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PREVENTING VICARIOUS TRAUMATIZATION OF MENTAL HEALTH THERAPISTS: IDENTIFYING PROTECTIVE PRACTICES

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This qualitative study identified protective practices that mitigate risks of vicarious traumatization (VT) among mental health therapists. The sample included six peer-nominated master therapists, who responded to the question, "How do you manage to sustain your personal and professional well-being, given the challenges of your work with seriously traumatized clients?" Data analysis was based upon Lieblich, Tuval-Mashiach, and Zilber's (1998) typology of narrative analysis. Findings included nine major themes salient across clinicians' narratives of protective practices: countering isolation (in professional, personal and spiritual realms); developing mindful self-awareness; consciously expanding perspective to embrace complexity; active optimism; holistic self-care; maintaining clear boundaries; exquisite empathy; professional satisfaction; and creating meaning. Findings confirm and extend previous recommendations for ameliorating VT and underscore the ethical responsibility shared by employers, educators, professional bodies, and individual practitioners to address this serious problem. The novel finding that empathic engagement with traumatized clients appeared to be protective challenges previous conceptualizations of VT and points to exciting new directions for research, theory, training, and practice.

Keywords: vicarious trauma, prevention, compassion fatigue, countertransference, empathy

The risks of working directly with traumatized individuals on a regular basis are well documented (Arvay, 2001; Buchanan, Anderson, Uhlemann, & Horwitz, 2006; Figley, 2002; Pearlman & Mac Ian, 1995). McCann and Pearlman (1990) first identified the problem of vicarious traumatization (VT), which they defined as the cumulative transformative effects upon therapists resulting from empathic engagement with traumatized clients. As part of their work, these clinicians must listen to graphically detailed descriptions of horrific events and bear witness to the psychological (and sometimes physical) aftermath of acts of intense cruelty and/or violence. The cumulative experience of this kind of empathic engagement can have deleterious effects upon clinicians, who may experience physical, emotional, and cognitive symptoms similar to those of their traumatized clients (Pearlman & Saakvitne, 1995a, 1995b; Sexton, 1999). However, there is consensus in the field that there is not enough empirical literature on the definitive factors that contribute to VT, nor the practices that may prevent or ameliorate its harmful effects (Arvay, 2001; Figley, 2004; Pearlman, 2004).

Although research and theory have begun to emerge about VT vulnerability and treatment (Figley, 1995, 2002; Saskvitne & Pearlman,

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1996), it is equally important to understand what protects and sustains clinicians in their work with traumatized populations. When individuals trained in the helping professions abandon the field, because of a perceived burden of caring and an insufficient ability to balance work with other aspects of life, this constitutes an enormous loss of resources and potential. When clinicians continue working, despite suffering from the damaging effects of VT, this constitutes a tremendous disservice to both clients and therapist, and the health of our community is undermined. It is imperative to address these concerns on ethical grounds, as clinicians and researchers alike must strive to provide appropriate, effective care for traumatized clients as well as those who work with them.

To date, very little is known about the success and satisfaction of clinicians who are able to manage in the workplace despite the potentially noxious demands of their work with traumatized clients. This study explored individual and organizational practices that contribute to the professional satisfaction and well-being of experienced clinicians who work with traumatized clients and to the sustainability of their efforts in the workplace. The purpose of the investigation was to gain and share knowledge about these protective practices, and ultimately contribute to the prevention of VT.

Review of the Literature

Over the past 15 years, researchers and theorists have given increasing attention to the construct of VT, defined by Pearlman and Saakvitne (1995b) as the negative "transformation in the inner experience of the therapist that comes about as a result of empathic engagement with clients' trauma material" (p. 31). McCann and Pearlman (1990) first identified and conceptualized VT as an interactive, cumulative, and inevitable process, distinct from burnout or countertransference (CT). They posited that all therapists working with survivors of trauma experience pervasive and enduring alterations in cognitive schema that impact the trauma worker's feelings, relationships, and life. Whether these changes are destructive to the therapist and to the therapeutic process, depends, according to these authors, largely on the extent to which clinicians are able to engage in their own process of integration and transformation of clients' horrific traumatic material.

Figley (1995, 1999, 2002) identified a related construct, Secondary Traumatic Stress (STS), which he described in terms of "the cost of caring for others in emotional pain" (Figley, 1995, pp. 9) that has led clinicians to abandon their work with traumatized persons. According to Figley, both direct and indirect exposure to traumatic events can be traumatizing and lead to a similar set of PTSD-like symptoms. He proposed the existence of secondary traumatic stress disorder (STSD), a syndrome of symptoms that parallel those of PTSD, among those who care for victims of trauma. In the case of STSD, the primary exposure to traumatic events by one person becomes the traumatizing event for the second person. Figley considers STS to be a natural, treatable, and preventable consequence of empathic engagement with suffering people. He recognized the importance of warning clinicians in training of the risks associated with caring for the traumatized. He also recognized the potential for clinicians suffering from STS to find a renewed sense of hope, joy, and purpose. Figley also popularized the term Compassion Fatigue, previously employed by Joinson (1992) to describe burnout among nurses. The terms STS and Compassion Fatigue are used interchangeably.

Arvay (2001) provided an overview of research findings on STS, most of which involved the use of surveys and standardized instruments. She suggested that VT and STS are the same phenomenon. The number of traumatized clients in a therapist's caseload appeared to be a factor related to development of STS. Working exclusively with traumatized clients was found to be positively correlated with development of STS symptoms, as were years of experience in the field and level of education. Younger clinicians, and those with less than a master's degree were found to be more vulnerable. The research was inconclusive (or contradictory) with regard to whether therapist personal history of trauma is correlated with the risk of STS. There was a consensus that VT/STS is distinct from burnout.

VT Versus Countertransference and Burnout

Unlike CT, which is typically construed as a short-term response that occurs and is contained within the context of a therapy session, VT involves "long term alteration in therapists own cognitive schemas, or beliefs, expectations, and assumptions about self and others" (McCann &

Pearlman, 1990, p. 132). Moreover, VT stands in clear contradistinction to the classical definition of CT, as described by Hayes (2004), because traumatic events in the client's life account for clinician VT. Whereas the clinician is the locus of origin for classical CT, which is elicited by the client's material but based upon preexisting personal characteristics of the therapist (e.g., unconscious, childhood based, inner conflict). Classical CT is understood to be an intrusion of a clinician's own unresolved material, including previous trauma experiences, retaliatory or aggressive fantasies, and so forth. Hayes differentiated between the classical and subsequent, expanded, definitions of CT. There appears to be some overlap between the construct of VT and an expanded, totalistic definition of CT, in which "all therapist reactions to a client, whether conscious or unconscious, conflict-based or reality-based, in response to transference or some other material, were considered CT" (Hayes, 2004, p. 6). Nonetheless, VT extends beyond the latter, inasmuch as it is cumulative across clients, manifests outside the therapy hour, and permeates the clinician's life and worldview. Gelso and Hayes offered a third, "integrative conception" (Hayes, 2004, p. 7) of CT, in which CT reactions may include conscious responses to phenomena other than transference, provided the source of these reside within the therapist. In contrast to this integrative conceptualization of CT, VT originates in external traumatizing events. Moreover, while unmanaged CT risks injuring the therapeutic process and client treatment outcomes (Hayes, 2004), VT risks damaging the therapist. Consequently, VT extends beyond and differs from even the most encompassing definitions of CT. Walker (2004) underscores this difference, stating:

> [R]esearchers . . . agree that working with traumatized clients has potentially considerable and often long lasting negative effects on therapists (see also Kirk, 1998; Walker, 1992). These are different from countertransference responses in that they have an ongoing and extensive effect that impacts powerfully on many aspects of the therapist's self and world. (pp. 179)

According to Pearlman and Saakvitne (1995a; 1995b), VT increases therapist susceptibility to some CT responses, which may be less recognizable and hence more problematic in therapy. Notwithstanding differences between VT and CT, knowledge about CT management is presumably germane to VT prevention (see below).

McCann and Pearlman (1990) suggested that there is some overlap between conceptualizations of VT and burnout, inasmuch as "symptoms of burnout may be the final common pathway of continual exposure to traumatic material that cannot be assimilated or worked through" (p. 134). In burnout, the nature of the external event is the source of distress (as contrasted with the internal focus of CT). Burnout is related to the work situation (e.g., a high stress work environment with low rewards, in which minimum worker goals are unachievable, or in which worker lacks control over unfair conditions) (Maslach, 1982; Maslach, Schaufeli, & Leiter, 2001) but not to the interpersonal interactions specific to VT (Pearlman & Saakvitne, 1995a, 1995b). Burnout lacks the specificity of therapist exposure to the emotionally disturbing images of suffering and horror characteristic of serious traumas (McCann & Pearlman, 1990).

Managing CT

According to Hayes (2004), research and theory suggest that therapist self-insight, self-integration, conceptual ability, empathy, and anxiety management facilitate management of CT. Hayes, Gelso, Van Wagoner, and Diemer (1991) conducted a survey study designed to provide an initial empirical basis for understanding the management of CT from the perspective of experts in the field. Their findings suggested that CT stems from a therapist's inability to disengage from identification with a client, rather than from empathy itself, which involves a process of partial or trial identification balanced with relative disengagement (standing back and observing). Their findings suggested that therapist self-integration and self-insight, including cohesion of self, self—understanding, and differentiation of self from others, played the most important role in managing CT. Similarly, Van Wagoner, Gelso, Hayes, and Diemer (1991) identified "five qualities theorized to be important in the management of countertransference feelings" (p. 412). Based on survey data completed by 93 experienced counseling professionals, they found that reputedly excellent therapists, when contrasted with therapists in general, were viewed by colleagues as: (a) having greater insight into the nature and basis of their feelings; (b) possessing increased capacity for empathy; (c) better able to differentiate between client needs and their own; (d) less

anxious both in session with clients and in general; and (e) more adept at case conceptualization, all of which were theorized to contribute to better management of CT or overidentification. However, the authors stated "much caution must be exercised in generalizing from perceptions to actual behaviors of excellent therapists" (p. 420).

Coster and Schwebel (1997) researched psychologist well-functioning (which they originally called *unimpairment*), defined as "the enduring quality in one's professional functioning over time and in the face of professional and personal stressors" (p. 10). Content analysis of interviews with six practicing psychologists with 10 years' postdoctoral experience yielded 10 themes as important contributors to well-functioning: Peer support, stable personal relationships, supervision, a balanced life, affiliation with a graduate department or educational institution, personal psychotherapy, continuing education, family of origin as source of personal values, awareness of cost of impairment, and coping mechanisms (such as vacations, relaxation, rest, exercise, spirituality, and time spent with friends). Self-awareness/monitoring for early signs of potential impairment and personal values rated as the top two reasons for psychologists' well-functioning on a questionnaire in a second study. Coster and Schwebel (1997) emphasized the importance of normalizing vulnerability to impairment: Accepting signs of impending impairment (as normal) is crucial to prevention of more serious problems. The authors advocated a strong role for professional organizations in the promotion of professional well-being and called for further investigation to correct an existing imbalance in professional education, wherein prevention of impairment does not receive ample emphasis.

Ladany, Friedlander, and Nelson (2005) addressed the important role supervision plays in CT management. Similarly, Walker (2004) asserted that supervision acts as an important protective factor for both CT and VT by "ensuring early recognition and response, and thereby acting as a protection against burn out and consequent damage to the therapist and to their client" (p. 179). Bernard and Goodyear (2004) propose that supervision serves a restorative purpose, beyond its formative and normative functions; they cite Hawkins and Shohet (1989), who state it is the responsibility of the supervisor "to provide supervisees the opportunity to express and meet needs that will help them avoid burnout (p. 12)." Moreover, the supervisory relationship is widely considered to be a crucial element of productive supervision (Bernard & Goodyear, 2004; Bradley & Ladany, 2001; Holloway, 1995; Nelson, Gray, Friedlander, Ladany, & Walker, 2001).

Transforming VT

McCann and Pearlman (1990) drew upon their own work experience to posit strategies for the transformation of VT. According to these authors, clinicians must acknowledge, express and work through painful experiences in a supportive environment—otherwise, therapist numbness and emotional distance risk interfering with ongoing empathic engagement with clients. They suggested that weekly case conferences and other groups for clinicians who work with traumatized clients can counter professional isolation and provide emotional support by helping to normalize and elucidate therapist reactions to client trauma. Furthermore, they recommended that clinicians receive regular supervision, balance caseloads with victim and nonvictim clients, balance clinical work with other professional responsibilities, such as teaching and research, and maintain balance between personal and professional life. They identified other coping strategies, including: advocacy, enjoyment, realistic expectations of self in the work, a realistic worldview (that includes the darker sides of humanity), acknowledging and affirming the ways in which trauma work had enriched lives (of others and their own), maintaining a sense of hope and optimism, and a belief in the ability of humans to endure and transform pain. Similar recommendations for ameliorating VT have been proffered by Saakvitne and Pearlman (1996), Pearlman and Saakvitne (1995a, 1995b), and Yassen (1995).

Method

A purposeful sampling procedure was used to recruit peer and organizationally nominated therapists who met the following inclusion criteria: (a) trained at the masters or doctoral level; (b), minimum of 10 years' professional experience with traumatized clients; and (c) self-identified as having managed well in this work. Potential participants were recruited through flyers distributed through professional networks and asked to complete the *Professional Quality of Life: Compassion Fatigue and Satisfaction Subscales, R-III*

(Pro-QOL) (Stamm, 2003), a short quantitative measure used for screening purposes only. Those who scored below average on the Burn Out and Compassion Fatigue subscales of the Pro-QOL (i.e., self-reports suggested they suffered less burnout and VT than the average practitioner) were invited to participate in the study. Clinicians who participated in the study had between 10 and 30 years of experience working primarily with traumatized clients in organizational (e.g., hospital, community mental health, residential program for alcohol and drug abuse) and/or independent practice settings. Their clientele included survivors of sexual and/or physical abuse perpetrated during childhood and/or adulthood; pediatric and adult palliative care patients and their families; survivors of torture and natural disasters; refugees from countries at war; firefighters; bank tellers involved in robberies; and people with a history of abuse dealing with poverty, racism, substance abuse, and suicidal ideation. Participants ranged in age from 49 to 59 years old and included female and male therapists of diverse sexual orientations (heterosexual, lesbian, and gay) who came from a range of religious backgrounds, including Judaism, Catholicism, Christianity, and Native American spirituality. The sample size ($n = 6$) allowed for in-depth exploration of the research questions.

Harrison collected narrative data through interviews, which took place in three phases. In an initial, structured interview, each clinician provided information about their age, work setting, caseload, years of experience, and social supports. The second phase involved open-ended, individual interviews (lasting approximately 2 hr) in which clinicians were asked, "How do you manage to sustain your personal and professional well-being, given the challenges of your work with seriously traumatized clients?" and "How could protective practices best be engaged in order to mitigate the risks of VT and sustain the efforts of others who work with traumatized clients?" With one exception, interviews were conducted in the clinician's workplace. Research conversations were recorded on audiotape, transcribed, and submitted to a multistage process of analysis. Transcriva software was used to store and partially analyze the data.

Data analysis was based upon Lieblich, Tuval-Mashiach, and Zilber's (1998) typology of narrative analysis, with a primary focus on thematic content analysis within and across participants' narratives. Through multiple readings of each individual transcript, Harrison selected passages relevant to the research questions and coded these according to emergent and convergent themes, through a process of constant comparison. He concomitantly drew concept maps and wrote reflexive memos in a research journal. To confirm the validity of identified themes, we submitted the coded interview transcripts to a peer-review process.

To further ascertain descriptive and interpretive validity (Maxwell, 1992), Harrison subsequently wrote and sent a detailed letter to each clinician, organized by the coded themes that had emerged in their respective research interview. This allowed us to share and receive feedback on our data analyses, and to verify that any interpretation on our part, which we regard as inevitable and inherent to the process of descriptive qualitative research (Alverson & Skoldberg, 2000; Sandelowski, 2000) was held to a minimum and did not stray from clinicians descriptions of their lived experiences. Harrison then arranged a third interview as a follow-up/member check, to incorporate any requested revisions. After incorporating minimal clarifications and corrections offered by the research participants we conducted a categorical content analysis across clinician narratives. Through multiple readings of the six letters, we subsumed the various codes into nine major convergent themes, presented below. As a further validity check, the authors subsequently sent this manuscript to all six research participants who read it and endorsed the accuracy of the cross-narrative themes identified below. Please refer to Appendix for illustrative examples of our multistage process of data analysis.

Results

The research findings describe how these exemplary clinicians engage in protective practices that mitigate the risks of VT. We have articulated these in terms of nine major themes: countering isolation (in professional, personal and spiritual realms); developing mindful self-awareness; consciously expanding perspective to embrace complexity; active optimism; holistic self-care; maintaining clear boundaries and honoring limits; exquisite empathy; professional satisfaction; and creating meaning. These themes are integrally interrelated and constellate in myriad ways. Indeed, we have come to view the researched phe-

nomenon as a fractal, whose intricacy is such that the overall pattern occurs in each part. Below, we describe the nine salient themes that emerged within and across clinicians' narratives of practices that protect and sustain them in their work with traumatized clients, thereby mitigating the risks of VT.

Countering Isolation in Professional, Personal and Spiritual Domains of Life

The first major theme has multiple subsets: Research participants counter isolation by drawing upon continuity in relationships in professional, personal, and spiritual realms, all of which risk being adversely affected by their work. Doing so helps them restore balance.

Supervision as relational healing. All clinicians spoke of the important role supervision plays in mitigating risks of VT. Regardless whether it takes place within an informal peer group, an organizational setting, or as paid consultation, they described how supervision helps decrease their isolation, and some said supervision helps diminish feelings of shame about VT symptoms. Most attend at least one peer supervision group. This practice enhances their self-awareness and ability to "self-monitor," and reinforces their commitment to implement self-care practices, as needed. Moreover, peer supervision groups provide a forum in which these clinicians benefit from learning about each other's strategies to address VT symptoms. This form of support within the professional realm also helps therapists maintain healthy relationships and balance in their personal lives by helping them recognize when "overloaded with my work or carrying too much." In turn their personal relationships further sustain them in their professional efforts.

Training, professional development, and organizational support. Clinicians also underscored the importance of good training, ongoing professional development, mentorship, and organizational support. These practices anchor them within a professional community, which decreases isolation, anxiety, and despair that can arise when clinicians feel solely responsible for redress of daunting and highly distressing problems. All participants asserted that organizations that employ therapists have a responsibility to value and foster clinician self-awareness by dedicating time and space for self-reflection at work and creating forums in which therapists can discuss VT in an open and nonjudgmental environment. Similarly, they recommend employers remain aware of how the work is affecting clinicians and institute policy to hold caseloads to reasonable levels. Additionally, some said nonauthoritative, inclusive administrative styles that convey appreciation for clinicians' expertise can enhance a sense of belonging, and professional satisfaction. One clinician spoke of the need for early, explicit training in self-awareness and self-care strategies.

> I really want people to get training (in self-care) before they go out and start working. I really want them to learn how to take care of themselves first, instead of having to learn on the job! Because sometimes the damage is already done and people have to leave early in their career because nobody taught them how to take care of themselves! I'd really like for that to be promoted as a part of professional practice. Just as you have to be really good at your communication with your clients, you have to be really good at self-care or all is lost. And people are too important to lose. People shouldn't go to work and be hurt to the point that they have to go on disability. So I think that, just like we do communication classes, we should do self-awareness classes.

Diversity of professional roles. All participants were involved in a variety of professional responsibilities (i.e., some combination of direct practice, teaching, supervising, and/or administration). Several explicitly stated that they found this to be protective and sustaining of their professional efforts, because this diversity expanded their professional role and put them into contact with a larger community, thus allowing them to feel a sense of interconnection and renewed hope.

Personal community. All participants value the role played by their personal community of family and/or friends in helping them to maintain balance and separate work from the rest of their life. Most described belonging to a rich network of mutually caring relationships, upon which they can rely when in personal need. Some contrasted the reciprocity in these nonprofessional relationships to the asymmetry of their professional role and explained that the former helps them to maintain clear, consistent boundaries with clients from whom they expect nothing in return (and whom they actively discourage from taking on a caregiving role in the therapy relationship). Because these clinicians are nourished and sustained by relationships in the personal realm, they find their professional caregiving role less depleting. Some have developed strategies to connect physically with loved ones and seek solace when distraught, in a way that neither betrays client confidentiality

nor burdens relational partners with potentially harmful details. This kind of physical contact with trusted close others acknowledges and helps clinicians contain the challenging knowledge and experiences that they acquire as a consequence of their work. In addition, they look to their relationships outside the professional domain for opportunities to experience levity and joy, to counterbalance or expand the restricted and "skewed perspective" on life that they otherwise risk developing based upon the frequent and repeated stories of suffering and cruelty to which they are exposed at work. Moreover, the participants rely on personal community to help them gain awareness at those times when professional concerns are intruding upon personal life.

Spiritual connection. Participants further described experiencing a sense of connection to a spiritual realm or a sense of larger meaning that transcends individual boundaries and reason. This sense of interconnectedness with the mysterious transcendent (e.g., "this other realm . . . the *mystery* stuff"), which is tacitly known and cannot be clearly articulated through words or otherwise apprehended, is sustaining of therapists' professional efforts and personal well-being because it helps counter isolation and despair. These clinicians are comforted by the belief that they are part of something larger, meaningful and good, that they are not alone in their efforts, and that these are not futile. This felt sense of spiritual interconnection reinforces their positive disposition and renews their conviction that: (a) people are resilient and can heal; (b) growth can occur in the wake of trauma; (c) life is about more than suffering; (d) their professional efforts are meaningful; and (e) they are not solely responsible in their efforts to heal trauma. In these ways, spiritual connection inspires these clinicians and helps them to keep going despite the difficult challenges of their work. Most described time spent in nature as an important aspect of this sense of spiritual connection. Below a research participant described how her personal, highly cognitive version of interconnection with humanity, nature, and the "web of life" helps her persevere:

> When I go walking by the ocean, which I do very frequently, I always think about and pay attention to how the ocean persists, and that's how humanity persists, people persist, you know, that kind of idea. Persevering and persisting and maintaining, right? It is important for all of us who do this work, I think, to have a sense of being connected, to being part of the web of life somehow, however we define that in whatever kind of way that is. Because trauma is so isolating, and we get isolated. So however you create meaning helps to break that down. I think you have to do it in the "*big* web of life", I will call it—some people call it "spiritual", and I think you have to do it in terms of being with some other folks who are not helpers. So from the big to the small. It just reminds me that I am part of this web of life, I am one of the threads and my job is to do my part good enough.

Developing Mindful Awareness: Integrated Practice of Spirituality

The practice of mindfulness (present focused attending to minute, ongoing shifts in mind, body, and the surrounding world), integrated into daily life from initial waking to final moments before sleep, helps most of these therapists to develop enhanced patience, presence and compassion. Mindulness, as described by participants, involves curiosity and holistic awareness of one's experience in relation to both external and internal environment. Breathing consciously and redirecting attention to their embodied experience of the here-and-now helps these therapists to stay calmly focused and grounded, which allows them to be less reactive and engage with greater equanimity. This contributes to increased ability to embrace complexity and tolerate ambiguity, as well as enhanced capacity to hold multiple perspectives, engage in both/and thinking, and remain hopeful in the face of suffering.

Mindfulness enhanced clinicians' ability to engage in many of the other protective practices identified below. Profound awareness and acceptance of "what is" helps them accept limits (including those of personal vulnerability, range of personal influence, responsibility for change, and limits of the known and knowable) and maintain clarity about self in relation to others, both in terms of interconnections and boundaries. Mindful awareness also helps participants recognize if and when their interpersonal boundaries are at risk of becoming overly permeable, as well as other times when they need to take action to restore balance in their lives (e.g., employ imagery or ritual, engage in self-care practices, seek consultation, and reach out to personal community). In addition, moment-by-moment embodied awareness of self and surroundings helps therapists develop the kind of interpersonal presence and clarity crucial to the practice of exquisite empathy (described below). Moreover, we propose that because it is impossible to be truly present in two places at once, the practice of mindful self-awareness helps these clinicians

keep personal and professional realms separate. Their ability to fully engage in the present moment, while in the personal realm, protects them against intrusions from the professional realm.

Most clinicians related mindful awareness to their practice of integrated spirituality and sense of purpose. Through mindfulness practice they seek to make "connections between mind, body, and spirit," to maximize and enrich every moment and interaction with heightened attention and loving acceptance. They described how this in turn facilitates professional satisfaction and related sense of making a meaningful contribution to life through work. While some currently or previously engaged in a structured meditation practice to develop mindfulness, others had never done so.

Consciously Expanding Perspective To Embrace Complexity

Participants consciously challenge negative cognitions to expand their perspective when caught up in despair. They purposefully remind themselves of other ways of viewing life by cuing themselves through self-talk, use of imagery or metaphor, time in nature, or interactions with people in other lines of work, to encompass wider horizons of possibility and counterbalance their skewed perspective on the world. Because these clinicians are able to embrace cognitive complexity, tolerate ambiguity, and simultaneously hold multiple perspectives (including those of client and self), they can accept the inevitability of pain and suffering as well as life's potential for beauty, joy and growth. Therefore, even the cumulative knowledge of clients' horrific experiences of trauma does not eclipse their positive worldview or sense of hope and purpose (more below). Moreover, they are able to see a "gift" side of loss, which is to say that devastating experiences can also be generative, and that these are not mutually exclusive. They recognize that positive growth does not diminish or efface agonizing pain; rather, pain and positive transformation coexist. This awareness is sustaining of clinicians because it allows for the possibility that clients, too, can achieve an expanded perspective that embraces life's pain and beauty in the wake of devastating trauma. The research participants have been inspired by their experiences of witnessing and accompanying clients who have done so. They described their lives as having been "enriched," deepened, and "empowered" by their vicarious experiences of client posttraumatic growth (Calhoun & Tedeschi, 1998, 1999; Tedeschi & Calhoun, 1995), as well as personal experiences of trauma and subsequent growth.

Furthermore, conscious shifts in perspective help these clinicians counter isolation and tolerate ambiguity. They remind themselves that they are not in it alone, that others are doing similar work to redress abuse, and that change is incremental and happens slowly over time. A clinician who worked in a residential treatment program described how such shifts in cognitive perspective are protective:

> You have to keep reminding yourself that behind the clouds there is sun. I'm standing in a dark place too, but I know beyond it there is something more. And the thing is it depends on your perspective. I mean, there is beauty even in the SUFFERING of these youth as they come in there. Their resiliency. If you have any idea of the human suffering, the human misery that some people have experienced, and yet there they are. Like, what a heroic story. It's a great tale of heroism. It's remarkable. You can either see the darkness of it or a very heroic story. It's both.

Ultimately, this expanded perspective encompasses openness to the unknown, and a belief or tacit sense that meaning and purpose transcend the limits of individual identity, language, and quantifiable knowledge. Participants accept their inability to articulate or apprehend this mysterious, transcendent unknown. They do not feel a need to name or otherwise define it (although several associate it with light). Many equated this elusive realm with their sense of spirituality, which they primarily practice outside the context of organized religion (most of the clinicians were raised in a religious tradition, which they subsequently left or moved beyond). Remaining open to the idea that some aspect of life transcends personal boundaries and interconnects all people makes trauma work less distressing for these clinicians, because it counters isolation on a larger scale (as described above), and helps them to feel that life is meaningful, even when difficult. Many equated their calling to trauma work with some ineffable or elusive purpose. Moreover, some took solace in mystery, itself, and found it comforting to accept that some things are beyond the ken of human understanding.

Active Optimism

The belief that people can heal is central to a positive disposition, which envelops and under-

lies the phenomenon of clinicians who manage well in their work with clients who have experienced serious traumatic events. Research participants shared an overarching positive orientation, conveyed in terms of an ability to maintain faith and trust in: (a) self as good enough; (b) the therapeutic change process; and (c) the world as a place of beauty and potential (despite and in addition to pain and suffering). These three attributes parallel the core assumptions that Janoff-Bulman (1992) identified as being shattered by experiences of trauma. The clinicians in our study viewed the world as ultimately benevolent, the therapeutic enterprise as meaningful, and self as good and capable in their professional endeavors. There is a circular quality to this positive orientation, inasmuch as the ability to sustain hope and maintain faith that things get better informs many of the protective practices these exemplary clinicians engage in, which in turn serve to renew their enduring hope and trust. Several explicitly equated optimism with awareness. One clinician drew upon a Buddhist parable to describe this:

> I don't see the people I work with as TRAUMA!! (booming voice) You know, I see them as people (softer) who in some way are very stuck in some holes and they believe that it is dark and fearful and they cannot get out of the hole. And for me, you know, life has holes. Big holes, little holes, but there is no life with no holes. And if I can almost like tell people, have a peek in the road, you know, get off the hole. But the awareness is not just where you ARE if you are in a hole. The awareness is there are holes and I accept it. And I also feel very . . . faithful [trusting] that I can get out of the hole. That life is not a hole. And that's how I protect myself. I accept my holes and I don't feel I get dragged in people's holes. I feel very sad, very sorry, but I feel very . . . empowered, I feel very honored that I am asked to assist people. And that for me is something that I grab like you know, a real light switch.

These clinicians put their optimism into action, through proactive problem solving. They approach problems as solvable. When the scope of a problem is too large, they look at what small part they can address, which may take the form of advocacy or self-talk to let go of anger and dwell in acceptance. This active approach to problem solving also informs how they respond to the unique challenges of their work with traumatized clients. For instance, they use their heightened self-awareness to recognize how work is affecting them, then determine what to do about this. Most have consciously developed a plan or personalized set of strategies to counter VT and recommend that other therapists do so, as well. Their practice of active optimism involves creating time and space for self-care practices to restore balance in their lives. They have purposefully developed strategies to separate work and personal life, as well as effective communication skills to deal with problems in either of these realms. Sometimes active problem solving involves using imagery or ritual to maintain clarity around boundaries or provide closure (more below). In addition, participants consciously seek out opportunities for laughter or to take in beauty, and some have deliberately joined book clubs populated by members in different lines of work, to be reminded of other perspectives on life. Moreover, most participants create and enact optimism by purposefully planning pleasurable activities, including travel or time in nature. One clinician described this as follows:

> One of my strategies is to always have something to look forward to. I always plan for something good to come next. And that's been a comfort. I mean, as *soon* as I finish one thing, there is the seed for something more. I never go without, even if the seed is a teeny tiny little kernel, even if I don't have the money even if I don't have the time yet, the seed is started and so it's a beginning place.

Holistic Self-Care

These clinicians take a holistic approach to self-care, which they consider crucial to their ability to maintain personal and professional well-being. They attend to physical (e.g., healthy diet, ample sleep, regular exercise, holding and being held), mental (e.g., training, continuing education, mindful awareness), emotional (e.g., personal therapy, trusting relationships, laughter and joy, emotional expression, release or redirection of anger), spiritual (e.g., meditation, time spent in nature, creating meaning and purpose), and aesthetic (purposefully "bringing beauty in") aspects of self-care. Some think of self-care in terms of practicing what they teach, or "walking my talk." They practice self-care within both the personal and professional realm, and their ability to separate these two realms of life is itself a form of self-care. Self-care provides balance, and at times "closure." Moreover, it is renewing and consequently allows them to be more present when engaging in both personal and professional relationships. They recommend all clinicians who work with trauma engage in self-care practices, including some form of personal therapy. Many have found group-based therapy to be particularly helpful. Moreover, these clinicians recognize that there is an ethical component to self-

care. If they do not take care of themselves, they are at risk of harming others. Consequently, they strongly believe that taking care of caregivers needs to become a higher priority in health care and related fields. They think that there is a need to incorporate self-awareness and self-care into professional training, at an early stage. Below, a clinician talked about the importance of daily self-care in her life:

> I get up every morning at five o'clock, and I have a friend, and we walk for about an hour and 10 minutes, Monday to Friday. We don't miss, doesn't matter if it's raining. Sometimes we walk in silence, sometimes we talk, but if I miss that, my day is totally different. That gets me grounded, that gets me connected. I see the seasons change, I am aware of things, I have a friend that I really love and care about with me every morning, and it's something I just—it's REALLY IMPORTANT TO ME. So walking becomes really, it is a walking meditation {laughs} to some extent.

Maintaining Clear Boundaries and Honoring Limits

These clinicians maintain clear and consistent boundaries in multiple realms of interaction. They accept, honor and maximize limits, including those of their professional role in relationship to clients. All participants acknowledge their own limits, including personal vulnerability to VT, and they believe that it is imperative for others in this work to do so, as well. In addition, they maintain clarity about the limits of their sphere of influence. They avoid dual relationships, and recognize that as therapists, they are not responsible for making change in clients' lives.

Furthermore, participants hold realistic expectations of self, other, and the world, and do not confuse the ideal with the actual or the likely. They recognize that change unfolds slowly, in small increments, and that larger scale change is a community rather than an individual responsibility. However, some do engage in advocacy. One said, "I do advocacy work, but only when I feel passionate about it. I'm really also very able to say 'NO. I give at the office,' so to speak." She recognizes that taking on too much volunteer work can interfere with the balance in life that she requires to sustain her professional efforts as a clinician. Moreover, these exemplary clinicians have developed a range of strategies to help maintain boundaries (both psychological and physical) between work and personal life. These include use of supervision, peer consultation, personal therapy, physical self-care and/or mindful attending to unresolved material in order to "process" it and to achieve closure; personal rituals before and after work; meditation practice; taking time off work to travel; and consciously setting temporal and spatial limits between professional and personal realms (e.g., keeping work-related books at the office, limiting time spent debriefing with partners, not working on one's birthday), among others.

Perhaps most importantly, they maintain clear boundaries with regard to the distinction between empathy and sympathy. While remaining highly attuned to clients, they do not engage in emotional fusion or otherwise confuse clients' feelings or experiences with their own. Instead, they maintain firm interpersonal boundaries that are sufficiently permeable to allow them to experience intimate connection within the context of a present-oriented professional relationship "with the person here and now", without losing personal perspective. Moreover, participants are attentive to those times when clients' stories resonate more powerfully with the therapist's personal history, in which case they may seek supervision or personal therapy to help maintain clarity and manage what gets stirred up for them. In these ways, exemplary clinicians differentiate between their own worldview and those of traumatized clients with whom they empathize. This clarity around boundaries is helpful to clients and protective of therapists. One clinician explained that although he feels "connected" and is often deeply touched by clients' stories of prior traumatic events, he remains clear that:

> It's still their story. It's not my story. [It] doesn't get painted on my wall, you know. It passes through. I don't lose myself in it. I don't have to. I can care [but] I'm not in [the trauma story]. I didn't have that thing happen to me. Certain stories you, know are ones that are harder for me for whatever reason, and of course, I'm in peer support groups, I have places to go to talk about stuff with people, I swim, I hike a lot, I live with someone, and I have those places to be with people, unload distress in an appropriate way [when] certain themes become cloudier for me around [whether] it's their story or is it my story.

Moreover, these exemplary clinicians employ visualizations, metaphor, and personal ritual as a self-management strategy to simultaneously stay fully present in sessions and maintain consistent boundaries when client material risks encroaching upon their personal life or perspective. This allows them to remain empathically engaged, highly "present and connected," yet protected and distinct in their role as attuned, caring witness to

client stories of traumatic experience. Below, a clinician described one such strategy:

> I try to think of myself as a screen door, where the wind blows through and doesn't attach to the screen. It's an image that I find particularly helpful. I see their story as the wind and I'm the screen. They will have stories that could, if forceful like a gale wind, be dangerous and something to be contended with, but if my door is solid and my screen allows for air to move through it, then even a gale force wind can pass through my screen door.

Exquisite Empathy

Most of the clinicians described how intimate empathic engagement with clients sustains them in their work. This finding surprised us, because we went into the research thinking that empathic engagement was a risk factor rather than a protective practice. However, when clinicians maintain clarity about interpersonal boundaries, when they are able to get very close without fusing or confusing the client's story, experiences, and perspective with their own, this exquisite kind of empathic attunement is nourishing for therapist and client alike, in part because the therapists recognize it is beneficial to the clients. Thus the ability to establish a deep, intimate, therapeutic alliance based upon presence, heartfelt concern, and love is an important aspect of well-being and professional satisfaction for many of these clinicians. One research participant elaborated on this:

> I actually can find sustenance and nourishment in the work itself, by being as present and connected with the client as possible. I move in as opposed to move away, and I feel that is a way that I protect myself against secondary traumatization. The connection is the part that helps and that is an antidote to the horror of what I might be hearing. It's about working with the heart from a place of warmth and care and even love.

Professional Satisfaction

All participants take satisfaction in being effective in their work, making a meaningful contribution through their professional efforts, and being highly skilled at what they do. In these ways, they find the work deeply rewarding. They are honored by their professional role, which has "expanded and enriched" their life in nonmonetary (as well as fiscal) ways. They consider it to be an extraordinary privilege to assist people who have experienced trauma, and this sustains them in their professional efforts. Clinicians suggested that organizational cultures and managerial styles that value therapist expertise and afford practitioners greater professional autonomy further contribute to professional satisfaction. One said:

> I mean I have been very, very privileged. I have experienced things . . . the depth of things or the beauty of things or the wisdom of things in this healing process that other people have never ever had. Most people, I think, don't ever get a sense to touch that kind of depth or that kind of stuff, so I wouldn't quit my job.

Creating Meaning

Finally, these therapists recognize the importance of their ability to create or perceive meaning, regardless whether through belief in an ultimate universal goodness, an elusive transcendent greater purpose, their commitment to family, work, and/or community building, or a sense of interconnection with the efforts of others in continuity over time. This last finding relates back to the notion of countering isolation in the spiritual domain of life. Furthermore, it parallels the work of Briere and Jordan (2004) and van der Kolk and McFarlane (1996), who found that the process of making meaning beyond concrete events helps to contextualize and reduce the threat of trauma. Below, a clinician explained how creating meaning sustains her professional efforts:

> Even though I've known people who have gone through difficult things, [and I] have had difficult experiences in my own life, I have a belief that there is some meaning or purpose in that, even if I'm not aware of it. That makes it more tolerable. That makes it more endurable.. When I just accept that the universe wanted me to have these experiences, and that they were meant to be helpful, supportive, then it all makes sense. And so then that is the ultimate goodness coming through. The ultimate goodness, which is, you know, we are meant to be here. We are meant to have experiences that challenge us and cause us pain, but ultimately it is about the goodness. Because then, it feels like, people [clients] will not be left only with pain and suffering, that they too will have the opportunity to process and work through this to a point where they make those connections to the goodness. They can look back and say, "That was really terrible and awful, and . . . That's not all that's there."

Discussion

This study yielded the novel finding that empathic engagement can be a protective practice for clinicians who work with traumatized clients. This finding challenges prior assumptions about the causality and inevitability of VT. Clinicians who engaged in what we have called "exquisite empathy" (a discerning, highly present, sensitively attuned, well-boundaried, heartfelt form of empathic engagement) described having been invigorated rather than depleted by their intimate professional connections with traumatized clients. Previously, therapist empathy for trauma-

tized clients had consistently been depicted as a key risk factor for VT. Consequently, the current study challenges prior conceptualizations of VT and points to exciting new directions for research and theory, as well as applications to practice.

Notwithstanding the differences between the constructs of CT and VT, prior research and theory on CT management may help explain our novel finding that a discerning form of empathic engagement characterized by "exquisite listening," loving attunement, and therapist ability to differentiate self from clients, appeared to be protective for some clinicians in their work with traumatized clients. Hayes and colleagues (Hayes et al., 1991; Van Waggoner et al., 1991) previously offered initial evidence in support of a similar hypothesis: that enhanced capacity for empathy plays a principal role in clinicians' ability to manage CT. These authors suggested that CT stems from a therapist's inability to disengage from identification with a client, rather than from empathy itself, which involves a process of partial or trial identification balanced with relative disengagement (standing back and observing). Their findings also suggested that self-integration and self-insight, including cohesion of self, self—understanding, and differentiation of self from others, played the most important role in managing CT (Hayes et al., 1991).

Similarly, our current findings suggest that effective, protective empathic engagement with traumatized clients involves neither overidentification with nor avoidance of clients' traumatic material. Rather, exquisite empathy requires a sophisticated balance on the part of the clinician as s/he simultaneously maintains clear and consistent boundaries, expanded perspective, and highly present, intimate, and heartfelt interpersonal connection in the therapeutic relationship with clients, without fusing, or losing sight of the clinician's own perspective. Moreover, we believe that, for some clinicians, efforts to avoid or resist the intensity of clients' trauma stories may be counterproductive. Instead, our findings suggest that some clinicians may benefit from accepting their relationship to clients' traumatic material and integrating this aspect of their professional life into their identity. This is in keeping with the literature on PTSD treatment, which guides therapists to help traumatized clients integrate traumatic experiences into their identity and self story, rather than splitting these off (Herman, 1992).

Implications for Practice

If VT is indeed a form of trauma, in which clients' accounts of traumatic experiences become the traumatic stressor for clinicians, it follows that clinicians may benefit from embracing their professional relationship to clients' traumatic material rather than attempting to distance themselves from this aspect of their work. Exquisite empathy may be a way of accomplishing this, because it affords clinicians opportunity to ethically benefit from "healing connections" (Mount, Boston, & Cohen, 2007, p. 372) with clients, without ever sacrificing clients' needs to their own. In this sense, exquisite empathy may constitute a form of mutual, reciprocal, healing connection, in which clients and clinicians alike benefit from the latter's caring, well-boundaried, ethical attunement to the client.

Additional findings herein appear to be verifying of previous recommendations for ameliorating VT and underscore the ethical responsibility shared by employers, educators, professional bodies, and individual clinicians to create time and space to address this serious problem (e.g., through: regular supervision, within the context of a supportive supervisory relationship; peer and social support networks; life-work balance; self-care, including personal therapy, as needed; and self-reflection within and beyond the workplace). Moreover, many of our results reinforce Coster and Schwebel's (1997) recommendations for psychologist well-functioning. However our findings about exquisite empathy and mindful self-awareness are notable additions to this prior research.

Results related to the important role that supervision and therapist self-care appear to play in mitigating the risks of VT could help inform the decision making processes of community agencies with regard to how to best support clinical staff, and also be highly beneficial to individuals in independent practice. Based upon these qualitative research findings, we recommend that greater time and attention be dedicated to therapist self-reflection and self-care as crucial components of ethical practice. Moreover, all clinicians who work with traumatized clients are advised to access ongoing, regular supervision and be part of either formal clinical teams or informal peer networks, to minimize risk of harm to self or clients. We consider it a shared responsibility

on the part of employing organizations, professional bodies, and independent practitioners to ensure that clinicians have access to and take advantage of these supportive resources. Furthermore, we recommend that clinicians acknowledge the importance of both their professional and nonprofessional relationships, and actively nurture these. Our results suggest it is important to the well-being of therapists, clients, and our communities that no clinician should work with trauma in isolation.

The current research may also raise questions about the value of organizational policy and structure in some community agencies, where programs for traumatized clients (e.g., sexual abuse) are staffed separately from other therapy services. This practice typically does not promote balance within caseloads or among professional tasks. All of the peer-nominated exemplary clinicians who participated in the current study had some diversity in their professional responsibilities as well in the type of traumatized clients that they treated. Furthermore, most of their caseloads offered some balance between trauma and nontrauma clients. It is not clear why therapists who worked exclusively providing direct service to clients traumatized by a similar type of traumatic stressor did not present for inclusion in the study, but one possible hypothesis may be that they are not managing as well as those who have greater balance in professional responsibility or diversity of clientele.

Implications for Training

In addition, the results from this study suggest it may be helpful to future clinicians and clients alike to incorporate mindfulness training in therapist education, along with curriculum that invites (and teaches) trainees how to expand perspective to embrace complexity, tolerate ambiguity, recognize their own limits, and differentiate between empathic engagement and sympathetic overidentification with clients. Finally, there is an ethical obligation to warn trainees about the risks of the working with traumatized clients, as well as to teach them about protective practices. In this way, training could also serve a self-screening function that might prevent future VT and professional attrition. Well-informed trainees who are uncomfortable with ambiguity and/or who experience a significant degree of interpersonal isolation could elect not to pursue this kind of work, or alternatively, actively seek to develop more expansive cognitive and social practices.

Limitations and Implications for Future Research

Although the qualitative research design and small sample size precludes generalizing from the data, the current findings may be helpful to others in the fields of psychology, psychiatry, social work, psychiatric nursing, and related health care disciplines, at the levels of education, training, and practice. It is, however, important to underscore the potential for individual differences among clinicians who work with traumatized clients. Consequently, we offer our results and recommendations tentatively, in the absence of further data from future studies with larger sample sizes. Moreover, the validity of our findings could be strengthened through future research comparing clinicians who are managing well in their work with traumatized clients with those who are faring less well. This kind of additional research is warranted to further explore the current findings and assess their representativeness, particularly the novel finding that empathic engagement appeared to be a protective practice for some clinicians.

Summary

Although previous research has been conducted on VT, there is a great paucity of research investigating protective practices that mitigate the risks for clinicians who work with seriously traumatized clients. Consequently, this study makes an important contribution to the existing literature and begins to fill a gap that deserves continued attention. Moreover, this study augments the existing literature, much of which has been based upon quantitative research, by offering thick, rich description of the lived experiences of exemplary clinicians who are managing well despite the risks of this work. While the current findings confirm and extend prior research, they also depart from previous literature in interesting ways. Most notably, the finding that exquisite empathy seems to be a protective practice for some clinicians challenges previous ways

of conceptualizing VT and points to exciting new applications to practice and avenues for further study.

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Appendix

Illustrative Examples of Data Analysis Process

The following excerpts are offered to illustrate our iterative data analysis process. We have entered corresponding codes to replicate the process of recording emergent codes.

Transcript Excerpt

Joy

One of the things that I do is I have supervision (1), and that is really helpful to me, and we have a vicarious [trauma] group (2) that I go to once a month, and it's from people in the service and we have a little bit of a core group. There is about seven or eight of us (3) from different teams who come together, and it is a place where for an hour and a half, at least, what we do is that we talk about, uhm, it started off us trying to really connect (4) with each other and not just tell horror stories (5,6), which were re-traumatizing? {giggle} to starting to trust each other (7) where we talk about ourselves (6) and some of the things that we notice might be going on for us, and different things that we are doing to help with some of those symptoms (8) that might be coming up. It's almost kind of like going on Weight Watchers, too. You have other people that you can talk to (9) so that it keeps it in your mind (6) that that's something that is telling you that you need to do some shifting here around some things (10,11,12).

RH

I just want to stay with that for a second. Does that also mean that having other people helps you remember it is important to YOU?. is it also being sort of being almost accountable to more than just yourself?

Joy

Yes it is. but on a very personal level again (13), right? And that is why I say it's almost like weight watchers, because when you tell somebody and you open up and it is no longer a secret (9,14) and you are no longer ashamed (15) about the fact that, you know, you are more irritable and you are snapping at somebody (5,6), and you know that and you actually put that out as a reality (9,16), then other people know that and then they are interested (17), they care, and they inquire about that (18) {laughs}.

RH

So you are building relationships (exactly), and I assume – you are making a gesture with your hands {hands offering forth from chest] – by "put that out there," you mean put the words out there?

Joy

Yes. So that helps you do. It helps you keep on track about those things and keep more mindful (19,20,21). The other thing I do that is just like the people I work with, is that it takes away some of the shame when you say these things (14,15,16).

Codes

(1) Supervision; (2) VT group; (3) Peer group; (4) Connection/build relationships; (5) Attentive to risk of VT; (6) Self-awareness; (7) Build trusting relationships; (8) Share strategies; (9) Counter isolation; (10) Make a shift;

(*Appendix continues*)

(11) Belief that something can happen; (12) Active problem solving; (13) Personal relationships; (14) Open up; (15) Counter shame; (16) "Express" reality; (17) Being witnessed; (18) Create caring networks; (19) Keep on track; (20) Self-monitoring; (21) Mindfulness.

Harrison highlighted and coded the original transcript in the margins. Through multiple readings, the following codes emerged: supervision; VT group; peer group; personal relationships; connection; attentive to risk of VT; self-awareness; build trusting relationships; share strategies; counter isolation; make a shift; belief that change can happen; active problem solving; being witnessed; open up; counter shame; express "reality"; being witnessed; create caring networks; keep on track; self-monitoring; mindfulness. These codes were then incorporated into a larger concept map that explored relationships between: self-monitoring/mindfulness, self-awareness re: risks and signs of VT, belief in the ability to shift, intention/decision to shift, forming personal relationships in professional contexts, supervision, personal therapy, countering isolation, decreased shame, being witnessed by caring others, shared strategies, active problem solving, enhanced personal relationships, and decreased VT symptoms. The codes that emerged from the transcript excerpt above were ultimately subsumed primarily under the cross-narrative themes, countering isolation (in professional, personal and spiritual realms), developing mindful self awareness, and active optimism.

Validity Checks

The following is an excerpt from the detailed letter Harrison sent to "Joy" to share his interpretive analysis of their research interview conversation and check its validity:

Dear Joy,

I am writing you this letter to share my emergent understandings of our research conversations about how you manage to maintain your personal and professional well-being given the challenges of your work with clients who have experienced serious trauma. In talking with you, I got the sense that awareness, focus, and presence within each unfolding moment, accompanied by a strong commitment to personal responsibility, well-developed abilities to check in with yourself and self-regulate as necessary, your rich relational life, and your enduring belief in both people's ability to heal and the inevitability of change, all play an important role in your ongoing, evolving practice of personal and professional well-being. You have developed strategies and opportunities to care for yourself emotionally, physically and spiritually, and you actively and consistently engage in these with commitment and purpose. This allows you to experience profound and sustained interpersonal contact and connection (with self and others), while maintaining a clear sense of personal perspective and boundaries in relationship to others. I will elaborate on these and other themes below:

Relational Self-Healing: Supervision, Peer Support, Personal Therapy

You are involved in several different peer supervision/support groups, which help mitigate effects of VT. You have built trusting professional relationships where you can share your concerns about VT symptoms. Doing so helps minimize isolation and shame, because you are able to give voice to your awareness of how trauma work is affecting your life. When you "put that out as reality" and it is witnessed by caring others, this reinforces your commitment to taking active responsibility for your well-being (which is informed by your enduring conviction that people, including yourself, can heal). You are able to benefit from shared strategies of other group members, and they also help you self-monitor by checking in with you periodically to ask how you are doing. Drawing on this support, you are better able to recognize and deal with your tendency to internally distance yourself from your partner and others, when you are feeling too "filled up" with work. You also use supervision and personal therapy to help manage those times when work begins to intrude upon personal life. All of this helps you maintain enhanced relationships in your personal life, which further sustain you professionally.

The participant subsequently confirmed the validity of Harrison's initial analysis of their research interview. After conducting a thematic content analysis across participant narratives, Harrison sent each participant the following email, along with a copy of this manuscript, as a further validity check:

Dear (participant),

I hope this email finds you well.

I have just finished a manuscript based on my dissertation research that I am submitting for publication. I am hoping you will be able to read through the attached draft, and let me know whether all of the findings apply to you, or whether some of the "cross narrative themes" articulated do not fit for you. This would allow me to incorporate any necessary corrections.

Thanks again for your participation in the research.

warm Regards,

Richard

All of the participants wrote back to endorse the accuracy of the research results, as presented in this article. Below are examples of their replies:

Richard,

I have no problem with any of the "cross narrative themes." I think it is an excellent paper.

Frank

HI Richard

article is good! Nothing I disagreed with and I was interested to read some of the other comments. Good job!

regards, Abigail

All looks good to me, Richard. and Congratulations on a job well done.

Ernest

Hi Richard - I am happy to read that you are attempting to get your work published. I think it is an important piece of work that was well down.

As with your dissertation, the paper is beautifully written and captures your passion. It is interesting to me that the nature of your research really has to do with connection, spirituality, life!!! and that you have been able to combine the intellect and the emotion and produce a very beautiful paper.

I am very happy to have been a part of your paper and I have no objection to anything - I think you did a wonderful job.

Good Luck,

Joy

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