowledge and address the ways that my thinking about myself, people, and the work had shifted. I noticed that I had begun wrestling with patients' case material when I was in bed and that I would recall my patients' warnings about remaining vigilant while on the subway. Supervision helped me to explore increased urges to rescue my patients from suffering and my fluctuating sense of competence as a clinician.

As this study helped me to expect, the changes I noticed in myself during my internship year did not occur in isolation. I noticed myself become much more careful of how I spent my social energy. It was as though my ability to connect to others had become increasingly finite, and I had been teetering on the edge of that limit more than ever before. Desire for support, understanding, and meaningful connection from my partner, my supervisors, and a few close friends increased. Perceived and actual misattunements caused greater distress. At the same time, my tolerance for connection with those I did not perceive to be innately supportive of me diminished. I did not notice a change in my overall desire for connection, but I required much more that it be on my terms. Apologies to my roommates for the irritability that arose when those terms were not met.

CHAPTER IV: RESULTS

Demographics

A total of nine participants were interviewed for this study. One participant's interview data was not used in the study after it became clear that they did not meet inclusion criteria C): identifying as having experienced indirect trauma as a result of providing therapy to trauma survivors. The results and discussion chapters of this research utilized data obtained from the remaining eight participants.

Of the eight participants whose data were used for the study, seven were female and one was male. The participants' ages ranged from 29 to 76, with a mean age of approximately 53 years old and a median age of 59 years old. Seven participants racially identified as White. One identified as White, Native American and Indonesian. Three participants also identified their ethnicity. Two participants identified as ethnically Jewish and one identified as Hispanic. All eight participants identified as cis-gender and heterosexual. Seven participants were licensed psychologists and one was a licensed clinical professional counselor (LCPC). At the time of the interviews the participants had been licensed therapists for an average of 19 years, with a range from less than one year to 36 years. During the interviews, five participants were married, two were single, and one was divorced.

Profiles

Below are brief descriptions of the eight participants included in this study. To protect confidentiality, names and other identifying information have been changed.

Kathy

Kathy is a woman in her early sixties, who at the time of the interview was conducting psychotherapy full time in private practice. She reported that approximately half her caseload had identified trauma as a focus of treatment. In terms of her personal trauma history, Kathy reported that her first husband was emotionally abusive. Kathy also reported that she came from a family of Holocaust survivors.

Kathy's experience of indirect trauma occurred during her work at a large physical and cognitive rehabilitation hospital. There, she conducted evaluations and therapy with patients that had survived accidents and endured traumatic brain injuries (TBI) or strokes. Kathy experienced a significant change in her sense of safety and her schema about the world that began during this time. She reported that the work "pierced [her] illusion that the world is a safe place." She noticed that she became much more anxious and that it became hard for her to have fun and enjoy life the way she used to.

Kathy was married to her first husband during her experience of IT. She reported that she initially tried to talk to him about her experiences at work in an attempt to receive support. However, she quickly realized that he did not want to hear about it. Kathy's husband repeatedly shut down conversations she tried to have about her job and also became aggressive about her inability to, in her words, "be Miss Fun Sunshine all the time" any longer. She soon stopped trying to talk to him about her work, which left her feeling lonely. After some time and additional psychosocial stressors in their relationship, Kathy decided to get a divorce. She remarried and had children, but later divorced a second time for reasons she said were unrelated to her work. In fact, Kathy did not report getting support with her IT from anyone. Her co-workers did not talk about it,

and she refrained from talking to friends because "it's a downer" and she did not want others to be impacted. While she had a growing romantic desire for her co-workers at the hospital because she believed they would understand her better, Kathy ultimately kept her concerns to herself. She said that the interview was the first time she had talked about these problems and that she did not even mention them when she was in therapy because she did not believe there was anything anyone could say to help.

Kathy's healing included significant training in trauma-focused psychotherapy, in addition to shifting the bulk of her patient population away from TBI. Her recent trauma work primarily involved survivors of sexual abuse, which she reported was easier for her to handle. Kathy expressed gratitude for her IT experience because it made her more optimistic of peoples' potential to heal and increased her own sense of competence. However, she still believes that she has a "hyperactive internal security guard," or heightened anxiety response, and a harder time having fun. She believes that her challenging experience helped her to grow and reported that she finds her current work tremendously rewarding, but stated:

> "I really don't know, if I had the experience, the knowledge, the understanding that I have today, whether I would choose to do that again… But I'd be a different person. So."

Nancy

Nancy is in her late fifties and currently works as a therapist in private practice. Her personal trauma history includes surviving sexual abuse and having been in lower Manhattan during the September 11th, 2001 terrorist attack.

Nancy described her experience of indirect trauma as "death by 1000 cuts," which peaked during a time when she volunteered with 9/11 first responders and then took a job conducting trauma-focused therapy in a firehouse that had lost a number of men in the rescue efforts. Nancy was personally traumatized by the attack, but also felt pressure to help. That same day she went to a hospital she had previously trained in, ready to work, and was disappointed when no one came in requesting help. In discussing how she was affected by her work, Nancy shifted almost unconsciously between describing her own symptoms and those of her patients. It was clear that she identified strongly with other survivors and struggled to relate to those that had not been through the experience. While her work surrounding the 9/11 attack was the largest source of Nancy's IT, she became tearful during the interview while describing a trauma survivor she worked with decades earlier. It was clear that her patients' stories had affected her greatly. Nancy discussed experiencing symptoms of hypervigilance and hyperarousal, drastically altered beliefs about how safe the world was and increased irritability as a result of her work.

Nancy is married and was married to her husband for the duration of her work. However, she described significant turmoil in her relationship for a period of time. She half-jokingly discussed her realization that something had to be done:

> "Well, yeah, my husband. I think there was a period of time where my anxiety and my irritability got to a level where I finally had to do something. And it wasn't like a gradual build. It was just, all of a sudden I realized 'This is a problem.' You know? And I realized I was either going to have to divorce my husband or do something like EMDR (laughing)."

In general, Nancy experienced a period of time where she struggled to relate to people that weren't either in the field of psychology or survivors of the 9/11 attacks. While she described that this problem isn't as present for her now, she acknowledged that she is still more particular about who she shares her time and energy with.

Nancy underwent her own Eye Movement Desensitization and Reprocessing (EMDR) therapy, which she found incredibly helpful. She no longer feels as overwhelmed by her work with patients and now believes that no trauma is insurmountable. She does, however, carry more anxiety than she did before getting into the field. At the end of our interview she made sure to point out her silver whistle necklace and keychain. When I did not understand their significance, she said, "If you're trapped in a building, in a collapsed building, this will get you found… That's the heart of trauma."

Emily

Emily, in her late sixties, was the only non-psychologist interviewed. She received a Master of Science in Education (M.S.Ed.) degree, and is a Licensed Clinical Professional Counselor (LCPC). At the time of the interview, Emily worked in a group practice providing therapy to children, adults, and families. Her reported personal trauma history included surviving a serious car accident.

For much of her career, and during her experience of IT, Emily worked in a community mental health center that was closely connected to her state's Child Protective Services. She worked with children and adults who had experienced domestic violence, physical and sexual abuse, and neglect. She still sees a similar clientele in her private practice. Emily has been working as a counselor for roughly 20 years. She went back to

school for counseling after years of working with similar populations in a non-therapy role at a non-profit organization.

Emily acknowledged that for much of her life she defined herself through her work. One of the effects she reported was that she became a "workaholic," which led to a host of additional challenges for her. Emily felt compelled to devote much of her life to her work and training because of how "powerless, devastated, and overwhelmed" she felt reading her patients' case histories and hearing their stories. Her desire to help her traumatized patients became so strong that at one point she almost fostered a child she was working with.

Emily's work had a significant impact on her relationships as well. For a long time, she pulled away from her friends and "hibernated." She began to feel that many of her friends were "sucking [her] dry," and that they were incredibly needy and draining. Emily didn't initially mention the effects on her nearly 50-year marriage to her husband. She later reported that her husband didn't believe in therapy and didn't want to hear about her work. He found it very painful to hear the stories she tried to share with him during her initial search for support. In response to this, and due to her concerns surrounding confidentiality, Emily doesn't speak about her work at home. She said that her and her husband were good at joking around together, but that they didn't relate over serious topics. She was able to say that she found her husband's response to her work invalidating, but often returned to discussing work when I asked about her relationship. She said that it had always been important for her to be passionate about a cause, and that despite her husband's stigma about counseling, she was determined to "drag him along" with her.

Despite the challenges she has experienced as a result of the work, and the ways her relationships were affected, Emily stated:

"I am still so excited about everything I do! I love it, I can't even imagine retiring… I love the idea that there's always something evolving, and something that you can learn… There's so many different ways that you can touch people's lives."

Emily noted that peer supervision, relationships with coworkers, trainings and readings, and witnessing the progress of her patients has helped her to cope. She still has a more difficult time having fun than she used to, but she has been trying to work on valuing her friendships and identifying herself in relation to them and to her hobbies instead of just her career.

Beth

Beth, in her late fifties, was no longer conducting psychotherapy during the time of the interview. She still worked as a psychologist, but had been teaching and conducting psychological assessments for roughly 20 years. Beth expressed a personal trauma history involving surviving a natural disaster. She also hinted at a problematic family upbringing without mentioning specifics. She reported that she is a descendant of Holocaust survivors.

Beth's experience as a therapist was primarily in an outpatient department of a city hospital. While there, she provided therapy to a number of children and young adults with traumas primarily related to domestic violence, abuse and neglect. She reported significant indirect trauma symptoms during her work in the hospital. Cognitively, Beth's perception of the traumas faced by "typical people" shifted to be much more extreme

than the difficulties she had experienced in her life. She came to believe that her own problems, and those of many of the people she knew, were entirely insignificant. In terms of her view of self, Beth experienced a total loss of confidence in her abilities as a clinician. "Who am I to say that I'm a good therapist?" Beth was angry at the systemic problems her patients faced, but also felt personally responsible for their outcomes. "I obviously had just been playing with this and playing with people's lives. And, you know, it's too much responsibility for me. I'm not very good at it." In addition to her change in schema, she experienced physical and emotional symptoms from her work.

Beth reported experiencing hypervigilance and physical symptoms of anxiety including increased heartrate and chest tightness. She had nightmares about her patients dying, or killing other people. She reported becoming "constantly depressed and, I would come home and be very weepy by myself. I was isolated. I didn't want to be around other people."

In terms of her relationships, Beth identified as single at the time of the interview and reported that she was not actively seeking a partner. Beth had never been married. She had been dating someone during her work at the hospital, but it ended during her time there. Beth reported feeling very invalidated when talking about her work, and developed a firm belief that no one cared about her difficulties. She quickly stopped talking to anyone about her problems and ended her romantic relationship. Beth even found her personal therapy unhelpful, as she believed that she made her therapist too anxious for him to possibly be helpful to her. Beth's relationships with her patients suffered equally, as her anxiety for both them and herself made it difficult for her to be emotionally available. Towards the end of her time at the hospital, Beth had prepared to

move internationally as an escape from the difficulties in her life. She conducted this

preparation in secret, not wanting others to know of her plans or persuade her to stay.

After leaving her job at the hospital, Beth's desire to move decreased. While she

maintains a negative view of trauma therapy, and still reports a belief that people are

generally uninterested in what she has to say, her other indirect trauma symptoms have

diminished.

Eva

Eva is a woman in her early thirties. Just days before the interview she had taken

a job in a healthcare startup that catered to corporations and provided a range of services

to employees, including outpatient psychotherapy. She identified as a survivor of sexual

abuse.

Eva's experience of IT occurred primarily during her postdoctoral year. She was

working as part of a PTSD research team conducting evaluations with, and providing

psychotherapy to, trauma survivors. Eva reported that the most difficult parts of the job

were the evaluations and the cases where she utilized Prolonged Exposure (PE).

Referring to the evaluations, Eva described how difficult it was to hear these individuals'

painful stories without being able to intervene. She discussed a feeling of being

"unloaded" on without the opportunity for resolution. With her therapy patients, Eva

reported that seeing them heal was one of her biggest protective factors.

Eva's experience working with adult survivors of childhood sexual abuse greatly

altered her perception of the world. She remembered going to her supervisor's office after

a particularly difficult session and telling him "We live in a fucked-up world."

Interestingly, Eva had previously conducted trauma therapy with a number of veterans

without much difficulty. She reported that the atrocities of war fit into her perception of

the world, but hearing about patients being abused by the very individuals that were

meant to keep them safe shattered her expectations. She began to fear that childhood

sexual abuse was occurring all around her, and that abusers were lurking around every

corner. She felt helpless trying to confront what seemed like an unending wave of human

suffering.

Eva was married before her experience of IT, and was still married at the time of

the interview. She reported that her marriage experienced a "really awful year" when she

was on postdoc. While many of the difficulties she experienced in her relationship that

year are now healed, she noted that there are still lingering challenges that she believes

started at that time. Eva reported that one of the biggest problems for her was that when

she came home at the end of a workday, she had no energy and no tolerance for

interacting with her husband, who was excited to see her. Eva had initially felt a need to

tell her husband about some of the atrocities circling in her mind, but quickly learned that

he was not interested in, nor capable of, hearing her out. Eva felt a "void" grow between

them during that year. She didn't want to unload her tension on him, but she also didn't

have much energy to hear about his problems. When Eva returned home she just wanted

to "disconnect" and watch TV mindlessly. Additionally, she didn't want to be vulnerable

with her husband any longer, as the work left her feeling that way regularly.

Eva and her husband still have difficulties with intimacy that began during that

awful year, but much else about their relationship has healed. She reported that she is

happy to see him when she gets home, and that she no longer feels the same pressure to

talk about work. Eva's relationships with her friends didn't change much during her

experience of IT and she noted that the two most helpful factors in her life were consultation with a friend who is a fellow psychologist and seeing her patients heal, proof that her efforts had paid off.

Maria

Maria is a psychologist in her late seventies. She has worked in private practice since receiving her degree, and has worked with trauma and dissociative disorders for much of her career. Maria's personal trauma history included surviving cancer and an accident.

During her most intense experience of IT, Maria was working with about 50% Dissociative Identity Disorder (DID) patients, many of whom were survivors of childhood sexual abuse and incest. Generally, Maria experienced an increase in anxiety as a result of the work and a change in her "naiveté," or innocence related to her understanding of the prevalence of horrific trauma in the world. Her most challenging indirect trauma experience, however, occurred with one of her earliest trauma-focused cases. Her patient was a survivor of ritualistic abuse, and had intense fears of being followed. Over time, Maria began to buy in to her patient's fears and came to believe that shadowy figures were recording conversations in her office and keeping track of her whereabouts. "Maybe they knew who I was, maybe they were going to punish her, punish me." The other general effect that the work had on Maria was the challenge it presented to her sense of competence. There were many times she felt helpless and thought "Oh boy, I am so out of my depth (laughing). And I don't know what I'm doing. And I'm not really good at this and I made a mistake."

Maria considered herself privileged to "have [her] husband as a supervisor in a way, another peer supervisor." As he was also in the field, she often turned to him for both support and consultation. She found aspects of what she heard at work so "horrifying, infuriating and sickening" that there was an urge to share, to not be alone with what she was hearing. Even her adult son knows about some of the traumatic case material she encountered. Though joking, it was clear that Maria meant it when she said that her son was very insightful and helped her with cases on a number of occasions. Though sharing these cases with her loved ones was helpful, Maria's husband eventually let her know that he couldn't talk about them over dinner. Hearing the material she felt pressured to share made him nauseous. Maria was disappointed, but not hurt by her husband's decision. She tried to "cheat a little bit" and discuss traumatic case material with him from time to time, but found that her trauma-focused peer consultation group, and discussions with her psychologist friends, eased the pressure she felt to reach out to him.

Maria's boundaries were certainly affected by her work. With family, that meant discussing case material in a search for support. With a long-term patient of hers, the boundary change was more extreme. In a dire effort to keep her patient safe in the face of suicidal threats, Maria agreed to hold her patient's excess medication for her. Eventually, Maria even stored the patient's gun in her office. In the "signature scariest, most impactful" moment of her career, Maria "couldn't hold the fear, couldn't hold the anxiety, couldn't hold the risk," and turned the weapon in to the police. Looking back, Maria was disappointed with how she handled the situation with that patient. She told me that she had intentionally withheld the story about the gun until the very end of the

interview. While Maria noted how emotionally overwhelming her work was, she had opted to continue on in partial retirement for years longer than she needed to financially. She was confident that the rewards of the healing process and the intimate connection she developed with her patients were worth the struggle she faced.

Nina

Nina is a woman in her late twenties who was newly licensed at the time of the interview. She works with adults and couples at an outpatient psychotherapy clinic. Nina did not report a personal history of trauma, but when asked about her trauma history she reported that her grandparents were Holocaust survivors.

Nina's experience of indirect trauma was recent, and she described that it developed gradually over the course of her current job. The symptoms that she experienced were mostly cognitive. Nina recalled going into her supervisor's office after a particularly difficult trauma-focused session and saying "The world fucking sucks!" She said that her thoughts about the world and the people in it have become more negative as a result of the work.

Nina made it clear that her relationships were greatly affected by her work. She described her social circle changing significantly as she began to value her friendships with fellow psychologists above all others:

> "I think my peer group has really changed since I started graduate school. With me putting more effort into relationships with fellow therapists. And just less time spent with people who are not. And I sort of feel like, 'You don't get it. And I need to be around people who do."

Nina came to believe that non-therapists would not be able to understand or support her in her experience as a trauma therapist, and that relationships with other therapists had greater potential for mutual support. While she still interacted with her siblings and non-therapist friends, she mentioned having to filter herself in their interactions:

> "I think this is where the censorship comes in. Which is what makes the other relationships feel that much more easy and liberating. Because I'm not going to share like, 'Yo, these problems are small (laughs).' It's more like, that's where the therapist-mode will kick on. Whereas with my [therapist] friends, everything gets shed and it's just raw."

Nina described falling into a familiar pattern of providing support to non-therapists, and struggled with the imbalance that resulted. To be "totally unfiltered and uncensored," or truly herself, Nina believed she needed to be connected to other therapists.

Nina's work and the beliefs she developed impacted her relationship to romance as well. She was single at the time of the interview and reported that she had hardly dated since beginning graduate school. Despite feeling that "in theory" it would be nice to date someone, Nina reported that she could not imagine being able to leave work at the end of the day and go on a date:

> "I'm envisioning what my schedule looks like, and who my [patients] are, my 5pm's and my 6pm's, or my 4pm's. And I'm just like, how can I go (laughs) from listening to *that*, to sitting across from you and A) pretending like I give a shit about what you have to say (laughs). Or even trying to be attentive to what you're saying. And then B) explain to you my day. And what I'm hearing and seeing. And so I think there's been an avoidance of that."

Nina was able to reflect on these beliefs and say that she had been on dates with a few understanding, psychologically minded non-therapists. However, she was largely unwilling or unable to pursue romance in her current situation.

Nina identified strongly in her connection to her traumatized patients. She felt extremely protective of them and equally guilty when she had to terminate to meet her clinic's session limit. Despite being "devastated" by the work, she found it incredibly meaningful. Nina described that, while the work at times was shocking and challenging, it aligned with her sense of purpose.

Bill

Bill is a man in his early-forties. He has worked with adults presenting primarily with trauma-related difficulties in an outpatient clinic for most of his career. Bill reported a traumatic experience that involved witnessing a gruesome accident. He also reported a belief that being a descendant of Holocaust survivors drew him to trauma work.

Bill experienced much of his indirect trauma in the setting in which he still works. He works primarily with veterans. Bill described IT symptoms including anxiety, irritability, and being preoccupied and dissociative. The largest impact Bill described, however, was that the work "shook [him] in [his] core" and required significant processing or "working through." Bill described how the war stories he heard required him to change his schema about humanity:

> "I mean *ultimately*, what it did was it helped me realize that as human beings we're capable of doing horrific, horrible, inconceivable, unspeakable things. To other people."

Looking back on this experience, Bill reported that a major component of his healing from indirect trauma involved working though was his own capacity for anger:

> "The idea that, under certain circumstances, people can really do horrific things to other people... Was something that, on the one hand was really disconcerting and sickening. And on the other hand, it helped me with my own, just allowed me to have my *own* aggressive and hostile fantasies and not be so freaked out by that. To consider that that's human. That's within the scope of being human."

Given his family history, it was difficult for Bill to arrive at the meaning he took from his experience. He reported that hearing the atrocities his patients had committed in war brought up fears related to the Holocaust that Bill had assumed were in humanity's distant past.

Bill has been married for the majority of his work experience. He has three children. He reported that his wife has been supportive of him and his work. She hasn't expressed being upset with him or the way he is affected by his work. He did, however, report that "being anxious, having sleepless nights [and] being preoccupied" at times made it difficult to be present and available for his family. It made it difficult for him to have fun. Bill has at times felt guilty and angry at himself when he is unable to connect to his wife or children the way he would hope to. In those moments, he feels like a burden, occasionally withdraws, and has a difficult time with physical intimacy. Bill made it clear that he valued his connection to his family extremely highly, and wrestled to balance continued closeness with the desire to isolate when experiencing IT symptoms. "Yeah, it's like both this need to be alone. But also, not completely." He reported working hard to

balance the disengagement he occasionally needed with his desire for closeness and connection to his family.

Ultimately, Bill reported that his experience of IT gave him greater freedom. It pushed him to grapple with significant aspects of himself, his history, and his humanity in ways that allowed him to experience his full range of emotions, including anger, hatred and disgust, with less self-criticism. He said that he was unsure if he would have been able to do the internal work that brought him to this place without the support he has received from therapy, supervision and his wife. He reported that the work was very challenging and very rewarding. Bill ended his interview reflecting on his values:

> "The importance of remembering that, 'There but by the grace of God go I.' I mean, you don't know what life is going to throw at you from one day to the next. But doing what you can to really make the most of these moments with the people that we care about. That we love. It's so important."

Theme I: Contributing Factors for Indirect Trauma

The question "What about your work do you believe *most* contributed to [your indirect traumatization]?" proved difficult for participants to answer. Each therapist was able to speak to the difficulties they experienced, aspects of their work setting they did and did not like, and how challenging the work was. However, they resisted attributing IT effects to any one contributing factor. While the participants were reluctant to ascribe causation to their challenges, the following factors were discussed enough to warrant consideration. Those challenges and grievances discussed most often are included as subthemes below: *Experience and Training, Work Environment and Burnout* and *Identification with Trauma Survivors*.

Experience and Training

There was a fairly even split between participants that described their indirect trauma symptoms building cumulatively over the course of their career, and those that struggled the most as trainees or newly licensed therapists. For those that experienced their symptom development cumulatively, the impact of a particular event or the start of a new job with a new patient population generally precipitated their most pronounced IT experience. Nancy described her symptom development as follows:

> "Well I think those patients may have been cuts along the way. But I don't think it got to a critical mass until I had many, many more experiences with trauma. And that really came after 9/11. That was the critical mass. You know, they say death by 1000 cuts. Wrong to even think of one person's experience as a cut, but 9/11 was like the floodgates. Because I had a massive exposure."

Nancy became flooded by her work with 9/11 survivors. She was not alone in identifying a shift in her patient population as a contributing factor to her IT. Maria reported that after working for some time in private practice, she began to find that two new groups of patients were showing up to her office more frequently:

> "Like the adult children of alcoholics and the ritual abuse survivors. It was not anything I imagined I would do. It wasn't anything I thought I wanted to do. But there they were."

Maria described that she thought for a time about referring these patients out to providers better suited to work with them. However, she ultimately decided to pursue additional training and education and continue with these new presenting problems. She described how these patients impacted her greatly, which coincided with her experience of IT.

While some participants described a cumulative development of IT symptoms, usually precipitated by a shift in patient population, others' most challenging experiences came at the very beginning of their careers. For the therapists that struggled the most in these early stages, particular patients' stories and therapeutic experiences had large, lasting impacts. Some of these participants recalled in elaborate detail patients and therapies dating back decades. Kathy described her experience participating in the interview and reflecting on some of her earliest therapeutic work:

"It's been interesting to talk about this. I haven't really ever discussed it before. It's interesting to be reflective about oneself and one's life and where one is relative to those experiences that were pretty important at that time. It's a little bit weird to realize how many years have gone by. And I always tell people, you know, PTSD is a disorder of time. And I guess, perhaps with indirect traumatization there's a little element of that too. That it feels very vivid to me still. Those experiences in the hospital are still so vivid. More so than many clients I've seen in years since."

Kathy related her experience of indirect trauma to her conceptualization of PTSD, describing how traumatic memories seem to freeze survivors in time. The inexperience of these new clinicians and their introduction to incredibly painful trauma narratives created an experience that was both jolting and memorable.

Related to this inexperience were the beginning therapists' identities as trainees. Participants described that early in their careers, they did not have the confidence in themselves that they would later develop. They also lacked the systemic power of more senior therapists. Some participants reported feeling taken advantage of by their training

sites; a feeling that contributed or allowed for the IT symptoms they developed through their work. Eva described the disillusionment she held about her training experiences:

"I think that a lot of chiefs of psychology and people in these powerful positions preach self-care. -And this is beyond just trauma work- But the reality is that they abuse trainees: externs, interns, postdocs, and even early career psychologists. So *I* feel like there's a lot of hypocrisy in our field. And over this past year in my postdoc, I really became disheartened with the field of psychology. If our field would change and the leadership could change to be more supportive and less punitive and infantilizing of trainees and people in the early stages of their career, I think it would be much... I don't know. People would feel more supported. They would be able to do better work."

Inhabiting the least-powerful role in their respective work environments is difficult for any trainee. A number of participants in the study described that this difficulty compounded the effects of the trauma they worked with.

Work Environment and Burnout

Whether in the position of trainee or experienced clinician, the participants portrayed how influential their work environments were on their experiences of IT. From limited resources and long hours to unsupportive colleagues and bosses, the therapists in the study described the ways that burnout-related exhaustion and job dissatisfaction compounded the effects of treating trauma.

Emily struggled mightily with the high demands and limited resources available in the small community clinic where she worked. She reported that clinicians often had to

purchase the toys and therapy equipment they needed to work with their child-patients.

She also described the effect of raises becoming less and less frequent over the course of

her time there:

> "That caused a lot of stress on staff that were already on the front lines anyway. It
>
> just added more to dealing with the trauma that we were already seeing. It was
>
> also, how do you manage in your own life? How do you value yourself when you
>
> don't feel like anybody else is valuing you?"

Despite the difficulty and displeasure she experienced with the clinic, Emily felt

compelled to continue helping her patients and the staff members she supervised. A

combination of burnout symptoms and trauma-related guilt led Emily to push herself to

continue working in the clinic part-time after she started a new full-time job. She

described the impact on her schedule and her life:

> "It was guilt, I felt guilty about leaving. And not being there to support my staff.
>
> But then I finally just had to say that's it. Like, I'm dead. I'm getting up at 4:30, 5
>
> o'clock in the morning to review reports. I'm coming home from work and
>
> working on them again until 10 o'clock, 11 o'clock at night."

Though she felt guilty for leaving her co-workers in such a difficult work environment,

Emily finally decided that the hours she was working were unbearable and transitioned

out of the clinic completely.

Many clinicians in the study pointed to ways in which work environment

contributed to IT symptoms and general stress levels. Nancy described regularly skipping

lunch in her private practice. Maria described working two jobs and long hours that wore

her down. Kathy described the pressure of working 60-70 hours per week and struggling

to meet deadlines for her testing reports:

> "We had to write these long, endless-seeming reports. Every day I would
>
> basically be with patients almost all day and then I would bring all this stuff home
>
> and I'd end up spending hours working on this stuff at home. I probably wasn't the
>
> most efficient person either. My supervisor wanted people to just spew this stuff
>
> out and dictate. And I was always more thoughtful and careful. So it probably
>
> took me longer. But I think I was working 60 to 70 hours a week, at that time. At
>
> least. So it felt like a lot of stress and pressure. And while I was there, you're
>
> running around the hospital trying to see people, trying to finish this testing with
>
> this one and this testing with that one."

While Kathy pointed to the time pressure of her assessment reports being particularly

challenging, Eva discussed how conducting evaluations left her holding her participants'

unprocessed traumas:

> "I've processed this with my supervisor. Those were harder because a lot of these
>
> participants- I'll call them participants because they weren't our patients- They
>
> would come in- I would do the evaluation- So they would unload all of this stuff
>
> in the three hours that I was with them, and then I really didn't do anything with
>
> them afterwards. Whereas, with my patients, we were working on the trauma."

Without the opportunity to process her patients' traumas with them, Eva felt like she

needed another outlet. When asked if she was able to use supervision to achieve this, she

stated:

"I didn't. Because I felt... (sighs) It was just like, the way that it was set up. I

didn't feel comfortable because I was like, 'Am I going to be the only person

talking about this?'"

Eva was not alone in feeling pressure to keep her difficulties with the work environment

and the traumatic material she was hearing to herself.

While some participants described burnout and stressful work environments as

contributing factors of their indirect trauma, it also appeared that IT could lead to

increased burnout. Nina reflected on the way that her traumatized patients affected her

and how this often made her work longer hours than required:

"Because we're shorter-term I- And this could really speak to my own dynamics

that should be addressed in therapy (laughs)- But I give them an hour as opposed

to 45 or 50 minutes. It's an hour minimum. And it can be a little over that

sometimes. Because I just feel like you're here for shorter-term, I need to give you

everything that I possibly can. Even if that means that I'm doing paperwork at

night. And taking on more myself."

The pressure that Nina experienced to extend her therapy sessions often left her feeling

exhausted. In a number of ways, participants experienced their work settings as

demanding and unsupportive. These contributing factors are common in the experience of

burnout. When combined with exposure to traumatic narratives, however, they

contributed to the development of indirect traumatization.

Identification with Trauma Survivors

Empathizing with patients and their narratives is an essential part of conducting therapy. Many of the participants in the study prided themselves on their ability to feel for and with others. As necessary as this ability is to therapists, it also exposes them to the pain that accompanies trauma. The therapists in the study discussed ways in which the more connected they felt to their traumatized patients, the more indirect trauma they experienced.

Nancy experienced a cumulative buildup of identification with her patients. Eventually, this empathy became overwhelming:

> "I think there's a tipping point where, because the trauma is so great, or your exposure is so great, you can't always shake it off. It's not that you can't shake it off, but you realize that you are just as vulnerable, you are just as human, you are just as capable of having whatever, terrible luck, bad choice, or crappy gene problem as the person in front of you. And you realize, 'There but for the grace of God, go I.' And I think that's what secondary trauma is. It's that tipping point where you just can't be disconnected."

Nancy realized over time, and after working with many traumatized patients, that her ability to separate herself from her patients and their pain had seemed to diminish. The vulnerability she experienced as a result contributed to her pain.

While over-identification was discussed as a contributing factor for IT, the therapists experienced a protective effect when their patients' traumas felt distant from their own experience. Maria described how helpful it was that she did not believe that the traumas her patients had endured would happen to her or her loved ones:

"Because these things didn't, they never seemed close, like it was going to happen

to me. Other than when I was afraid of being tracked. But my circle, my life, my

people, my support systems, no. I absolutely think that helped."

Unfortunately, not many participants maintained the belief that they were protected from

the traumas that their patients experienced.

For a few participants in the study, switching patient populations led to an

increase in IT symptoms. Greater identification with the new population and their trauma

was hypothesized to contribute to this upturn. Eva described how working with veterans

who had survived combat was much easier than treating survivors of childhood abuse:

"It was different because most of the trauma there was combat-related. Which for

me was a lot easier to leave at work, essentially. I can't imagine being in combat. I

can, because you see it in movies and you hear stories, but I can't like, physically.

Whereas if it's more of an inter- I don't want to say that combat's not interpersonal

but..."

She could more easily imagine the devastation of being harmed by the people supposed

to care for you.

Two participants in the study reported an incredibly strong identification with

specific patients they treated. Bill discussed having a near-identical dream to one of his

patients. The connection he felt made it all the more painful when the patient said Bill

would never understand him. Nina described sharing a "spiritual connection" with one

traumatized patient. She stated that the patient "had [her] cousin's eyes," and that it felt

like she must have known him in a past life. The identification she felt made her more

willing to care for this patient, but also made it more painful to terminate with him:

"He's taken amazing risks in therapy. And his ability to access longing and be able to say like, 'I really want to be taken care of,' given his history of just total neglect and hiding so much. Yeah, I'm like, 'Oh, you want to be taken care of? I'm all for it. I'll take care of you for life.' But, we'll be terminating (laughs). So that's… It's horrible. Devastating. I've never cried this much about terminating with a patient."

Both Bill and Nina described identifying with these patients as both rewarding and incredibly painful. They discussed a relationship with these participants that felt familiar. As they wondered what made their connections with these patients so strong, both therapists pointed to having family who survived the Holocaust. They questioned whether intergenerational trauma passed down from their grandparents and parents may have contributed to this identification. Whatever the reason, the stronger these therapists connected to their patients' pain, the harder it was to escape the pain themselves.

Theme II: Impact on Sense of Self, Others and the World

All eight participants reported experiencing at least a period of significant change in their perception of themselves, others, and/or the world as a result of working with trauma survivors. Though these changes were not uniform throughout, the following subthemes describe the most frequently reported changes in schema. Impacts to sense of self, others and the world are described in the subthemes *Reduced Sense of Efficacy and the Resultant Desire to Save, Increased Awareness of the Human Capacity for Evil* and *Diminished Sense of Safety,* respectively.

Reduced Sense of Efficacy and the Resultant Desire to Save

Confronted by extensive pain and suffering, many participants reported experiencing a profound questioning of their competence as clinicians, and more broadly as caring people with the ability to influence their world. As their self-efficacy was reduced, the therapists often felt increased responsibility to ease their patients' suffering. Maria concisely described her experience of shaken confidence:

> "One of the things that I meant to mention, is how challenging some of this was to my sense of competence. And I thought 'I don't know what to do with this. How am I going to help this person? I'm not trained for this."

As noted in her profile, Maria experienced beliefs that she was out of her depth, unaware of how to help, and ill-suited for her career. Beth similarly came to believe that she was not a good clinician, and that the work demanded someone who was. For Beth, that belief became so extreme that she decided to step away from her role as a therapist. To this day, she is still ambivalent about returning to practicing therapy. Each therapist in the study held a desire to help their traumatized patients heal. When they were unable or unsure how to do so, it greatly impacted their feelings of competence.

In addition to struggling when unable to help a patient overcome their suffering, the therapists reported distress when their natural desire to help was challenged. Bill had a particular experience with a threatening, traumatized patient that made him extremely angry and resulted in a belief that he was not the clinician he thought he was:

> "It made pretty clear to me this line where I- There was a part of me that *really* wanted to destroy this guy. I wanted to just *completely* wipe him out. Like he never existed."

At the time, Bill could not balance the rage he felt with his identity as a kind, caring

therapist:

> "I felt like there was something about the whole experience that I really felt
>
> humiliated by? In that I like to see myself as being a very dedicated and devoted
>
> therapist. And I like to think that I'm good. And he made me feel like I was not
>
> good… I had to come to terms with my own anger and rage."

Bill was eventually able to see himself as a devoted, caring therapist again. Though to get

there, he needed to put effort towards further self-exploration and receive the support of

people he cared about deeply.

Trauma work challenged participants' sense of competence in their work. At the

same time, it often increased the perceived responsibilities they held for their patients. A

number of participants reported some sort of urge to save their patients after hearing their

stories of trauma; an urge that at times led them to consider or engage in interventions

they would not have otherwise considered. Emily reported that most of the intrusive

symptoms she experienced related to this increased sense of responsibility she had for her

patients:

> "Most of my waking up in the middle of the night is wondering, 'Oh, what else
>
> can I do? Oh, I need to do this a little bit better.' So yeah, it's mostly the concern
>
> about how I can better move them through their trauma or their experience."

She noted how this pressure motivated her to train and study, but also how it sometimes

resulted in her contemplating more extreme measures. Emily's reaction to one

traumatized child she was working with reveals the lengths she considered undertaking

for her patients:

"I wanted to save her. That was where the countertransference came in… And I just thought about 'Well, I could become a foster parent.' But 'Oh, wait, I work so much. How could I be a good foster parent? I'd have to stop working. Well, I can't stop working, I really need the money.' It was this whole internal dialogue with myself. And then feeling so very guilty that I didn't take her on, and that I didn't become her foster parent, and that she had to move away."

Emily related her desire to foster her patient to the countertransference reaction she experienced. She described that the intense, maternal countertransference she experienced was particular to children who had experienced trauma.

Emily was not alone in harboring maternal feelings towards her traumatized patients, as both Beth and Nina reported similar maternal responses. Beth was taken aback when her impoverished, neglected patient expressed how lucky he believed she was:

"So he picks up this card and it says, 'Who's the luckiest person in the world?' And he looked at me and says, 'You are.' I said, 'Me? Why me?' And he says, 'Because you're rich, and you're White.' I just wanted to shove him into my uterus and go home at that point and say goodbye to the hospital, because it was just such a pathetic thing."

In a similarly maternal vein, Nina described her reaction to terminating with an adult survivor of childhood sexual abuse:

"I felt *devastated* for this person. I have been calling this patient my baby (laughs) for the duration of treatment. Which is not typical for me. I don't usually refer to patients as my baby (laughs)… I really feel a maternal pull."

While Emily, Beth, and Nina had strong *urges* to go above and beyond for their traumatized patients, Maria's desire to save led her to shift the boundary with one of her patients in a way she later regretted. She initially discussed how she stored the patient's extra medication for her:

"I didn't feel she was in a safe place. So trying to figure out how to support her not being self-damaging, continuing to be in therapy, was scary all the time. I did things, now I don't know how great they were. I would ask her to bring in all her extra medication. And I would put it in a drawer here."

While Maria felt comfortable disclosing this piece of the story in the heart of the interview, she reported saving the more extreme example for the end:

"Well I've been withholding the scariest thing. Would you like to hear about that? (Laughs) Again, with the scariest patient, she was licensed to carry a gun. And at one point, she was threatening to use it on herself. And so she brought it into the session and asked me to keep it for her. And I did. For years. So there's something about, I think, my relationship to people that have this kind of trauma, where I'm willing to go above and beyond, and even put myself at risk. It was all wrapped up. No bullets. I didn't touch it. But what if it was discovered? And for *years*, that anxiety was always there. I wouldn't think about it every minute, but something would bring it up. I hate guns. I have no interest in guns. Guns are scary to me… Well, finally something happened that triggered an extra round of anxiety about this person's potential use of the gun if I returned it to them. And so I turned it in [to the police]. (Whispering) And boy was she pissed. Because I told her. And it was her gun. And it was worth a few hundred dollars. And I said 'It just scared

me too much. And you're absolutely right. I should have discussed it with you,

that I couldn't hold it anymore.' I couldn't hold the fear, couldn't hold the anxiety,

I couldn't hold the risk. So that was, you know, the signature scariest, most

impactful moment… What's left is that I felt I handled it badly. And I wish that I

had the courage to say 'I have to do this,' and tell her ahead of time. So that was a

disappointment in myself about that. And she was appropriately angry."

In a long career of working with trauma survivors, Maria described this as the scariest

and most difficult experience she faced. She was not alone in her yearning to do

everything in her power to help her traumatized patient heal. IT forced these therapists to

cope with a diminished sense of competence and control. Many responded with the urge

to do whatever it took to ease their patient's pain.

Increased Awareness of the Human Capacity for Evil

At the same time that these trauma therapists were experiencing urges to save

survivors, they were being confronted by the reality that perpetrators exist in the world in

ways they never recognized. A number of participants described a realization that

traumas occurred in much greater numbers than they previously believed. Some

described a shift in schema that incorporated their new acknowledgement of the human

capacity to cause suffering.

Eva discussed how she had a relatively easy time working with veterans. She

already knew that war was violent. It was not until she started working with survivors of

childhood trauma that her perception of the world started to change:

> "You know what I think it is, is that with combat trauma, I can rationalize it. Though horrifying things go on when war is happening, it's very justified in the need to serve your country. Protect the people that you're with, your unit. And to protect yourself. And you do whatever it takes to do that. And so that makes a lot of sense to me… Whereas, this horrifying story of... childhood sexual abuse, incest, it doesn't make sense at all. Like, this is somebody that's supposed to protect you. And that's not happening, they're hurting you. So I think that's the big difference for me."

What Eva was not prepared to integrate into her view of the world was how a child's protector and caregiver could be the same person to perpetrate traumas against them. Eva's experience was common among the participants that worked with survivors of childhood sexual abuse. The notion that people in the world intentionally harm innocent children is hard to comprehend.

While Eva felt that she was able to rationalize the violent, traumatic experiences of the veterans she worked with, Bill reported that his awareness of the tragedies of war shifted as a result of his work. A descendent of survivors of the Holocaust, Bill described believing he was fairly aware of the darker side of human experience before becoming a trauma therapist. However, his work moved his understanding even further:

> "Probably my internship year, or maybe when I first started my career? I was working with a Vietnam veteran who was someone I felt pretty connected with. And I had heard a lot about his experiences on the receiving end of being ambushed. Being rocketed, mortared. And what he shared though, a while into us working together, was that he tortured Vietnamese soldiers. Like, people that they

would capture. And that he personally participated in the torture. And it was

brutal. And I remember having this sick sense in my stomach. This disgust of like,

here's this guy. This is 'Dave'. And I like Dave. I know Dave. And here's this side

of him that I didn't know, and how is Dave different than a Nazi? …And it really

kind of freaked me out, that I could have empathy for someone who could do

something as cruel and sadistic as what a Nazi could do. So that was tough… That

feeling of disgust stuck around for a while. I remember feeling a lot of nausea…

At the time it made me question like, 'Oh my God. Am I going to be able to

continue working with veterans, knowing that he's not the only one?' …And what

does it say that I was empathizing with them? Is that a *good* thing? It just made

me ask a lot of questions of myself… I wanted to believe that someone gets

driven to do that because (long pause) ...Because they're doing that in the service

of protecting their own lives. And that's not the case. I learned that that's not the

case. That sometimes people go above and beyond. Their lives are for the most

part protected, and then they do some really sadistic and hideous things."

The participants in the study all described at one point or another how treating trauma

survivors caused or demanded a change in their beliefs. Eva and Bill's stories altered

what they knew about the human capacity to cause pain. Other participants described

how their views of the world as a whole changed as a result of their work.

Diminished Sense of Safety

Each trauma therapist interviewed described that their work led to some change in

their beliefs about safety. Some focused on a diminished sense of safety amongst

humanity at large. Others elaborated more on how their personal lives now seemed much more dangerous. Kathy discussed being caught off guard when she noticed that working with brain injury survivors had begun to make her more fearful of a similar injury occurring to her or her loved ones:

"There was no warning. Nobody ever said, 'You're going to be seeing a lot of people that are just like people you've known all your life, who just had something horrible happen to them, and they might never be the same again. And it's going to fundamentally shake up your whole illusory sense of security in life… And when my first daughter was born, everybody close to me was laughing about this. Saying that, you know, she was going to come out with a helmet. And I was always kind of cautious about bicycles. Wasn't excited about them bicycling because that's one of the major ways that young people get head injuries. So I was probably a little on the overprotective side. But they did have bicycles… Yeah, I don't think I would have had the same reaction before this work. I think it has kind of changed me permanently, in a way. I do think so."

While Kathy's concern related to the brain injuries she saw every day, Eva, Nina and Maria described general beliefs that the world no longer felt like a good place. The interpersonal traumas they worked with tainted their perceptions of humanity at large. All three described that when they were early career professionals, they sought supervision to express their concerns. Eva stated:

"This was something that I talked to my postdoc supervisor about. Because at one point I was like, 'The world is so fucked up.' And it was this change in how *I* saw the world… Like, this person's parent did this. This person's brother. This

person's, you know, whatever, friend, spouse. And it was just one case after the

other where I was like, 'We live in a fucked-up world (laughs).' …So that was

scary to me too, because I was like, 'This could be happening anywhere!' And

then I would look at people on the train or the bus or wherever I was, and I was

like, 'This person can be an abuser or being abused, and I can't do anything about

it.' And so I felt helpless in a- This is very existential, but in the greater scheme of

things in the world. Like, I knew I was helping *my specific* patients, but that's

only, I don't know, 20 people a week. Whereas like, *everyone* else in the world is

dealing with trauma."

Nina echoed Eva's newly formed thoughts about the world and the people in it:

"But I remember after that session, going to my supervisor and saying 'The world

fucking sucks (laughs).' And I think my cognitions about the world, and people,

have definitely shifted towards the negative (laughs), since then."

Maria learned that the world was not as forthcoming as she had previously believed:

"It was *shocking* beyond belief to me to have so many patients come in, be

discussed in our team meetings and whatever, who had experienced incest or

other kinds of serious abuse. Chronic, ongoing abuse in their families… The

world seemed like a much less safe place than I had imagined… I didn't

understand about secrets. Here were all these people who had secrets, terrible

secrets."

Each of these participants expressed how their perception of safety in the world at large

had faded. Be it the fear of a tragic accident, or the anticipation of interpersonal harm, the

work they conducted required a change in their beliefs.

Not all of the changes in participants' schemas of safety were so globalized. Some of the therapists in the study reported beliefs that specific people or environments in their own lives no longer felt safe. Maria worked with a survivor of ritualistic abuse who had fears that she was being followed to the therapy office. Eventually, Maria began to share her patient's fears:

"I started to believe her. That maybe she was being followed, maybe they knew who I was, maybe they were going to punish her, punish me, or whatever. So one day, I'm in the workroom. And I look up at the ceiling, and it was a drop ceiling, and there was a metal something coming down out of the ceiling. And I thought, 'She's right, it's a bugging device.' And I really was panicking. And I was afraid to go into that room."

When she later pulled the piece of metal down from the ceiling tile, Maria was embarrassed to find out that it was the remains of an old, broken plant hanger that had been in her office since she moved in. She described how that realization provided her with an opportunity to reflect on how significantly her work was impacting her. Beth also described increased fears in her workplace, though she did not describe reflecting on how her patients' traumas may have altered her sense of safety:

"Well, I told you, I raised the issue of patients bringing weapons in with my union leader. And he was very sympathetic. But, you know, as far as he was concerned, there was nothing that could be done… You can't have a metal detector in a hospital."

Beth's perception of inadequate safety in her work setting, the helplessness precluding her to recommend metal detectors, and her belief that no one else cared to increase the

safety, led her to leave her job. It became clear that these therapists' sense of safety diminished after empathizing with the terror that their traumatized patients felt.

The altered sense of safety in the world that these therapists experienced impacted their lives significantly. The revelations that they experienced about the extent of trauma and pain in the world altered some participants' ideas of what types of problems were deserving of therapy. Given her exposure to numerous childhood trauma survivors, Emily described how she needed help from her colleagues to take her patient's presenting problem of anxiety seriously:

> "And so I wasn't a very good therapist to her. Now I could see where that could have been really huge. But at the time I really just, 'You're here about grades? Do you realize that kids are getting the crap beat out of them? (laughs) And you're here about grades?' …I had to talk about it in supervision. Just, 'This really seems like such a joke.' And they really had to bring me back down into 'Well, this is really more what life is about.'"

Exposure to patients' trauma caused significant changes to the therapists' belief systems. Their expectations that the world is a safe place, that people are ultimately good and that they themselves are capable and in control were all challenged by IT. These altered perceptions of "what life is about" affected the way that the therapists approached their lives and the people in them.

Theme III: The Connection Conflict

All participants in the study discussed at length that working with trauma survivors impacted the way they related to people in general. This theme outlines the

patterns that emerged from their descriptions. The experiences that the participants portrayed will be discussed in the following subthemes: *I Can Only Give So Much*, *I Need Support and Understanding* and *How Could You Possibly Understand?*

I Can Only Give So Much

For better or worse, every participant described that the work they did challenged them. As the therapeutic work required them to give of themselves, they began to notice the personal effects of that giving. The participants realized that giving aid and support to their traumatized patients seemed to deplete the internal resources they had for others. They reported being drained and exhausted. They described the need to turn off their minds momentarily to decompress. Indirect trauma affected their romantic relationships, friendships, familial relationships, and therapeutic relationships.

To varying degrees, participants in romantic relationships all noticed a strain on their relationship that co-occurred with periods of IT. Nancy's husband plainly stated a common effect that participants experienced with their partners: "You come home and you're all used up. You can't even talk to me." Nancy agreed with her husband on that point. She described the need to eat and to have some quiet time after her workdays. She wasn't alone in experiencing a drained inability to connect with her partner at the end of the day. Eva described a similar experience:

> "(Laughs) I mean, in the moment, I was like, 'Leave me alone.' But I think just
> 20 minutes after, I felt terrible. Because he was excited to see me. I should be
> excited to see him and I'm not. And I quickly, we both quickly put together that it

was the type of work that I was doing. I think he was a saint in that aspect, where

he understood and then adapted to that."

Eva not only felt unable to connect with her husband when she first got back from work,

she also reported being so drained that she didn't want to think:

"I would not want to interact with him. When I got home I felt like I could

completely decompress. And I didn't want to think. I didn't want to talk. I literally

just wanted to sit and do nothing or just have the TV on but not even be- I wanted

to watch stupid reality nonsense. Mindless TV. And he was like, 'What's going

on? We haven't seen each other all day and now you just want to do nothing and

not really interact?' And I would tell him, 'I just, my brain is fried. I literally

cannot think. It's tough for me to- I don't want to form a sentence right now.' So

he definitely got the brunt of that."

It was challenging enough for some participants to speak to their partners at the

end of the day. When it came to physical intimacy and sex, a number of the therapists

described a diminished interest and increased difficulty. Bill related his periodic difficulty

with connection and intimacy to depression-like symptoms:

"Well, at those times I think that I'm more withdrawn. So intimacy is hard, at

those times. I mean, I just feel like I'm kind of depressed. What I tend to do is a

lot of trying to distract myself. I'll watch distracting stuff on TV. Shows where I

don't really have to think very much. I'll spend more time alone sometimes. Go

on walks… But I don't totally shut myself off. I mean, I'll talk about what's

bothering me with my wife and my colleagues, but… So, it's both this need to

kind of be alone. But also, not completely."

Bill wasn't alone in having difficulty being intimate. Eva, in discussing the ways her sex-life was impacted, described that intimacy began to feel transactional. Something about her situation made sex feel like it was draining a resource that was already depleted. She also reported that during some of the limited occasions she was interested in sex, her patient's trauma would enter her mind and ruin the moment for her:

> "I think that for the first part of that year intimacy was very much like, not transactional, but that's the word that's coming to mind… In terms of our intimacy, it just dwindled… And then I think I shut him down so many times that he was just like, alright, I'm not even going to try. So he gave up and then I think he tried to meet my immediate needs. Whether it was like, cooking or reading a book instead of having the TV on because I can't study with that on… In terms of the sexual trauma survivors I worked with, that's a good question. I want to say it might not have come to mind *every* time, but I think there were probably times where that crossed my mind. And I think that was very jarring."

For both participants with and without consistent romantic partners, the experience of indirect trauma seemed to interfere at some point in the process of successful intimacy.

For those participants without consistent romantic relationships, challenges in intimacy occurred in the dating world. Beth reported that her libido remained the same despite her IT, but her desire to have a sexual partner was low:

> "I wanted to be distracted. But I had very low expectations… I wasn't really looking to date anybody. What with the breaking up with what's his name there. And especially planning to leave the country. In terms of my libido, I've always

had a raging libido, I've always been interested in sex. So that didn't change. Not

that I was having sex with people… I can't tell you this."

Like Beth, Nina reported that she was not sexually active during her most intense period

of IT. Despite this, she had a dream that viscerally elucidated the work's interference in

her personal life:

"I mean, there's *definitely* trauma flavors. And I think it can definitely speak to

the effect of trauma on a person who's a therapist. But essentially, I was...

Sexually intimate with someone and simultaneously, the person I was with was

getting sexually molested by his father. And it was *horrible.* And then suddenly, I

was obviously interrupted (laughs), but then I watched the father emotionally

decompensate. And suddenly I was serving as a therapist to the father…

Intergenerational trauma and also this penetration on my personal life. Like I can't

enjoy a sexual moment because I'm dealing with my partner's baggage right there

in front of me… I really woke up and I was like, 'Why am I (laughs) a therapist? I

should have gone to law school.'"

Nina's account portrayed one way that the effects of trauma therapy are difficult for the

therapist to keep separate from their personal lives. While sexual and romantic

relationships were greatly affected by IT, the participants described effects on platonic

relationships as well.

The individuals in the study touched on ways that relationships with friends,

family members and coworkers were affected. Emily described that the cost of some of

her friendships became too great:

"You know, having friendships, it takes time, and it takes a lot of energy. And I don't think I had the energy. And I know that I had to cut off two friends because I felt like they were sucking me dry. That they were a little bit too needy. And I didn't have it in me to be able to maintain those relationships. I wanted them to go out and fix themselves and then come back (laughs). But I couldn't do it for them anymore… I just, I didn't want to be a counselor to my friends."

The feeling of being a therapist to non-patients was expressed by a few of the participants. Nina felt compelled to switch into "therapist mode" with her family:

"I think there's a bit of compassion fatigue with my family. Sort of like, these are really non-issues. And I don't have much empathy for problems that I deem insignificant (laughs), but they might deem significant… 'If you heard the shit that I heard, this would be a non-issue'… I think this is where the censorship comes in… With my sister it will be like, 'Yeah, listen, you're a first-time mom, cut yourself some slack.' I mean not that I sound like that as a therapist, but in the moment, I'm like, 'Shut the fuck up (laughs).' But, no, just joking. I would not be that rude to her."

While Emily and Nina struggled with pressure to take on the therapist role in some of their personal relationships, they both had other relationships which felt rejuvenating. Beth, on the other hand, seemed to adopt a worldview that if she wanted to connect to people, she had to prepare to be their emotional caretaker:

"And people just, they're like, 'Well, that's what you're training for. You're a psychologist.' And it's just like, 'You fucking bozo, what do you know about being a psychologist?' And I probably would have broken up with these guys

anyway, but it was easier to break up with them when they're moronic assholes…

And the other thing was that even with girlfriends it was a sense that no one really

wants to hear what's going on. And all they want to do is talk about their own

petty little lives and their petty little problems and their petty little relationships.

And I'm supposed to listen to them. So this is the price I pay to have people

around me. I have to listen to their petty little problems and say nothing and be

amusing."

The participants all described a cost to the work. The toll it took was described as

depleting some internal resource or as taking on someone else's weight or pain.

Inevitably, their work with traumatized patients spilled over into the participants'

personal lives. Confronted with such relational costs, the therapists in the study often

found themselves craving support and understanding from others.

I Need Support and Understanding

In the same vein that participants reported struggling to give of themselves, they

described experiencing an increased need to receive from others. During times of distress,

they turned to partners, friends, family, colleagues, and their own therapists to try to find

care and acceptance. Bill reported receiving support and understanding from his

coworkers in peer supervision when his IT symptoms were most intense:

"I don't know the lasting impact that these experiences would have had, or would

still be having, in the absence of good supervision, good therapy… The most

important thing that I felt after the peer supervisions was the idea that whatever I

was feeling was understandable, and it was okay. Because at the time, I've got to

tell you- On an intellectual level, I know that. But on an experiential level, I did

not know that at all. And I felt like there was something wrong with me. That I

was having these kind of crazy reactions. 'This is not okay as a therapist, to

experience this.' And of course it is. Of course it's okay… I think a lot of that has

to do with my relationships with these people that I would talk with. To just

genuinely know that I was still okay in everybody's eyes. I didn't do anything to

jeopardize that at all… And each of these folks knows enough about my own

history to be able to understand why I might have the reactions that I was having.

And that was helpful. Because I wasn't connecting that before I spoke about it

with them."

Bill's coworkers supported him with his indirect traumatization from a place of

knowledge and understanding about him and his experience. He was not alone in

wondering how much worse things could have gotten had he not had these people's help.

Maria expressed a similar sentiment:

"If it had not been for the supervision group, and my husband is also in the field

so I could talk to him, I think it would have escalated much more than it did. I

mean that was bad enough. But I would come home and talk to him about things

that were *so* upsetting and made me really sad, agitated, whatever. And finally, he

said, 'You cannot talk to me about this over dinner, it makes me nauseous.' So he

articulated that I had traumatized him too (laughing)."

Like many of the participants, Maria expressed that what she was hearing at work seemed

intolerable to hold alone. The urge to share, to find comfort and support, was palpable. It

led her to utilize all her social supports. She turned to her husband, friends, colleagues, and even her son:

> "Even my son, we would talk at dinner, and my son knows about this [patient].
> Yeah, I think he's very insightful. And he would sometimes say things that were
> helpful (laughs). Or ask good questions. You know, I tried to be careful about
> what I talked about in front of him. But he knew enough."

With the exception of Maria, the participants' partners and romantic interests were not in the field. While the participants were often able to feel support and love in their relationships, many also described the unique support and understanding that came from other therapists in their lives. These could be co-workers, friends, or the participants' therapists. Emily touched on the experience of having her pain be known by her coworkers:

> "If we went and had a few drinks or something after work, we were blowing off
> the steam. And it's not that we were talking about work, but it was just *known* that
> we were all, yeah. I can't talk about these things when I come home from work.
> Well, first of all, my husband wouldn't want to hear it (laughs). But the other
> thing, obviously, it's confidential. So I can't really talk about that. So I end up
> keeping a lot inside. And finding a good place to get rid of it."

Emily was not the only participant to describe the comfort that came from connecting with other therapists. Despite their IT symptoms making connection more difficult, most of the therapists in the study related with ease to others in their field. Nina expanded upon this idea in talking about her therapist-friends:

>"You can be a mess and not have to apologize for it. Because you know that you'll
>
>be doing the same for them the next night (laughs). You know, you'll take turns
>
>and it's genuinely this mutual relationship. I find that, in other friendships
>
>growing up, I didn't realize it of course, but I was a therapist. And now it's 'Oh,
>
>wait. Both of us can be the therapist because we are both therapists.' You can be
>
>*totally* unfiltered and uncensored. And *genuinely* not give a fuck what you sound
>
>like."

Nina began to spend more of her social life with other therapists, emphasizing the burden

of interacting with those that did not understand her situation and the relief of being

understood by fellow therapists. When asked to elaborate on what made talking about her

trauma work with other therapists so helpful, Nina stated:

>"When you're not alone with all this really heavy material, you can share it. But
>
>it's also being shared with someone who you know can understand. And so you
>
>don't really have to say much because they get it. I should also mention I'm fresh
>
>off a session last night where a lot of racial stuff was brought up. Where basically
>
>I was told that I couldn't understand, because I'm White. And so I have reactions
>
>coming up to this as I'm saying it. Because I'm sort of speaking of not having that
>
>capacity with people, and my patient not being able to have that with me. But
>
>that's another story."

Recognizing the inherent differences in her comparison, Nina related her belief that non-

therapists would be unable to understand her indirect trauma to her Black patient's belief

that a White person could not understand the minority stress she experienced. Nina's

example portrayed a belief that, unless someone shared in her experience of being a

therapist, they would not be able to support her in the way she needed. At the same time, she acknowledged that she did not completely ascribe to this belief as she trusted in her ability to empathize with patients who had different experiences than her.

The depictions shared by the participants suggest that indirect traumatization is a painful and potentially isolating experience. Giving empathy to patients who experienced trauma left these therapists needing support and understanding of their own. Participants sought to meet this need by reaching out to their entire support systems. For some, the degree of relief that these connections provided seemed tied to the extent that they felt the other person comprehended their internal experience. For many, connecting to other therapists provided the most relief.

How Could You Possibly Understand?

Many of the participants in the study described that the challenges they were facing seemed unique. A number shared a belief that non-therapists could not possibly understand what they were going through. While in some instances, this belief seemed more related to their pain than the people around them, the therapists also reported experiences where people in their lives truly did not understand their pain or were unwilling to try. Possibly the most painful impact of indirect traumatization was the way it impaired the therapists' ability to connect to the people in their lives. Nina posed the question of this dilemma and attempted to rationalize the conflict:

> "It's like, how does this person, how could they *possibly* understand? You know, I
>
> don't really even know how to relate, or connect. I mean, it's not totally fair. I

have been out with people who are super psychologically minded, or *way* more so

than I expect. And it's really refreshing."

Nina was able to hold onto the notion that non-therapists she had dated had the capacity

to understand what she was going through. However, she reported that understanding and

support from these men was rare. She described a familiar thought process which

involved her imagining what it would be like to listen to her patients' traumas all day and

then immediately leave for a date where she would listen to a non-therapist's typical day

and try to find an appropriate way to speak about her own. The thought of navigating this

experiential divide was often enough to prevent Nina from trying. She was not alone in

believing that talking to non-therapists about this work would not go well.

Sitting with patients' traumatic material seemed to impact the therapists'

relationships with all types of people in their lives. A few reported that they avoided

disclosing their work with trauma survivors in casual conversations because they feared

having to tolerate insensitive responses. Some went as far as sharing false professions

when asked. Nancy described with intensity how she seemingly yelled at her friend's

mother when she broached the subject:

 "When somebody asked me, a friend's mother asked me about what I heard as a

9/11 volunteer, I couldn't even believe she was asking it. And I said, 'You don't

want to know!' And she looks startled. And I said, 'No, really.' You know, she's

kind of smiling this sort of nervous smile like (feigns nervous laugh). You know,

and I was like, 'No, you *really* don't want to know."

For some, avoiding conversations about this work with strangers or distant acquaintances

was not the end of it. After succumbing to the belief that no one could help her feel

better, Beth decided to keep her painful internal experience to herself entirely. This

decision impacted her relationships pervasively. With co-workers, Beth described:

> "There was supervision, but I didn't bring these things up. If this is what it's
>
> going to be like with the union leader and the head psychiatrist, why bother my
>
> peers and other people with things that they're just going to feel helpless and bad
>
> about too? …I mean, when I was with my peers, when we had meetings at the
>
> hospital, I just wanted to have a good time. I didn't want to bring up things that
>
> were just going to make everyone feel bad, because there's nothing anyone can do
>
> about them. And then they just hate the messenger."

Beth's beliefs were similarly hopeless regarding the man she was dating at the time:

> "He didn't care! He didn't care. He didn't care about the profession. He didn't care
>
> about me. He just cared about himself and what he wanted. What he wanted from
>
> me… After a while it was becoming very clear to me that it was all about him and
>
> what he wanted, and why wouldn't I do what he wanted?"

She did not feel cared for in her work or in her relationship. For Beth, it seemed that as

the intensity of the need increased, so did the difficulty she had getting it met. Even

therapy did not provide her with the relief she sought:

> "I tried going for therapy. But I couldn't talk about what happened to my
>
> therapist. He was even more cuckoo than I was."

The intensity of Beth's belief that no one could support or understand her was certainly

greater than that of the other therapists interviewed. She was still holding much of the

pain of her indirect traumatization by herself years later. However, the expectation of

being misunderstood or left unsupported was common amongst the participants.

While indirect trauma itself seemed to increase expectations of empathic failures, the therapists in this study also experienced these failures firsthand. They described painful misunderstandings that occurred in even their closest relationships. The therapists discussed how these insensitive experiences impacted their connections with others in their lives. From disappointment to divorce, the participants' relationships were all impacted by their partners' inability to perfectly hold their pain. At the minimally-impactful end, Maria described being disappointed when her psychiatrist-husband told her he could no longer provide her with the listening and supervision-like support she sought:

> "I don't think I felt hurt. Disappointed. I mean, it was an outlet that was very helpful for me. And I was disappointed. But it seemed fair. You know, he didn't volunteer to see these people, I did."

Eva similarly reached out to her husband for support at the end of her workdays. She had been experiencing frequent intrusive imagery of her patient's trauma. Like Maria, Eva's husband eventually let her know that he was not okay with her sharing:

> "I mean obviously this was something that happened when [the patient] was very young. I didn't know her then. I didn't know the people. But it's almost like I can describe it as- I used to love reading when I was young. And I would imagine what Harry Potter looked like. So it was kind of like that. Like I had imagined this scene of what happened to her, and that was the image. Whatever my imagination had created, was what would pop up. And it was to the point where I would tell my husband in a de-identified way, but I would talk to him about this horrifying

thing. And then he was like, 'Why are you bringing this up so much (laughs)?'

And I'm like, 'Because it's so challenging for me to deal with this right now.'"

Eva knew that she and her husband had different backgrounds, and different wants and needs related to her work:

"I don't think he knew how to respond to that? Like I said, he's in a totally different, very concrete field (laughs). And I think he was like, 'Yeah, that sucks.' But then he would change the subject, and then I was like, 'See, you're changing the subject. I need to talk about this.' But he was like, 'I don't really want to hear about other people's suffering.' Because I think then *he* gets very emotionally invested too? It's painful. And that's not necessarily what he wanted to do at nine o'clock at night with his wife, on a Wednesday (laughing). Which I totally understand now, being on this side of it. But in the moment, that's what I felt *I* needed or wanted… I think I probably felt unfulfilled, or like there was a void. Like I needed to, for me, for my emotional well-being. But again, my go-to will be this rational thought of 'I'm going to respect him, because this really isn't something that he needs to be working with right now. This is my job and these are my patients. He doesn't need to be brought into it.' And I think eventually I was like, I actually don't want to be talking about this with him… I felt like I would just talk about it forever."

When Eva was told that her traumatic stories were not welcomed at home, she ultimately agreed. She decided that she would be better served seeking work-related support from friends that were fellow psychologists, and eventually found that the urge to speak about

her IT with her husband decreased. Both Eva and Maria tolerated the disappointment of being told that their partners did not want to hear about the details of their work.

Not every participant was able to identify and discuss with their partners how their work was impacting their relationships. Many of the participants in the study found that indirect trauma coincided with periods of relational turmoil, but that the cause was unknown at the time. Their partners' inability or unwillingness to provide support, and the pain of the IT they were experiencing, caused significant rifts that were not all repaired.

Emily changed careers to become a counselor well after she was married. Though she has been married to her husband for 47 years, he didn't believe in counseling when she decided to become a therapist. Emily discussed what it was like to have her husband invalidate her career choice and her passion:

 "When I started to talk [to my husband about work], saying, 'I'm not going to tell you much but,' and I'd start to talk a little bit, he'll go 'I can't do that. I can't, I can't listen.' It's traumatizing for him. He doesn't believe in counseling… He thinks that everybody has- I think he's changing over the years, that was his initial belief- He thinks that people have it inside themselves to be able to make the changes they need to make. So don't go in and be messing with somebody's head. Just those old beliefs. He's still kind of stuck in that… So to not be validated, I think it was... I think that for me, it's always been very important throughout my life to be passionate about a cause. And so advocating for these people, that just became a part of me then. I think that just became who I am, or maybe what I

always had been? And if people don't like it, then too bad… And I just dragged

him along with me (laughs)."

Emily laughed through the pain that came up in the interview. She described that while

she persevered in her career, and poured herself into her passion, it was not easy when

her husband responded the way he did. Having meaningful conversations with him

became very difficult for her, and she described how the two of them have slowly grown

apart.

Like Emily, Nancy said that the effects of the work she was doing contributed to

tension in her marriage. Nancy described how it was difficult to understand what was

getting between them at the time:

"I don't know. But it's weird because, does it bring you closer? Does it bring you

less close? And to some degree, it brought us closer? But I think there was a way

that I couldn't identify what the problem was. So I could be so angry at him for

things that maybe weren't worth being angry about? …There was a lot I wanted

him to change. And I felt like he wasn't on my team. And I think that's because I

wasn't on his team, either. Somehow I had gotten into a position of more like,

enemies. Well not enemies, that's too strong. But we weren't working together.

We were just, we had lost the team process."

At multiple points in her interview, Nancy attempted to dial back the level of pain that

she seemed to experience in her marriage:

"Well, like I said, it was weird, because I don't have the sense that we were close

to separating. At all. But I had the sense that we were, you know, colliding against

each other. In good and bad ways, like, trying to be together, but not being- It was

just volatile. That makes it sound stronger than it was, but…"

Nancy ultimately came to realize that she needed help if she was going to protect her

marriage from the effects of her IT:

"I think there was a period of time where- I think my anxiety level and my

irritability got to a level where I was like- I finally had to do something. And it

wasn't a gradual build. It was just kind of like, all of a sudden I realized 'This is a

problem.' And I realized I was either going to have to divorce my husband or do

something like EMDR (laughing)."

While Nancy joked about giving herself this ultimatum, it was clear that her distress

during that period was intense. The conflict of connection significantly impacted the most

important relationships in these participants' lives. As their IT symptoms increased, so

did the urge to find relief. Nancy was far from alone in her desire to "do something" to

cope with what she was experiencing.

Theme IV: Coping with Indirect Trauma

Indirect traumatization profoundly impacted the participants' internal and

relational lives. In doing so, it forced them to find ways to cope. The methods that the

therapists used to navigate their IT varied. Some of these methods were conscious

decisions to do something differently, while others were unconscious reactions to the

conflict they were experiencing. The following subthemes describe common types of

coping shared by the participants: *Processing Indirect Trauma, Working as Coping* and

Renegotiating Boundaries.

Processing Indirect Trauma

Being present with the numerous traumas their patients shared left the participants with an internal discomfort or pain. Much like directly traumatized patients heal by processing traumatic experiences, exposing themselves to aspects of their lives they have come to avoid and making meaning of the trauma, part of coping with indirect traumatization required the therapists to work through the internal struggles they now faced. The participants used different descriptors to portray their approaches. They spoke of seeking to metabolize, unload weight, gain control, or achieve acceptance in order to cope with IT. Nina wondered about being left to "digest" some of the pain her patients shared with her:

> "I've been thinking about the pre-verbal stuff and how trauma, by its nature, can be really fragmenting and how you're sort of left to digest that when a treatment is over. And that some of it maybe just doesn't get digested. And in the same way that trauma will often go unprocessed, there's a parallel in the treatment in that you don't metabolize it. Right?"

Similarly to Nina's description of wanting to be able to digest or metabolize trauma, Maria spoke of feeling full of her patients' traumatic experiences:

> "Well, what I was hearing was just overwhelming. Things that were *horrifying*, just beyond horrifying. The kind of torture I was hearing about, the way people were treated, the experience of this *specific* person. It was horrifying. It was just (disgusted noise), it was disgusting. It was horrifying. It was infuriating. It was sickening, I mean, whatever. And I just felt full of that. So I wanted to

(whispering) 'Do you believe what happened?! You can't believe what happened!

She told me this!'"

Maria's urge to relieve the sensation of being sated with horrifying material led her to

share it whenever she was able. Initially, most of this sharing was with her husband. After

she found a peer supervision group comprised of other trauma therapists to share with,

however, her uncomfortable sense of fullness diminished:

"I told the stories less. Once I was in the group, we could tell the stories in the

group. And so I didn't feel as much of a need to tell [my husband]."

For Maria, a major coping mechanism was sharing her experiences and finding an outlet

for the pressure she was holding.

Nancy did not report feeling full or overwhelmed, but instead described her IT

experience as a weight that she was carrying. Wanting to ease that burden led Nancy to

enter into her own therapy. She spoke of the freedom she experienced as a result of

processing her indirect traumatization:

"After I'd been doing [EMDR] for maybe six months, I said to someone, maybe

the EMDR therapist I worked with, I said, 'I feel like I've been carrying two 10-

pound weights in each hand and I just dropped them.' But somehow I just let go

of them. And I really felt lighter. I felt freer. I felt less encumbered… [EMDR]

helped me to process the traumas so that they weren't walled off in some place."

Though she did not seek out therapy of her own, Emily sought a freedom much

like Nancy described. For Emily, processing indirect trauma meant finding a way to

avoid being stuck in the terrible histories of her patients. Focusing on the future allowed

Emily to feel more control in her present:

"I would have to pull myself back and say, 'Okay, I can't change what's happened with these children, so how am I going to move forward?' I think it would be taking their case histories and just absorbing it. And then realizing that 'Okay, so that's already been done, what's the next step that I'm going to move towards?' And I think that's a real good tool, now that I think about it. I think maybe that's how I've been able to cope with all the trauma. Because I didn't get stuck in what had happened to them. I was able to know that they had a future and then was able to help them see that they had a future beyond their trauma, too."

Each therapist described that something about their exposure to their patients' most painful, horrifying experiences was personally impactful. For Bill, processing that impact involved a search for acceptance. He discussed becoming more open to the reality of the human capacity to inflict pain. In doing so, he became more accepting of his own anger and aggression. He reported that much of this internal work began after the realization that a veteran he was treating, whom he liked as a person, had tortured prisoners of war in Vietnam:

"I find that now it's a lot easier for me to hear [about trauma]. Which, I don't know what to say about that. I think there's something *sad* about that. That like, I've heard stories- That wasn't the last of those kinds of stories that I've heard from veterans… There was something about that, that really shook me in my core… I've never acted in that kind of way before, but... It just allowed me to have my *own* aggressive and hostile fantasies and not be so freaked out by that… That's within the scope of being human."

From digesting, to moving forward, to accepting, the processing of IT looked different for every therapist. Just as the experience of IT was personal, so too was the internal work towards its resolution.

Working as Coping

Despite intimately understanding how challenging trauma therapy is and how it was the source of their indirect traumatization, a number of the therapists described that conducting therapy was also a source of coping. These participants discussed differing aspects of the work being helpful to them, but each mentioned pouring themselves more completely into their work as a response to just how difficult the work was.

Kathy and Eva both described themselves as people whose primary response to a challenging situation is to push straight through the problem. Both participants utilized this strategy to confront the challenges they experienced as trauma therapists. They also shared in feeling relief by helping their patients to recover. Kathy discussed her experience in the context of establishing a support group for survivors of brain injury:

"Put in a situation, I'm going to plug along and just do. That's it. Like, 'Okay, this is my lot, I have to do this. This is what I'm going to do.' And yet, at the same time, I think I was turning to my husband at the time trying to get some degree of support. He was having, I don't know, he had his own issues. He probably wasn't the right guy for me. And so I was also dealing with that, him not seeing me at all. So basically, I just kind of worked. I think that's what I did. I just worked… It helped me to feel... I at least felt like I was providing a way for all of these people to get what I wasn't getting. Which was support from peers, in a sense. And it was

really heartwarming to see that and to see friendships develop. And yeah, I mean,

some of the warmth was coming my way, which was helpful. And I was seeing

the best sides of them, which was helpful."

Kathy directly benefitted from the warm and supportive atmosphere that she helped to

cultivate in her group. She also indirectly experienced relief by bearing witness to her

patients' healing. Eva reported on her experience of conducting Prolonged Exposure with

a traumatized patient. Entering the work with the same mindset as Kathy, she described

how her experience of the work shifted in line with her patient's progress:

"I'm one of those people that will just like, plow through something… 'This is

only for a year; I can do anything for a year.'…I think what shifted the work from

feeling challenging to feeling rewarding was because it worked (laughs)? Like,

the patient got better. And that was rewarding… And to see her understand her

behaviors now, her avoidance now, and how that relates to what happened to her

so many years ago, was rewarding."

These two were not the only ones that felt pressured to push forward in their work despite

the challenge.

While Kathy and Eva generalized their "plow through" coping style, other

participants reported specifically that seeking to improve their skills as therapists was an

important method of coping. Emily became a self-described "workaholic" during the

most indirectly traumatizing portion of her career. She described how she poured her life

into her work in an attempt to better help the traumatized children she worked with:

"When I became a workaholic, I mean that pretty much gets in the way of just

about everything. Gets in the way of *all* your relationships. So when I wasn't

working, I was reading a book about work. Or taking online trainings or, there

was always that thing. If I find that *perfect* book or that *perfect* thing, I'll be a

good counselor, you know?"

Being one of the only therapists conducting trauma-focused work with children in her

rural community was not enough for Emily. She sacrificed her personal life to continue to

search for the next tip or trick that would help her to relieve her patients pain more

effectively. Maria similarly invested herself in her craft. She described that attending

conferences and reading new material helped her to combat feelings of helplessness in

her work:

"Counter-balancing the feelings of (laughing) 'I don't know what the hell I'm

doing.' I mean, that was very validating for me. It was nice to have the

counterbalance, as well as being helpful for [my patient] … Some workshops,

whoever was speaking communicated a concept that I- 'Yes! That's going to

really help me!' There were many moments like that."

These therapists had signed up to help other people for a living. Confronted by their

patients' tremendous pain and suffering, they invested themselves in becoming better

helpers. This not only benefited their patients, but also allowed them greater opportunity

to share in the healing.

Renegotiating Boundaries

As discussed in detail in theme III, indirect trauma had a profound impact on the

participants' interpersonal relationships. One of the primary ways that the therapists

coped with these effects was to adjust their relationships to allow for their new

experiences. At times, these adjustments involved disengaging and taking space from friends and family. At other times, the therapists coped by increasing the intentionality in their connections with people in their lives.

Beth experienced an extreme urge for disengagement at the peak of her distress. It led her to leave the hospital where she had worked and to step away from therapy all together. She described the intensity of her desire to escape:

"I was so traumatized when I left there that I was just planning, actually, I wasn't even planning on working or staying in the United States anymore. I just felt like I had to leave entirely. Like there was nothing left for me here."

Shortly after leaving her work environment, the intensity of Beth's distress reduced. She found that she was able to engage meaningfully as a psychologist, but that trauma therapy was not the format for her to do so.

"And I realized within a couple weeks after I started teaching, I just felt lighter. This constant pounding of my heart, this constant anxiety, this constant feeling that I wanted to weep incontinently, was gone. And I realized I didn't really need to leave the country. I don't even need to leave the city, I just needed to leave the hospital."

After transitioning to teaching, Beth noticed a significant change. The trajectory of responding to indirect trauma by initially desiring to disengage and then finding a way to re-engage meaningfully, was common amongst the participants.

Early in Emily's career as a therapist, she experienced the urge to distance herself from her friends and family. She felt pressure to work more and to have more time to herself:

"I think I pulled back. I think I hibernated. I think I became a workaholic. And

didn't meet with my friends, and didn't do as much... I wasn't as playful as I used

to be. And I had to be very conscious about restoring that."

Emily described that it required conscious effort to have fun in the way she did before her

IT. Much of that effort involved re-engaging with the people in her life. She mentioned

that, for a period of time, she became so invested in her work that she defined herself

solely by her profession. The intentionality that Emily later brought to her relationships

involved reminding herself how meaningful they were. She described how she worked to

expand her definition of herself to include her friendships:

"But I think things are changing. It's not just through my work, it's with my

friendships now. I have friends that are from my undergrad years. And we get

together five or six times a year, and we're spread out all over. Maintaining

contact with them, and some old work friends, we see each other on a monthly

basis. And there's other friends that I see on a monthly basis. And then there's

people that I kayak with. So yeah, I've made it a very important piece in my life

now."

During her most intense experiences of IT, Emily set rigid boundaries to distance herself

from the people in her life. Over time and with effort, she allowed herself to once again

become closer with her friends.

For Bill, the desire to disengage was not a problem. Instead, his *ability* to engage

meaningfully was challenged. He described how his IT symptoms made it difficult for

him to be present with his family:

"Being anxious, having sleepless nights, being preoccupied. That's the thing that

had the most impact, you know, being preoccupied, less patient maybe, irritable.

But not being as present. Being totally worried about something and then not

being available to the people in my life like my wife and my kids… It's like both

this need to kind of be alone. But also, not completely."

Bill wanted so badly to stay connected to his family, but despite his intentions he

struggled for a time. Bill managed to cope with this challenge by setting up specific times

in his week to spend with his family members individually. Weekly activities such as

yoga and gymnastics with his kids allowed Bill to mindfully engage and to feel closer to

his family again, despite his IT. Like Bill, Eva struggled at times to have substantive

interactions with her partner while experiencing indirect trauma:

"I would be very upset and irritated. So that would happen and would cause

conflict, obviously, because he was happy to see me and I was *not* happy to see

him."

When given more space, however, she was able to reflect that she truly did want to be

close to him. Unfortunately for Eva, this led to feelings of guilt on top of the IT

symptoms she was experiencing. In order to cope with the tension in her relationship, Eva

invested her free time into connecting with her husband:

"But there were a lot of weekends where I just wanted to be with my husband

and that's it. And I think part of that was I felt guilty because during the week it

was really rough. I felt guilty about how I treated him during the week mostly,

and then I felt guilty that I was so busy. And I wanted to just spend time with him

and focus on the relationship."

Each participant in the study was confronted with interpersonal challenges during their experience of indirect trauma. Disruptions in their ability to connect meaningfully required these therapists to cope. Their initial reactions were often self-protective, but ultimately isolating or overwhelming for their partners. In many cases, the therapists developed intentional responses that allowed them to re-engage with the people in their lives while continuing with their work.

Theme V: Lasting Effects

The therapists involved in the study experienced indirect trauma in unique ways. At the time of their interviews, each therapist was in varied proximity to the height of their IT symptoms. For some, decades had passed. For others, the traumatized patients that profoundly affected them were still coming to their offices. No matter this proximity, every participant reported that the trauma therapy they conducted and their experience of IT had lasting effects on them and their lives. The final theme will discuss the lasting effects, both positive and negative, that the therapists reported. The subthemes of *Loneliness and Seriousness, Appreciation and Hope,* and *Sense of Purpose* will be used to portray the therapists' descriptions.

Loneliness and Seriousness

Two primary challenges seemed to persist for the therapists interviewed, despite their attempts at coping and the abatement of other symptoms. Some of these therapists described feelings of loneliness, or difficulty connecting to others, that were not

completely resolved. Many of the therapists also described a seriousness that developed during the course of their work and appeared to have become an enduring characteristic.

This loneliness and seriousness seemed interwoven for Kathy. She described a lasting effect of being less joyous as a result of her work. After being spurned by her husband for this more-serious version of herself, Kathy eventually decided to separate:

"He just wanted me to be Miss Fun Sunshine all the time, you know? And I wasn't. And so the result of that was I just simply stopped talking to him about it… And eventually our relationship, I mean, I'm not going to go into all that, but it basically fell apart. I think I had become a slightly less joyous, more anxious person from doing this work. I do think so. And that's, partly the hard work itself, and partly I guess the piercing of the veneer of life. You know, that life will bring good things to all. That sort of thing."

The exposure that Kathy had to tragic accidents and irreversible loss of functioning changed her in enduring ways. Just like Kathy, Emily expressed a lasting shift that impacted her and her relationships. Emily described a damper to her sense of humor:

"I don't think I'm as funny (laughs). I used to be really funny. I used to just have a *lot* of fun. And I don't think I laugh nearly as much… And I think that's one thing I miss about myself."

The seriousness that Emily developed persisted. It impacted her internal experience of the world as well as her relationships. Emily described that her and her husband did not see eye-to-eye about a number of things that she took quite seriously. As a result, she described avoiding serious conversations with him, and eventually experiencing a reduced sense of intimacy and connection.

Empathizing with people who have experienced the worst humanity has to offer

made it challenging for the therapists to interact with the world the way they had before.

Eva described that the trauma narratives she heard led her to become disillusioned with

people, an effect that put a damper on her connections and increased her loneliness:

> "I think a big one is that I feel like trauma is around every single corner. And I
>
> hadn't thought about it in a little while. But it's kind of disappointing about
>
> humanity and just like, what people do and are capable of doing."

Among a host of other interpersonal effects, Eva discussed that reduced intimacy with her

husband was an enduring result of her IT. While much of the strain placed on her

relationship was able to be repaired, she discussed that regaining intimacy was an

ongoing task:

> "I think the intimacy is still something that we struggle with. And I very much
>
> think that it started during that year. But also, the relationship has really improved
>
> from that really awful year. Now I come home and I'm happy to be here, and I'm
>
> open and welcoming when *he's* happy for me to get home. I personally don't think
>
> that I need to be as supported when it comes to my work? …So in some ways our
>
> relationship generally improved after that year. But in some ways, it's still like,
>
> well I guess all relationships are a work in progress (laughs). But it's a work in
>
> progress getting back to where we were before."

Appreciating the improvements in other areas of her relationship, Eva was hopeful that

the intimacy could also be restored.

Unfortunately, not every participant was as optimistic about their challenges

during the time of the interview. Beth consistently reported significant challenges and

negative experiences during her interview. Years after her experience of IT, she still

described interpersonal isolation and pessimistic views of others:

> "I still feel the same way, that no one really is interested in hearing what *I* have to
>
> say. It's like I have to sit there and listen to them. And kind of 'Yes, yes, poor
>
> baby,' kind of stuff. But I guess now I'm okay with it."

She described resigning herself to her role. Always the giver of empathic support and

never the receiver. When asked if there were any positive takeaways she could attribute

to her experience conducting trauma therapy, Beth answered:

> "No, I don't think suffering is redemptive in any way. Or listening to suffering is
>
> redemptive in any way."

Thankfully, most of the participants in the study did not experience this level of dejection

in relation to their work as trauma therapists. While this group was universally

challenged, even pained at times by the work, the majority reported appreciation for their

experiences as trauma therapists and hope in the human capacity for healing.

Appreciation and Hope

Despite confronting tremendous suffering in their work as trauma therapists, most

participants reflected positively on their experiences. They discussed appreciation for the

intimacy they developed with their patients and hope that they held for trauma survivors

and for everyone facing life challenges.

A major focus of the therapists' increased hope was on the human capacity to heal

after trauma. Working with people who had lived through nightmarish scenarios left

Nancy with a firm believe that, with help, trauma can be overcome:

> "I don't see trauma as so insurmountable, you know. So somebody has a brother
> who was traumatized in the Vietnam War. Really *awful*, *terrible*, PTSD. *Terrible*
> nightmares, screaming, almost has flashbacks while awake. Just really crazy
> difficult substance abuse. All kinds of stuff. And she would bring him up a lot.
> And I really kept saying, 'VA, VA, got to get him into the VA' (laughing).
> Because I knew that this was treatable. It's really treatable. I don't want to say
> curable, but highly ameliorable… I do think that everybody can significantly
> improve. If not feel... Pretty cured."

Nancy was sure to point out that traumatic memories and experiences cannot be erased.
People live with their histories. However, her understanding of how much trauma
symptoms can improve increased greatly as a result of her work. Kathy shared in this
hope. So much so that after working with survivors of brain injury, Kathy came to
believe that people could recover and even grow from nearly any trauma:

> "It was easier to see the heroism of these people that had managed to figure out
> ways to live their lives and find joy despite their illness… Nobody else's
> problems really seemed significant (laughing)… Nothing seems like it's
> insurmountable compared to having a brain injury… I've sort of been identified as
> the person that they might send people who have had some form of sexual abuse
> or some sort of assault… And I think, to me, you can heal from it… I really
> believe that EMDR and therapy and time, you really can get back to who you
> were, or even something better than who you were, in a sense."

Kathy experienced hope for survivors and appreciation for their heroism. Bearing witness while her patients confronted the most painful aspects of their lives allowed her to share in the process of recovery.

The therapists experienced appreciation for a number of features of human strength that they discovered during their work. Maria discussed the gratitude she felt for her developed understanding of the complexity of human life. She described how much more interesting the world became to her:

"I learned to think of the world as more complex, but not necessarily more dark. I think it was the complexity that struck me more. It was more interesting. I was more attracted to that. And more wanting to move in that direction. So it was very gratifying."

Though dark and painful events opened Maria's eyes to this newfound understanding, her appreciation was tied to an interest in both positive and negative human experience. In addition to this increased interest, Maria touched on the significance of the intimacy that her traumatized patients developed with her during their therapy. She discussed how difficult that intimacy was to establish with one of her patients, and how special it felt:

"If you think about someone who has that kind of history, who hasn't been able to talk about it ever. And they trust you with that information, and with their secrets, with their shame, with their- It has to be *much* more intimate than somebody who, you know, has a more immediate life challenge… It was very gratifying to work with him. And every now and then I'll get a note from him or whatever, and a 'Thank you, my life is so much better because...' People who have ordinary problems tend not to (laughing) write you thank you notes 10 years later."

As she learned how dangerous it felt to her patients to develop an intimate relationship

with her, Maria's appreciation for their bravery increased. Each time she witnessed her

patients take a new risk in their path towards healing, that appreciation grew:

"Oh, risk! Risk. Taking risks. The other side of trust is supporting people in

taking risks. That feels intimate. If somebody takes some kind of life risk while

they're working with you. And abused people do need to. For example, I

supported one patient in her telling her family about the fact that she was in a

lifelong gay relationship. They didn't know. And it was *so* powerful. And so

healing for her. So much that her mother called me and thanked me. And that was

risk and trust… It opened up *everything* for her. You know, wow! She could have

a real relationship with her very large family. And she didn't have to hide

anymore. It was great."

Much of the participants' hope and appreciation was related to them bearing

witness to their traumatized patients' recoveries. As they helped their patients work to

overcome the horrendous experiences they had survived, the therapists shared in the

reward. For many, these experiences were not only the highlight of their professional

careers, but also provided them with a sense of purpose in life.

Sense of Purpose

When asked about the positive effects of their work, most of the therapists pointed

to emotionally meaningful experiences they had with their patients. In therapy, the

patients experienced moments of connection, gratitude and healing. Through the empathy

they shared to facilitate these achievements, the therapists simultaneously grew. Many of

the therapists specifically reported that their work provided them with a sense of purpose. The difficulties they faced, including indirect trauma, often served to highlight the importance of the work they were doing.

In sharing in their patients' pain, the therapists opened themselves to pain. After tearing up while discussing a patient's trauma, Nancy reflected on the pain she still holds for patients she worked with years ago. Importantly, however, she also discussed the humanity of her feeling for someone else:

"I think I would be robotic if, in talking to you about this stuff, I didn't feel something. There was that moment where I felt a little teary when I talked about my one client. But, you know, my heart doesn't race. I don't feel an overwhelming sadness, or intense anxiety. Yes, in talking about it, there's a little bit of arousal. But I don't think I'd be human if there wasn't. You know?"

Sharing her patients' pain, bearing witness, felt natural to Nancy. Despite the difficulty, doing so felt right. Being in touch with her sense of humanness proved meaningful.

As previously mentioned, Emily felt that the work she was doing treating and advocating for abused children encompassed who she was. Her work deepened her connection to her sense of self. Additionally, Emily discussed in no uncertain terms the love she had for her chosen career:

"I am still so excited about everything I do! I love- I can't even imagine retiring… I love learning… And I get really, really excited about it. And so I think that's what keeps me going. Knowing that there's so much going on in this world. And there's so many different ways that you can touch people's lives and

maybe help them see a different way of grabbing onto something positive or

making a change."

For Emily, the process of improving in her mission to help others make positive change

provided motivation and meaning.

Nina reported on the intimacy being central to the meaning she found in her work.

She shared her belief that not everyone was capable of expressing care and sharing

empathy the way she was. Her ability to work with trauma survivors felt purposeful to

her:

"There's a lot of meaning in the work. There's an intimacy, and you're really

getting into the mess with someone (laughs). It's interesting, because now I'm

thinking back and it's like, how to convey to someone the horror, but also the

beauty, in being able to do this work with someone. And I think maybe it's

because I feel like I *can*. So, there's also a sense of being in touch with my sense

of purpose. Being able to, you know, live meaningfully."

Bill shared in the reflection of his work as rewarding. He noted how challenging it

is to conduct trauma therapy, while also discussing the ways it has helped him to grow:

"It's obviously very challenging work. It's very rewarding work. And I think

there's something to be said about like, you need to be able to open up to allow

yourself to experience whatever comes up for you. That's really key and crucial

when you're working with this population. To just be very accepting of that. And

similarly, to have the same kind of acceptance to be able to hear some

unspeakable, horrific things that people experience. You know? But the more

accepting that you can be of your own reactions, the better you're going to be able

to hold that experience for whoever you're working with."

Bill's increased capacity to accept his internal, emotional experience helped him

significantly in his work. This growth not only helped him to connect with his patients,

but facilitated deeper connections with the people in his life:

"Oh! I think that it's helped me to understand more about my grandparents'

experiences. My mother's experience being the daughter of Holocaust survivors.

My grandfather's experience in terms of being a veteran. It was a great gift, before

he died. He didn't talk much about his experiences of war. But, *he did*, you know,

with me. And that was very special and very important to me. Helped me feel

much closer to him. Because he was kind of cut off in some ways. And it helped

me to better understand my own struggles and my own experiences. For sure. And

know how to work with that and have a healthier attitude toward, I think, life.

And the importance of living life in spite of struggling with whatever you're

struggling with. And not letting whatever you're struggling with paralyze you.

That life continues."

The lasting effects that Bill described are applicable to many of the therapists in the

study. Struggling through challenging and painful work with patients increased their

capacity for self-acceptance and for meaningful connection to the people in their lives.

We need not suffer alone with our pain, but find comfort and closeness in those willing to

listen.

CHAPTER V: DISCUSSION

Interview Themes

I.   Contributing Factors for Indirect Trauma

The present study both echoes the centrality of the most established contributing

factors for indirect trauma in the literature and highlights the contribution of less-

established factors. While identifying and weighing contributing factors for IT was not a

primary aim of this study, this area was explored to contribute additional data to the

inconsistent findings in the literature (Baird & Kracen, 2006; Branson, 2019; Knight,

2013; Sabin-Farrell & Turpin, 2003). The current study relied on participants' subjective

reporting of the contributing factors for their indirect trauma. As such, therapist reports of

the greatest challenges and grievances experienced during their IT symptoms were

utilized to infer contributing factors.

When asked about contributing factors of their IT symptoms, the participants

universally discussed identification with patients' trauma. Some therapists mentioned that

significant identification contributed to their most difficult periods of IT, while others

reported the belief that identifying less with their patients' traumas served as a protective

factor. Existing research into vicarious traumatization does not indicate identification as a

contributing factor, but rather proposes that this identification *is* VT. Pearlman and

Saakvitne (1995) postulate that empathizing with patients' traumatic material is the

primary mechanism by which vicarious traumatization is developed. Boulanger (2018)

states that "being vicariously traumatized [amounts to] identification with the patient's…

overwhelming affect and confused cognitive state during a particular event."

It is possible that the participants' discussion of identification with patients' trauma may relate to their own trauma histories. Eva's report that she identified less with, and was less disturbed by, patients' combat trauma compared to sexual or childhood abuse may indicate this connection. Maria hypothesized more directly that the fact that she had not experienced, nor known anyone in her personal life who had experienced, the traumas that her patients described may have been a protective factor for her. The research synthesis conducted by Baird and Kracen (2006) reported "persuasive" evidence exists that a personal trauma history increases the risk of vicarious trauma occurrence. They also report that such a history was found to be a risk factor for secondary traumatic stress. Six of the eight participants in the current study reported a personal history of trauma, with the remaining two discussing the effects of intergenerational trauma, specifically being descendants of Holocaust survivors, when asked about personal trauma history. While most participants endorsed personal trauma histories, none specifically discussed their own histories as contributing factors for IT. Perhaps participants avoided discussing personal trauma history to maintain privacy, to avoid painful memories or because more distant past experiences did not readily come to conscious awareness while reflecting on their work as therapists.

The participants in the present study subjectively reported additional contributing factors that generally echo prior findings. Knight (2013) sites research by Jankoski (2010), Knight (2010) and others suggesting that more exposure to traumatic material related to increased IT. The qualitative nature of this study did not closely monitor the amount of exposure to traumatic material, however all participants in the study had conducted trauma focused therapy ranging from one year's practice with traumatized

individuals to decades long practices. Nancy, in particular, reported that her extensive post-9/11 trauma work opened the "floodgates" and that this massive exposure contributed significantly to her symptoms.

Supervision experiences have been researched as another potential contributing factor. The current study echoes prior reports that less or no supervision and subjectively unsupportive supervision may contribute to the development of IT (Cohen & Collens, 2013). Beth, Kathy and Eva all reported that their supervision experiences did not make space for or welcome discussions of IT, which led to increased isolation and IT symptoms. Maria and Bill reported that supportive peer supervision was possibly their most helpful source of coping. Perceived coping style, identified as somewhat established as a risk factor for VT by Baird and Kracen (2006), will be discussed in further detail later on. However, participants that coped with their IT symptoms by connecting to other people reported less longstanding difficulties and greater relationship satisfaction than participants that coped through work or distancing and did not talk to others about their IT.

The primary contributing factor discussed by participants in this study was the identification with patients' trauma. The experience of feeling isolated or alone in the work also seemed to be the participants' second largest contributing factor for IT.

II.   Impact on Sense of Self, Others, and the World

The effects of IT on the therapists in the current study are consonant with previous research findings related to changes in schema of self, others and the world (Pearlman & Mac Ian, 1995). Broadly speaking, the participants experienced decreased

feelings of efficacy and control, diminished regard for other people and a reduced sense of the world as a safe place.

The participants in the study experienced disruptions to their sense of efficacy and control in the world that were particularly impactful in terms of their work. They questioned their ability to help their traumatized patients heal, whether it made any difference to help such a small portion of trauma survivors and even whether or not they were innately "good" or "caring" enough to work as therapists. These effects relate closely to the "fundamental psychological need" of power, which McCann and Pearlman (1990) describe can be disrupted by therapists' exposure to their patients' helplessness and vulnerability.

A common response to the helplessness they felt was for the therapists to go above-and-beyond in an attempt to help their patients heal. Faced with overwhelming stories of trauma, and witnessing their patients suffering, the participants in the study experienced an increased desire to save their patients form traumatic pain. Participants described an increase in maternal countertransference, a desire to foster or otherwise provide for child-patients, and experiences of transgressing normal boundaries in an attempt to protect patients from harm. Maria went so far as to store her patient's gun because, at the time, it seemed like that was the best way for her to help. McCann and Pearlman (1990) describe how therapists may consciously or unconsciously attempt to combat reduced feelings of power or efficacy by urging clients to take action rather than by listening to them, by attempting to increase their own physical power by taking self-defense courses, or by becoming more dominant in social interactions.

Through empathizing with their traumatized patients' stories, the participants in the study were introduced to the existence of incredible pain, hurt and suffering. Viewed through the lens of Jean Piaget's theory of cognitive development, this new information would either have to be able to assimilate into the therapists existing schema, or they would have to accommodate their prior beliefs to incorporate the levels of pain and suffering they were hearing of (Miller, 2011). Existing research generally supports that trauma therapists will inevitably experience changes in schema as a result of their work. Pearlman and Mac Ian (1995) suggest that the resulting distress associated with accommodating these stories will depend on the therapist's personal trauma history. While the therapists in the present study did not discuss their own trauma in detail, some spoke to their intimate knowledge of trauma before becoming therapists. Bill discussed the information he learned about the Holocaust from his family members who had survived it. Eva discussed the way in which childhood and sexual abuse impacted her more than combat trauma. Eva, new to the field, described what would amount to a greater disruption in other esteem than did Bill, who has been working with trauma survivors for much longer. The relationship between a therapist's personal trauma history and their diminished regard for others in this study seemed to follow the proposal from Perlman and Mac Ian (1995): Perhaps those with personal trauma histories require less accommodation of prior beliefs and therefore will experience less distress.

In addition to a reduced sense of self-efficacy and diminished regard for others, participants in the study experienced a diminished sense of safety in the world. All of the participants in the study described experiencing an increase in fear or a diminished sense of safety in some way. Kathy became more nervous of her or her family suffering a

traumatic brain injury, Bill became nervous that an angry patient would threaten his family, Maria began to believe her patient's claims that people were monitoring her whereabouts. The therapists universally experienced the world as less predictable and less safe as a result of this work. As Charles Figley (1995) described in his writings on secondary traumatic stress, trauma therapists may experience symptoms nearly identical to the PTSD their trauma survivor patients experience. The changes in schema experienced by the patients coincided with PTSD-like symptoms of avoidance and hypervigilance. Knight (2013) discussed how therapists may react to these symptoms with a preoccupation of thoughts about their clients, hypervigilance, or re-experiencing client's traumas in memories and dreams. She also discussed that clinicians may defend against these symptoms through denial and detachment in the working alliance. The therapists in the present study certainly experienced those effects. Additionally, the results of this study suggest that indirectly traumatized therapists are at risk of experiencing detachment and disruption in all of their relationships.

III.   The Connection Conflict

The results of the current study strongly indicate that indirect trauma has a pervasive and unavoidable effect on therapists' relationships. The major relational effects that indirect trauma had on the participants were threefold: they experienced a drained or exhausted emotional state and were thus less willing or able to invest energy into their romantic and platonic relationships, they experienced distressing beliefs and affects that led to an increased desire or need for support and understanding from others, and they

both experienced and anticipated misunderstanding and invalidation from others, which contributed to increased isolation.

Nearly all of the therapists in the study described an emotional exhaustion or compassion fatigue that impacted their relationships in some way. Nina discussed difficulty empathizing with the problems her sister and non-therapist friends shared. Emily cut off old friends that she felt were too needy. Eva, Kathy and Nancy all described an inability or aversion to connecting with their partners after the end of a work day. Bill reported that he felt pulled to isolate from his family, though he generally managed to combat that urge and stay connected. These results echo some of the findings in the review conducted by Sabin-Farrell and Turpin (2003). While the results in their review were mixed, they did include feelings of emotional exhaustion, difficulty engaging in emotional intimacy, and increased isolation.

Every participant reported an increased desire for support and understanding from loved ones and colleagues with the exception of Beth, who appeared to believe that others were entirely incapable or unwilling to provide such support. Bill described how receiving understanding from his colleagues helped soothe feelings of innate badness that working with angry, aggressive, traumatized patients engendered in him. Maria reported that sharing the impact of her work with her husband and peer-supervision group helped to ease her intense sadness and agitation. Emily and Nina similarly spoke to the relief and ease they felt when speaking about work with other therapists. Speaking with others whom they trusted to understand them and know their struggles provided craved validation and connection.

A number of therapists reported on the difficulties that arose when their loved ones and colleagues were unsupportive or invalidating of their struggles. Furthermore, most therapists discussed adopting some beliefs that others could not understand or support them. Kathy and Nancy both reported that they hid their professions from casual acquaintances to avoid expected invalidation. Nina, Eva, Emily, and Beth all described ways in which they felt unable to discuss the impacts of their IT in supervisory relationships. They reported how these relationships, meant to be supportive, became additional stressors as they felt pressure to hold back their most pressing work-related concerns for fear of invalidation, dismissal, blaming, or distressing over-reaction. Nina and Beth avoided dating due to the expectation that potential partners would not understand or empathically respond to their work. These altered perceptions are concordant with the Sabin-Farrell and Turpin (2003) finding that therapists experienced a loss of faith in others.

Not only did indirect trauma introduce new disturbances into the therapists' relationships, but it also intensified prior challenges that sometimes led to significant relational conflict. Coupled with life stressors, IT contributed to therapists avoiding dating, emotionally separating from partners, contemplating divorce, and actually divorcing from unsupportive partners. Some of the participants experienced major relational turmoil that coincided with periods of IT. While there is insufficient evidence to argue that IT was the sole cause, some of these participants attributed significant impact to their IT-related distress. These results differ with Knight's (1997) findings that only a small percentage of therapists experienced intensified problems with emotional or sexual intimacy as a result of conducting trauma therapy. The most intense IT symptoms

reported in the present study contributed to pervasive negative appraisal of others, increased isolation and relational disruption. The best-case IT experience reported, which required purposeful and active coping, still led to affective distress, disrupted beliefs about self and others and the urge for interpersonal disconnection.

IV.   Coping with Indirect Trauma

While not the primary focus, a major motivation for this study was to gather information that may help trauma therapists cope with indirect traumatization. The participants discussed attempts to cope that aligned with three major categories: processing the traumatic memories and affects they were exposed to, seeking to increase power and control by delving further into their work, and renegotiating interpersonal boundaries to increase emotional support. These three coping strategies have much in common with the suggestions for preventing and addressing indirect traumatization by Courtois and Ford (2009), which "highlight four aspects of self-care: social support, professional consultation, spiritual renewal, and radical self-care" (p. 214). It should be noted that none of the therapists in the study discussed specific training in protecting against indirect trauma prior to or during their experiences as trauma therapists.

One major coping strategy discussed by therapists in the current study involved the need to process the traumatic material that they were hearing. Though the desired process seemed similar, each therapist used different terminology to talk about their need. Nina reported a challenge to "digest" or "metabolize" the "fragmented" memories and feelings she experienced. Maria reported being "full of" or "overwhelmed by" disgust, horror and fury, which she wanted to expel. Nancy related her symptoms to carrying a

burden and described a sensation of unloading weight by processing her thoughts and emotions in her own therapy. Bill described that the work ultimately forced him to accept more completely the human capacity for evil and pain and his own capacity for anger and aggression. Each of the above participants utilized professional consultation to address their distress, or as Courtois and Ford (2009) state, "examine personal responses [to traumatized patients] in a supportive, confidential, trauma-informed, professional consulting relationship…" Additionally, Bill's examination and acceptance of the self and human evil aligns with the researchers theme of spiritual renewal or, "opening the self to the darker aspects of human experience, [which] can contribute to personal and professional perspective and growth." Just as various mechanisms of change have been identified to treat direct traumatic stress, the participants addressed varied cognitive and emotional conflicts in the course of processing their indirect trauma.

Separately from those identifying and processing the personal effects that IT had on them, a number of participants reported that the major focus of their attempt to cope was to delve deeper into their work. Kathy, Eva, Emily, and Maria all reported that they either increased their focus on work, felt relief through their work, or benefited from additional education and training. The participants that utilized this coping mechanism often described it as an unconscious response or a compulsory urge to increase their proficiency as helpers. This coping style appeared to succeed when it helped to increase the therapists' competence and confidence in treating trauma, connected them with professional circles that became support systems or led them to witness more healing from their traumatized patients. The coping style appeared less effective and potentially damaging when the therapists increased the responsibility they felt to help their patients

heal and when increased focus on work prevented them from pursuing social support and consultation. This idea aligns with the spiritual renewal concept in Courtois and Ford (2009), which states, "One of the best antidotes to VT is to be transformed positively by the work." They go on to describe that relating to others and their trauma may provide therapists with positive spiritual change, a greater appreciation for life and increased personal strength.

The last major coping method discussed by the participants was to renegotiate boundaries with people in their lives. While some of the therapists such as Beth and, for a time, Emily reflexively distanced themselves from the people in their lives, most of the participants discussed taking strides towards increasing their intentionality regarding boundaries with others. Bill set specific weekly activities with his children. Eva invested her downtime in relaxing with her husband. Eventually, Emily identified who in her life felt draining to spend time with and who helped her to feel rejuvenated. She described significant improvement after altering her boundaries to set herself up to experience social replenishment in her personal life. This coping mechanism matches closely with Courtois and Ford's (2009) "radical self-care," one aspect of which is, "To develop and maintain sustaining intimate, family, and other interpersonal relationships." The researchers also suggest disengaging from relationships that are depleting. They describe this process as an "ethical imperative" for all therapists due to the importance it plays in maintaining therapists' emotional wellbeing.

Additional prior research into preventing and managing IT that is perhaps most relevant to therapists' relationships bears mentioning. Schauben and Frazier (1995) found that therapists who sought social support as a coping mechanism reported less symptoms

of vicarious trauma. Social support included professional support groups, personal therapy, peer engagement, and organizational or institutional support. As discussed in theme III, individuals experiencing IT may have significant difficulty engaging, and feeling relief from, social supports. However, the most successful outcomes for participants in current and prior studies seem to coincide with the ability to navigate conflicts in connection and to maintain engagement with supportive others.

V- Lasting Effects

McCann and Pearlman (1990) characterized the effects of working with trauma on trauma therapists as "likely permanent, even if worked through completely." The results from the present study echo the notion that this work will have lasting effects on the therapist, though the type of effect is variable. The participants most frequently highlighted three ways in which they experienced lasting changes as a result of their work. Many expressed viewing life more seriously and experiencing an aspect of disconnection or loneliness. About half of the therapists reported increased hope in human and/or personal resiliency and appreciation for the connections that they did have. Finally, most therapists in the study described an importance, beauty, excitement, and/or sense of purpose that motivated them to continue the work despite the challenges they faced.

Nearly all of the therapists in the study reported general positive regard for their profession during the interview. Despite this, a number still reported that they experienced some lasting, negative changes as a result of their work. The first commonly discussed change was that they viewed themselves as more serious and less humorous or

care-free. Kathy described being less joyous, more anxious and more protective of her children. Emily reported missing the fun, funny side of herself that seemed to have faded away. Eva and Nina reported feeling disappointed in humanity for the magnitude of interpersonal traumas committed. These reports fit with existing literature suggesting that internalized schemas about self, others and the world can be changed by IT. Cohen and Collens' (2013) metasynthesis of 20 qualitative studies about vicarious trauma and vicarious posttraumatic growth (VPTG) stated:

> "In order to make sense of their vicarious experiences, participants reported engaging in an existential meaning-making process, questioning themselves, their lives, and their identities."

For some participants, the loss of humor and fun they experienced was part of a larger negative reaction to their work. For most, this change may have been associated with their engaging in more existential thinking and meaning making as they were bearing witness to trauma.

A similar process of change could clarify the loneliness that participants reported. For Eva and Nina, the newest trauma therapists in the study, the distance and disconnect they felt from certain people in their lives seemed related to an ongoing accommodation of their schema to fit the shocking new traumatic information they were empathizing with. These trauma therapists were exposed to emotionally potent information outside of their existing beliefs of the world; information that most people in their lives did not have, nor want, any exposure to. For these new therapists, as well as those experienced therapists that underwent significant relational turmoil during their trauma work (such as Nancy, Emily, and Kathy), the loneliness and disconnect may be best explained by the

"radical self-care" coping mechanism posited by Courtois and Ford (2009). The pain and turmoil associated with disconnection may have been in service of developing rejuvenating relationships while disengaging from emotionally draining ones. The relational extension of the process of accommodating schema to address their new, trauma-informed experiences. Unfortunately, disconnection and loneliness seemed to be a lasting effect for Beth. There a number of potential factors that could have contributed to this lasting negative impact, such as unresolved personal trauma, limited social and organizational support, and poor training related to trauma therapy and IT. Ludick and Figley (2017) comment on the potential costs of empathizing with trauma:

> "The empathy paradox has the ability to both protect and harm. It is both the keystone to helping others as well as a pathway to the high costs of caring. Empathic concern is also susceptible to attrition."

Awareness, active coping and support are certainly necessary to reduce the lasting negative consequences of IT.

For the majority of participants, the negative effects of IT were counter-balanced by lasting, positive changes. A major component of the positive change the therapists experienced was increased appreciation and hope. Nearly all of the participants described great appreciation for the people in their lives that they found supportive and rejuvenating. IT prompted the therapists to undergo the difficult work of identifying supportive individuals and establishing or deepening open, trusting relationships. Once in place, the support and intimacy was invaluable. A number of the therapists also described appreciation for the intimacy present in the therapeutic relationships they established. Maria described how the difficulty establishing trust with traumatized patients seemed

directly related to how special it felt once developed. Nancy described being in touch with her own humanity while feeling sadness for her former patients. This sense of appreciation was present for both the new and experienced therapists in the study.

A second positive, long-term effect that only seemed to develop for more experienced clinicians was an increased sense of hope. Despite years of additional exposure to traumatic material, nearly all of the more experienced clinicians in the study reported that they were more hopeful that, with help, trauma can be overcome. That humans are capable of surviving unspeakable tragedies, and even growing in the aftermath. It is hypothesized that the mediating factor for increased hope during or after indirect trauma is vicarious post-traumatic growth. Cohen and Collens (2013) states:

> "Experience and time were noted as key factors, moderating the negative
> emotional impact of the work, with more experience and time leading to less
> overwhelming emotions and distress… It seems that having been a witness
> to the growth of their clients, this witnessing process facilitated the
> participant's own growth."

It is understandable that, for new therapists yet to have witnessed many positive transformations in their traumatized patients, the distressing emotions and hopelessness associated with IT would have a stronger influence on their schema. For the therapists with more experience aiding in the healing of traumatized individuals, distress decreased and hope returned, potentially stronger than before. This process seemed to be actively unfolding at the time of the interview for Eva. Despite disappointment in humanity associated with the interpersonal traumas she had heard, Eva reported that one of her greatest sources of relief was seeing that the Prolonged Exposure treatment she was

utilizing worked and her patient healed. Perhaps witnessing additional positive therapeutic outcomes may further reduce her hopelessness in humankind. A similar process may be related to participants' reports that the assessment and evaluation of traumatized patients was particularly difficult. Kathy and Eva both described experiences in which patients would discuss terrible traumas during intake interviews or assessments and they would never see these patients again. Hearing of the terrible pain these individuals experienced without the opportunity to help them heal was particularly difficult.

Though sharing in patient healing and recovery may be an important factor in reducing therapist IT, Cohen and Collens (2013) also describe a "complex picture, where positive changes could co-occur alongside some of the negative emotional impact of trauma work." It is probable that trauma therapists rarely experience their work in wholly positive or negative terms, but rather undergo a process of simultaneous pain and growth.

For those therapists that managed to address their most distressing periods of IT, empathizing with and treating disconnection, pain and hopelessness paradoxically resulted in deeper personal connections and increased hope. A number of the therapists discussed ways in which this difficult work provided them with a sense of purpose, meaning or identity. Nina and Emily particularly described how important the work was to their sense of self and sense of purpose. Nancy described that it helped her connect more deeply with her sense of humanity, while Maria spoke to the way she learned more of the complexities inherent in the world. Bill described how the worked pushed him to identify and accept a fuller picture of his internal experience, which in turn helped him to connect more deeply with people inside and outside of his work setting. These

experiences of deep personal satisfaction and growth align with hypotheses in Cohen and

Collens (2013) stating that the benefits of vicarious post-traumatic growth fall "within the

eudemonic tradition of self-actualization rather than positive or pleasurable emotions."

Courtois and Ford (2009) pull from the positive psychology of Peterson and Seligman

(2004) to discuss the spirituality associated with the positive transformation obtained

through this work:

> "Aligning your life to your 'signature' strengths, using those strengths to
>
> contribute to others, and experiencing gratitude can contribute to personal
>
> happiness and fulfillment. These processes seem spiritual in nature, because they
>
> connect the helper with his or her authentic self, allowing and supporting self-
>
> transcendence."

Nina certainly valued this utilization of her "signature strength," discussing how

important it felt to her to possess the ability to do this work that so many could not

imagine attempting. To paraphrase from both Nina and Bill, the experience of treating

trauma made possible a profound acceptance of the beauty and horror present in the

world and the notion that, through it all, life continues.

Limitations

A primary limitation of this study rests on the continued lack of conceptual clarity

around the construct of indirect trauma and inconsistency in findings related to it. For the

purposes of this study, the related terms of vicarious trauma, secondary traumatic stress

and compassion fatigue were all included under the umbrella of indirect trauma. Research

aiming to clarify this experience and the terminology used to research and address it has

suggested that VT, STS and CF are overlapping, yet separate phenomena that also differ from burnout (Baird & Kracen, 2006; Knight, 2013).

The qualitative nature of the present study allowed for detailed exploration into the subjective experience of the participants. However, it also comes with inherent limitations. The small sample size of eight participants limits the generalizability of the findings. This study included only one male. Gender was identified as a potentially important factor in the development of IT, with women typically reporting higher levels of distressing symptoms than men (Sabin-Farrell & Turpin, 2003). However, Knight (2013) cautions that this may have more to do with female therapists' increased willingness to disclose personal, distressing information than male therapists. It is possible that this played a role in the limited response rate for men who received the recruitment email. Additionally, the participants in the study were racially homogeneous and all identified as White or partially White. Only one participant was not geographically located in the northeast United States. Therefore, potential racial and socio-cultural influences on the experience of indirect trauma and its effects on interpersonal relationships are outside the scope of this study.

Another potential limitation in the present study relates to the personal nature of the subject matter. Despite incredible openness and self-reflection, it did at times appear that some participants were resistant to discussing intimate details of their romantic and familial relationships such as sex and marital discord. While the researcher was particularly interested in the concrete ways relationships were affected, it is understandable that participants may not have felt comfortable sharing intimate details of their relationships. While it is likely that this was partially to maintain privacy, it also

appeared that participants were less likely to associate certain relational challenges with their work as trauma therapists. Many of the therapists described that they had not previously contemplated the relational effects of their work, or had not done so to the extent the researcher asked them to. These participants were processing years of work and relationship history during a 60 to 90-minute interview. It is possible that, given more time for self-reflection, the participants would make additional connections between their trauma work and their relational experiences.

The semi-structured interview questions may have impacted the collected results. The questions asked primarily focused on the negative effects of conducting trauma therapy on the therapists and their relationships. It is possible that some participants would have described additional positive experiences if the inquiry into this area was as comprehensive. However, the positive effects experienced by the therapists may be more closely associated with vicarious post-traumatic growth, a separate yet related construct.

As the interviewer served as the primary tool for data collection in present study, it should be restated that this individual's background, experiences and biases likely influenced data collection and analysis. As discussed in the methods section, the interviewer is the son of a trauma survivor and was conducting his psychology internship with a trauma-heavy patient population at a Veterans Affairs Medical Center during parts of the data collection and analysis. It is possible that the interviewer may have made assumptions about the participants' experiences based on his own personal and professional experiences. These assumptions may have guided data collection towards specific answers or themes, or have reduced opportunities to gather additional clarification or elaboration of data discussed during the interviews.

Implications for Training

The results of the present study demonstrate a need for increased dissemination of information regarding indirect traumatization symptomatology, effects on personal and professional relationships and methods of coping. It is imperative for trainees to learn this information early in their careers, as it is uncertain when they will be exposed to traumatic information that may lead to disruptions in existing schema. Trainees, at the time of building competence and confidence in themselves as clinicians, may be at increased risk for the development of IT. Not only could this information prevent feelings of hopelessness, ineptitude and burnout, but widespread understanding of indirect trauma would likely prevent or reduce relational distress among trainees. Though graduate schools and training sites often mention the importance of self-care, none of the participants in this study reported receiving substantial teaching about indirect traumatization prior to their experiences of it.

In addition to information dissemination, training sites and supervisors must be sensitive to, and validating of, trainee expression of indirect traumatization. Trainees working with traumatized patients would benefit from supervision that promotes self-reflection, openness to internal experience, and the exploration of countertransference. As reported by the early-career therapists in the present study, invalidating responses, reduced power in the trainee role, and fears that doing so would be inappropriate, prevented the open discussion of IT in supervision. Knight (2013) suggests that supervisees are unlikely to discuss manifestations of indirect traumatization in supervision unless explicitly encouraged to do so by supervisors. That study also promotes the notion that an egalitarian approach from supervisors may contribute to

increased openness among supervisees. For trainees to truly benefit from the available research on IT, supervisors will need to take initiative to explicitly discuss this information with their supervisees in a way that encourages personal dialogue while maintaining appropriate boundaries.

A major factor that reduced therapists' IT-related distress in the present study was sharing in their patients' recovery. Trainees, however, often have very little control over how long they work with any particular patient. Not only do they typically switch training sites on an annual basis, but each site may have multiple rotations or session limits that reduce the length of each therapeutic relationship. In addition to their lack of experience, early terminations may make it more difficult for trainees to benefit from vicarious post-traumatic growth to the same extent as career professionals. For Nina, early termination resulted in her feeling devastated, like she was abandoning her traumatized patients. While externship and internship time limits may be inflexible, training directors and supervisors should consider time limitations when assigning traumatized patients to trainees. Trainees should be assigned patients who have the potential to experience positive improvement during the timeframe of their work together to bolster trainees' sense of effectiveness. At the very least, trainees should be assisted in understanding the limitations of what can likely be achieved in a short timeframe with patients experiencing significant trauma and disrupted attachment.

Implications for Practice

For the individual practitioner, the first step in addressing and reducing indirect trauma is to acknowledge and accept the difficult thoughts and feelings generated by

working with survivors. Speaking to these experiences allows for therapists to begin a process of normalizing and validating them, reducing feelings of loneliness and self-judgement (Knight, 2013). Bill described how transformative it was for him to reduce the shame associated with his countertransferential feelings of anger, aggression and disgust. Beth described the lingering pain associated with the belief that no one cared about her experience of these feelings and the suffering related to continued isolation.

Potentially the most helpful factor reported by therapists in the present study to reduce indirect trauma was having regular conversations with knowledgeable, supportive colleagues. These relationships were portrayed to help in multiple ways. They provided therapists with the support and understanding that they often did not receive from people in their lives without knowledge of trauma and IT. Colleagues gave therapists a relational experience that was rejuvenating and did not require them to act as the sole caretaker. They promoted self-reflection by validating potentially shameful or isolating countertransference experiences and introduced the therapists to outside perspectives on these experiences. Finally, supportive professional relationships offered additional learning and insight during stuck-points in treatments that enabled the therapists to achieve additional vicarious growth. It is imperative for organizations that treat trauma to promote collegial relationships that allow for the expression of affect and personal difficulty. Additionally, it is important for therapists working in organizations or private practices where they don't have access to such relationships to seek them through external group supervisions or informal professional gatherings.

Another important factor in reducing IT was the therapists' ability to feel effective and to have hope that their patients' traumas could be overcome. A major part of feeling

effective tied to the participants witnessing their patients heal. Being trained in specific treatments proven to be effective in addressing trauma provided even experienced participants with an increased sense of control and increased hope in the human capacity for healing.

Outside of their professional lives, therapists working with trauma would benefit from paying particular attention to their personal relationships. Broadly speaking, therapists should consciously adjust, monitor and adhere to their relational boundaries. Given the demanding nature of trauma therapy and the depleting feelings associated with IT, it is important for these therapists to experience rejuvenation in their personal connections and to reduce additional burdensome interactions. Alternatively, therapists in the present study identified periods of IT where their own urge for isolation caused them to distance themselves from others. While it is necessary for trauma therapists to make room for escape into joy, sensory pleasure and creativity (Knight, 2013), it is important to indulge this need without eliminating opportunities for supportive connection with others. One effective method that therapists in the present study utilized to accomplish this balance was to create regular opportunities to have fun with others. Emily made a group of friends that frequently kayaked together. Bill scheduled weekly yoga and other activities with his children.

In the present study, most therapists had either personally survived traumatic experiences or had intimate relationships with trauma survivors. Another important implication for practice is that therapists should be encouraged to address their own traumas and the implications they may have for their therapeutic and personal relationships. Having experienced trauma personally should not preclude therapists from

working with traumatized patients. To the contrary, helping others to heal from traumatic experiences was shown to provide therapists in this study with appreciation, hope and meaning. It is important, however, to have a conscious, self-reflective understanding of these effects. Lasting disruptions to schema related to other-esteem, self-efficacy and potential for healing stemming from therapists' personal trauma histories may produce increased distress when empathizing with other survivors.

On the organizational level, the primary recommendations are to prioritize the awareness and validation of IT, encourage social connection and support, and promote the egalitarian supervision described under implications for training. Organizations that treat trauma would benefit from regular group supervisions, case consultations or simply staff meetings that allow for the open discussion of difficult cases and therapists' affective experiences. The more the workplace culture expects and validates the difficulties associated with trauma work, encourages staff members to discuss their internal experiences, and meets personal and affective expression with support, the easier it will be for employees to minimize indirect trauma. Institutions would also benefit from monitoring the potential sources of IT development within their settings. Eva and Kathy described that there was no discussion about IT in their workplaces, both of which were assessment and evaluation-heavy locations. In general, the possibility that evaluations may hold equal or increased risk for IT development should be taken into account. This type of work often exposes therapists to traumatic stories and distressing affects without the opportunity to intervene or work towards healing.

Suggestions for Future Research

The results of this study and limitations described above provide suggestions for future research in the area of indirect trauma. A primary focus of continued research in this area should aim at continuing to clarify and legitimize the terminology of indirect trauma, vicarious trauma, secondary traumatic stress, and compassion fatigue. Research aimed at clarifying these concepts and establishing the use of appropriate terminology is ongoing. The present study promotes the notion that VT, STS, and CF are all specific, separate sets of symptoms and that indirect trauma is the most appropriate umbrella term to encompass the other three. This conceptual construct has been utilized in a number of recent publications in the area (Knight, 2013).

As the effects of indirect trauma continue to be studied and clarified, additional attention to its relational effects is deserved. One such area of continued investigation might delve further into the connection between IT and significant relational turmoil amongst therapists. The therapists in the current study were unlikely to identify IT as the primary contributing factor for relational problems such as divorce and separation, even if these problems occurred during their most pronounced IT experiences. These participants identified contributing factors outside of their work as trauma therapists, which were certainly meaningful. However, future research may be able to further illuminate a potential correlation between indirect trauma and therapist separation or divorce. Quantitative research independent of therapists' subjective perceptions could explore whether therapists working with trauma are more likely to experience separation, divorce or relationship dissatisfaction more broadly. The present study was also limited in terms of participant diversity. Future research may explore the ways that male and

non-White therapists experience relational impacts of indirect trauma. Prior research suggests that men may be less likely to share their IT experiences openly, and that doing so in the service of gaining social support and consultation is a critical component of healing (Courtois & Ford, 2009; Knight, 2013). Future research with more diverse participants will be important to further understand risk and protective factors and effective coping strategies, which may differ between therapists.

While the present study was not aimed at clarifying risk and protective factors associated with IT, the participants' descriptions of their experiences introduce potential areas of future investigation in these domains. Though the results are mixed, prior research identifies personal trauma history as a risk factor for indirect trauma. The results of this study, however, would suggest that *unresolved* personal trauma in particular may be responsible for this increased risk. The experience of personal trauma alone seemed less likely to impact the therapists than lasting disruptions to schema about self, others and the world, which may stem from personal trauma experience. Additionally, this study did not investigate the therapists' baseline relationship satisfaction and historical relational beliefs and experiences. Future research may be able to clarify the influence satisfying and supportive relationships, in addition to optimistic interpersonal schema, have in protecting against IT. A number of the participants in this study identified family histories of trauma. The relationship between intergenerational trauma and indirect trauma may warrant further study, as both constructs place the individual in a position of empathizing with trauma survivors.

Finally, additional research into how organizations and individuals can best protect against and cope with the distressing effects of indirect trauma will be invaluable

to the field. While this research is ongoing, the results of the present study suggest that

the moderating effects of vicarious post-traumatic growth (VPTG) may be an area of

particular interest going forward. Though Cohen and Collens (2013) suggest that the

positive effects of VPTG and the negative effects of VT can co-occur, the participants in

the present study that experienced VPTG seemed to have better long-term outcomes. This

research could seek to examine if trainees and practitioners conducting evaluations or

short-term trauma therapy are at heightened risk for lasting distress with less opportunity

to share in patient recovery.

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APPENDICES

Appendix A

Recruitment Email

To Whom It May Concern:

I am a doctoral student at the Graduate School of Applied and Professional Psychology (GSAPP) at Rutgers University. I am seeking therapists who have experienced indirect trauma (or vicarious trauma, compassion fatigue, secondary traumatic stress) and would be willing to share how the experience personally affected them. I am writing to ask that you please forward this request for research participation to licensed therapists who self-identify as having experienced indirect trauma. Therapists licensed in the United States in fields such as psychology, psychiatry, clinical social work, mental health counseling, and marriage and family therapy will all be included in the study. Participation will involve one 60 to 90-minute interview to be conducted either in-person or via secure telehealth video-conference. Participants will also be asked to complete a demographic questionnaire that may take an additional 5-10 minutes. The researcher will keep all personal, identifying information confidential by assigning participant codes which will be stored separately from collected data. Participants may discontinue their participation in the study at any time. If you or anyone you know is interested in participating, or if you have any questions pertaining to this study, please contact me at the attached address. Please note that there is no compensation for your participation other than potentially assisting future trauma therapists.

Thank you!

Sincerely,

Samuel Golden, Psy.M.

Appendix B

Phone Screening Script

Thank you for considering participating in my study. I have a few questions to ask to confirm that you meet the criteria for the study, okay?

1)   Are you licensed to practice therapy in the United States?
Inclusion: Yes.

2)   Have you conducted therapy with at least three clients who have survived an interpersonally caused traumatic experience?
Inclusion: Yes.

3)   Do you believe that you experienced indirect traumatization, or the negative effects of empathizing with traumatized individuals including but not limited to: anxiety, avoidance, hypervigilance, emotional dysregulation, significantly altered thoughts of self, others or the world (sometimes referred to as vicarious trauma, secondary traumatic stress, or compassion fatigue) as a result of working with this population?
Inclusion: Yes.

4)   Have you ever experienced a directly traumatizing event during your work as a therapist (such as being assaulted at work or as a direct result of your work)?
Inclusion: No.

Great, you meet the criteria for the study. Let me tell you a little bit about what to expect if you decide to participate. The purpose of this research study is to explore the experiences of indirectly traumatized therapists. More specifically, it is exploring the effects that indirect trauma has on therapists' relationships. Your participation would involve an individual interview that will last anywhere between 60-90 minutes, plus a few minutes to fill out some brief demographic and consent forms. Your participation is voluntary and you may stop participating at any time. Please note that you will not receive any compensation beyond contributing to the knowledge of therapists' experiences of indirect trauma. The interviews will be audio recorded so that I can transcribe what is said later. The audio recordings will be deleted immediately upon completion of transcription. All identifying information will be removed from or altered

in these transcripts before they are analyzed. None of your identifying information will be recorded or used in the study.

Do you have any questions? Are you interested in participating? Let's schedule a convenient time, method and location to conduct the interview. Would you like to meet in person, perhaps at your place of work? If not, would you be willing to conduct the interview via the secure telehealth video-conferencing program doxy.me?

If the caller does not meet the inclusion criteria, the researcher will state: "I'm sorry, but you don't meet the inclusion criteria to participate in this study. Do you have any questions about that? Thank you for your time."

Appendix C

INFORMED CONSENT AGREEMENT AND PRIVACY STATEMENT

You are invited to participate in a research study entitled <u>The Effects of Indirect Traumatization on Therapist Relationships: A Qualitative Study</u>, conducted by Samuel Golden, Psy.M. Before you agree to participate in this study, you should know enough about it to make an informed decision. If you have any questions, please ask the investigator. You should be satisfied with the answers before you agree to participate.

Purpose of the Study:
The proposed exploratory research seeks to better understand the experiences of trauma therapists who have experienced indirect trauma. For the purposes of this study, indirect traumatization will be defined as:

> *Any negative effects resulting from empathizing with trauma survivors. These effects can include but are not limited to: intrusive thoughts or images, hypervigilance, anxiety and/or avoidance, difficulty regulating emotions, or changes in core schema regarding oneself, others, or the world.*

Specifically, the study will focus on how indirect trauma impacts therapists' interpersonal relationships and their experience of those relationships. Despite substantial quantitative research into the phenomenon of indirect traumatization, there is currently limited research into its relational effects. This study will be used to enhance understanding of those relational effects by presenting detailed descriptions of indirectly traumatized therapists' lived, interpersonal experiences. A doctoral student at the Graduate School of Applied and Professional Psychology (GSAPP) at Rutgers University is conducting this study in fulfillment of dissertation and doctoral requirements. It is anticipated that 7 to 11 other individuals will participate in this study.

Study Procedures:
You will be interviewed about your experience of indirect trauma and how it impacted you and your relationships. The interview will take approximately sixty to ninety minutes. Interviews will be audio recorded to allow for later transcription and data analysis.

Risks:
The interview will focus on your experience of indirect trauma and ask personal questions about your relationships. It is my hope that the interview will be a positive experience for you. However, recalling some experiences may be unpleasant and may lead to some discomfort when answering questions. If you experience emotional distress related to the study, the study's faculty advisor, Dr. Brook Hersey, has made herself available to talk with you. Dr. Hersey will be glad to debrief your experience with you and help to collaboratively determine the next steps required to assure your comfort and safety.

Benefits:
Participation in this study may not benefit you directly. However, the knowledge that we obtain from your participation, and the participation of other volunteers, may help us develop a more comprehensive understanding of what experiences therapists have while navigating and recovering from indirect trauma. Sharing your experience as one such therapist may also provide a valuable forum for personal reflection.

Confidentiality:
This research is confidential. This means that while the research records will include some information about you including your age, gender, sexuality, and professional experience, your name will only appear on consent forms and will be kept separate from research records. Research data will be stored in a secure, locked location. The research team and the Institutional Review Board at Rutgers University are the only parties that will be allowed to see the data, except as may be required by law. Your responses will be grouped with other participants' responses and analyzed collectively. All identifying information will be disguised to protect your confidentiality. This will include changing your name and other demographic information.

Interviews will be conducted in person in a private location agreed upon by you, or via the secure telehealth video conferencing service, Doxy.me. Interviews will be audio recorded and transcribed, and audio recordings will be destroyed immediately after transcription. Audio recordings will be stored on the recording device, and kept by the principal investigator in a locked bag. Audio recordings will be assigned a case number in order to protect participant confidentiality. Transcripts of interviews will be stored in a password protected document on a password protected computer. Consent forms and participant identification numbers will be maintained in a locked file cabinet. All collected information will be destroyed three years after the study aside from the finalized dissertation document. Should you desire to be notified when the dissertation is available, please inform the researcher.

Compensation:
There is no compensation for participation in this study.

Contact:
I understand that I may contact the investigator or the investigator's faculty advisor at any time at the addresses, telephone numbers, or email addresses listed below if I have any questions, comments or concerns regarding my participation in this study.

Samuel Golden, Psy.M.	Brook Hersey, Psy.D.
Principal Investigator	Faculty Advisor
Rutgers University, GSAPP	Rutgers University, GSAPP
152 Frelinghuysen Rd	152 Frelinghuysen Rd
Piscataway, NJ 08854-8085	Piscataway, NJ 08854-8085

If you have any questions about your rights as a research subject, please contact an IRB Administrator at the Rutgers University, Arts and Sciences IRB:

Institutional Review Board
Rutgers University, the State University of New Jersey
Liberty Plaza / Suite 3200
335 George Street, 3rd Floor
New Brunswick, NJ 08901
Phone: 732-235-2866
Email: human-subjects@ored.rutgers.edu

Rights as a Participant: **Participation in this study is voluntary**. If you decide to participate, you may withdraw from the study at any time without penalty and without

loss of benefits to which you are otherwise entitled. If you withdraw from the study
before data collection is completed your data will be removed from the data set and
destroyed. Also, if you refer other individuals for participation in this study, your name
may be used as the referral source only with your permission
I have read and understood the contents of this consent form. By signing below, I consent
to participate in this research project.

Participant Signature   _____   Date_____
Investigator Signature   _____   Date _____

Appendix D

CONSENT FOR AUDIO RECORDING

You have already agreed to participate in the research study titled "The Effects of Indirect Traumatization on Therapist Relationships: A Qualitative Study," conducted by Samuel Golden, Psy.M. We are asking for your permission to allow us to audio record as part of that research study.

The recording(s) will be used for analysis by the principal investigator.

The recording(s) will be distinguished from one another by an identifying case number, not your name.

The recording (s) will be stored on the recording device in a locked bag and transcribed by the principal investigator.

All audio recordings will be deleted immediately after transcription. All transcripts of interviews will be maintained in a password protected electronic document on a password protected computer. Transcripts will not contain identifiable information or will contain altered identifying information to protect participant anonymity. Transcripts will be identified by case number. All transcripts will be destroyed three years after the study.

Your signature on this form grants the investigator named above permission to record you as described above during participation in the above-referenced study. The investigator will not use the recording(s) for any other reason than that/those stated in the consent form without your written permission.

Participant Name (Print) _____

Participant Signature _____ Date _____

Investigator Signature _____ Date _____

Appendix E

Demographic Questionnaire

Please complete the items below. If you would prefer not to respond to any of the items, please indicate this.

Age: _____

Preferred gender: _____

Race/ Ethnicity:_____

Marital/Relationship status: _____

Graduate degree(s) and therapy license:

_____

Years of experience conducting therapy, post licensure:

_____

Years of trauma-focused therapy experience, post licensure:

_____

Please provide a brief description of trauma-specific courses or intensive training

programs you have completed:

_____

What was the average size of your caseload when you where most affected by indirect

trauma?

_____

Of that caseload, approximately how many clients had disclosed a history of trauma?

_____

Of that caseload, approximately how many clients were you treating primarily for

trauma? _____

What type of practice were you working in at that time (hospital, community mental

health center, private practice, other)?

_____

Were you receiving supervision during your experience of indirect trauma?
_____

Please describe your theoretical orientation as you see fit:
_____

Do you identify as having personally experienced direct traumatization? If so, would you be
willing to briefly describe the type(s) of traumatic experience(s)?

_____

Appendix F

Semi-Structured Interview

A. General Experience of Indirect Trauma:
   a. What was the experience of indirect trauma like for you?
   b. What aspect(s) of indirect trauma were the *most difficult* for you?
   c. What about your work do you believe *most* contributed to these negative consequences?
   d. Did specific types of client trauma impact you more than others? If so, which types? Why do you think that was the case?
   e. Aside from type of trauma experienced, did any client or type of client have a greater impact on you in terms of indirect trauma? Why do you think that was?
   f. Maintaining confidentiality, can you tell me about a particular client/case that stands out for you in terms of the impact of the work. How did working with this client affect your professional work in general? Personal relationships?
   g. What helped you to feel better during this time?

B. Romantic Relationship Status
   a. Can you describe your relationship status during the peak of your indirect trauma experience? Was it different before or after?
   b. What about your living situation? Who do you live with now and who did you live with before and during the worst of the indirect trauma?

C. Effects on Intimate/Romantic Relationships
   I. If in a Romantic Relationship:
      a. Will you describe the effects indirect trauma had on your romantic relationship?
      b. If participant requires prompting:
         i. How, if at all, would you say this experience affected the way you *interacted with* your partner?
         ii. How, if at all, would you say this experience affected the way you *felt about* your partner?
         iii. How, if at all, did this experience affect your sex-life and physical intimacy?
         iv. How did your partner respond to your indirect trauma symptoms?
   II. If *not* in Romantic Relationship:
      a. Were you interested in dating before the indirect trauma? What about during or after? If not, can you think of any reason for this?
      b. If you were dating, will you describe the effects indirect trauma had on your dating life?
      c. If participant requires prompting:

       i. How, if at all, would you say this experience affected the way you *interacted with* your dates or potential dates?

       ii. How, if at all, would you say this experience affected the way you *felt about* your dates or the prospect of dating?

       iii. How, if at all, did this experience affect your sex-life and physical intimacy?

       iv. How did your dating partner(s) respond to your indirect trauma symptoms?

D. Effects on Platonic Personal Relationships:
   a. Can you describe the effects indirect trauma had on your closest non-romantic relationship(s)? (closest friend or family relationship)
   b. If participant requires prompting:
      i. How, if at all, would you say this experience affected the way you *interacted with them?*
      ii. How, if at all, would you say this experience affected the way you *felt about them?*
      iii. How did indirect trauma effect your thoughts and feelings about socializing in general?

E. Effects on Therapy Relationships:
   a. In what ways did your experience of indirect trauma effect your therapy relationships?
   b. If participant requires prompting:
      i. How did this experience change the way you *interacted with* your clients?
      ii. How did it change the way you *felt* about your clients?
      iii. Did you notice changes in how you felt about *yourself as a therapist*?
      iv. What happened to the boundaries you kept with your therapy clients during this time?
      v. Who, if anyone, were you able to speak to about the traumatizing case? What came from those conversations?
      vi. How do you think your organization supported you or added to your stress at this time?
      vii.   Did you discuss this experience in personal therapy? Can you tell me about that experience?

F. Positive Effects/ Vicarious Growth:
   a. In what ways has your experience of indirect trauma positively impacted your life and/or your relationships?
   b. Currently, what would you say are the lasting effects that indirect traumatization has had on the way you relate to others?

G. Concluding Questions:
      a. Is there anything I didn't ask you about your experience of indirect trauma that you would like to share?
      b. How has participating in this interview been for you?