

EXPLORING THE IMPACT OF TRAUMA ON THERAPISTS: VICARIOUS RESILIENCE AND RELATED CONCEPTS IN TRAINING

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An integrative training framework articulating multiple perspectives on the impact of trauma work is offered with a training/supervision exercise to address the complex and systemic relationships that affect therapists in both positive and negative manners. The concepts of vicarious trauma, vicarious resilience, compassion fatigue, resilience, posttraumatic growth, altruism born of suffering, and reciprocity are reviewed. The paper highlights the importance of vicarious resilience as a dimension of experience that counteracts the normally occurring fatiguing processes that trauma therapists experience.

This paper offers an integrative training framework that connects key concepts in trauma work: vicarious trauma, compassion fatigue, resilience, posttraumatic growth, altruism born of suffering, and vicarious resilience. It draws on the reciprocity of the therapeutic process to anchor these concepts. Vicarious resilience is highlighted as an important dimension of experience that counteracts the fatiguing processes that trauma therapists normally experience, strengthens therapists' motivation, helps them find new meanings and

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discover ways to take care of themselves (Hernández, Gangsei, & Engstrom, 2007). In addition, the paper offers a training/supervision exercise developed and implemented by the first author.

Vicarious trauma, empathic stress, and compassion fatigue remind us that there is potential for therapists to be psychologically harmed by doing trauma work. Such concepts describe the toxicity experienced by trauma therapists in the course of their work and explain how these therapists may develop negative outcomes as a result. Addressing the potential negative impact of trauma work in training and supervision is essential to help therapists become aware of their own vulnerabilities, attend to self-care issues, and establish personal and organizational support networks.

In a parallel and related manner, another body of knowledge has addressed survivors' capacity to overcome the impact of trauma, grow, and develop ways to help others. Concepts such as posttraumatic growth and altruism born of suffering explore that phenomenon and, in the context of training and supervision, draw attention to the reality that trauma may paradoxically have positive effects on clients. Also real, though less recognized and discussed, is the positive impact of helping when one is caring and sensitive to the needs of others. The concept of vicarious resilience describes and explains how trauma therapists may strengthen their own well-being by appreciating and incorporating what they learn from their clients' healing processes.

VICARIOUS TRAUMA, VICARIOUS RESILIENCE, AND RELATED CONCEPTS

Quite a few authors have explored the impact of trauma from various vantage points, thereby providing a multifaceted understanding of the processes by which the therapeutic relationship and the self of the therapist are influenced by traumatic material (Figley, 2002a, 2002b; Pearlman & Caringi, 2009; Hernández, Gangsei, & Engstrom, 2007; Staub & Vollhardt, 2008; Tedeschi & Calhoun, 1995, 2004; Weingarten, 2003; Wilson & Brwynn, 2003). Well-known aspects of training and supervision for therapists working with trauma include addressing the impact of clients' trauma material on therapists, therapists' own histories of trauma and coping, organizational issues facilitating or hindering therapeutic work, the meaning and impact of social contexts framing clients' traumatic experiences, and self-care

(Saakvitne & Pearlman, 1996). Early conceptualizations of the impact of client trauma on trauma therapists focused on the costs of helping when one is caring and sensitive to the needs of others. The following concepts illustrate that focus.

VICARIOUS TRAUMA AND COMPASSION FATIGUE

In trauma work, the empathic listener is confronted with powerlessness and disruption. The length and intensity of traumatic stories naturally affect therapists in negative ways parallel to the impact of trauma on the client. *Vicarious trauma* refers to the cumulative effect of working with traumatized clients: interference with the therapist's feelings, cognitive schemas, memories, self-esteem, and/or sense of safety. It is a unique, though common, consequence of trauma work and it does not reflect psychopathology in either the therapist or the survivor client. Figley (1998) speaks of vicarious trauma as a term describing the transmission of traumatic stress by bearing witness to stories about trauma. However, he advanced our understanding of the impact of trauma work by explaining how traumatic stress, secondary traumatic stress, and cumulative stress affect helping professionals; he labeled these processes "compassion fatigue" (Figley, 2002).

In his trauma transmission model, Figley (2002) explains how therapists' compassion is related to their ability to be empathic and to display an actual empathic response. This response is mediated by the emotional impact clients have on the therapist and the therapist's concern for clients. The compassionate quality of therapists' responses thus depends on their ability to protect or insulate themselves from the pain, their perception of achievement by providing help, and their means of handling the stress inherent in the therapy process. Compassion fatigue emerges, increases, and decreases as a function of prolonged exposure to suffering, the therapist's own historical traumas, and circumstantial disruptions in the therapist's personal or professional life.

In sum, these concepts both illustrate and highlight the negative impact of doing trauma work. Vicarious trauma emphasizes the notion of cumulative stress from bearing witness as a natural and inner experience of therapists. Compassion fatigue explains the factors involved in compassionate response and in developing fatigue. Incorporating these ideas into training and super-

vision helps therapists recognize issues that affect their work at a personal and organizational level, and encourages them to attend to self-care issues. Larsen and Stamm (2008) discuss the multiple factors involved in trauma therapists' quality of life. They state that professional quality of life includes both positive and negative factors at the individual, organizational, and societal levels. Both positive and negative aspects are critical to understanding the impact of trauma work on mental health professionals.

An important and related area of focus in training and supervision is the *positive* impact of trauma and trauma work. Research in the fields of resilience, vicarious resilience, posttraumatic growth, and altruism born of suffering addresses survivors' capacity to overcome the impact of trauma, grow, and devise ways to help others.

RESILIENCE

A resilience framework reminds us that effective psychotherapies identify and nurture clients' strengths, promote personal control, and foster authentic relationships. Walsh speaks succinctly of the challenges and opportunities involved in traumatic loss:

Mental health professionals cannot heal all the wounds suffered in tragic loss and humanitarian crises. What we can do is create a safe haven for family and community members to share both deep pain and positive strivings. Of value is our compassionate witnessing . . . for their suffering and struggle, and our admiration for their strengths and endurance. We can encourage their mutual support and active strategies to meet their challenges. We can rekindle their hopes and dreams for a better future, support their best efforts and actions, and mobilize resources toward their aims. (2007, p. 224)

POSTTRAUMATIC GROWTH

Posttraumatic growth refers to a process by which trauma survivors are positively transformed by their experience of trauma. Specifically, it refers to positive changes that go beyond adjustment in spite of adversity. These positive changes do not, however, mean that trauma survivors will not experience distress and struggle in the aftermath at the same time (Tedeschi & Calhoun, 1995, 2004). Positive changes include improved

relationships, the recognition of new possibilities for one's life, a greater appreciation of life and personal strength, and spiritual development. Tedeschi and Calhoun (2004) observe that there is a dimension of the trauma experience that seems to produce valuable gains in spite of the losses. Post-traumatic growth does not necessarily lessen the trauma survivor's emotional distress. However, it may include or trigger a reconsideration of assumptions about life, the world, and others and a search for meaning (Calhoun, Cann, Tedeschi, & McMillan, 2000). These meaning-making processes become a part of the survivor's life narrative. Studies in the U.S. have confirmed the presence of posttraumatic growth processes in people who have experienced bereavement (Edmonds & Hooker, 1992), cancer (Cordova, Cunninham, & Carlson, 2001), the September 11th terrorist attacks (Park, Aldwin, Fenster, & Snyder, 2008), and sexual assault (Frazier & Berman, 2008). Studies in other countries have yielded divergent results. Laufer and Solomon (2006) identified posttraumatic growth in Israeli children exposed to violence. Likewise, Powell, Rosner, Butollo, Tedeschi, and Calhoun (2003) found evidence of posttraumatic growth in Saravejo refugees. However, Hobfoll et al. (2007) question the possibility of posttraumatic growth in areas of ongoing, medium and high-intensity conflict such as Palestine.

ALTRUISM BORN OF SUFFERING

The concept of altruism born of suffering emerged from the field of social psychology and refers to the development of altruism, empathy, and prosocial behavior in the context or aftermath of suffering (Staub & Vollhardt, 2008). Vollhardt states that "something about the experience of suffering—either the situation itself, the psychological processes that accompany it, or additional experiences that transform the meaning of suffering may give rise to altruism and prosocial behavior" (2009, p. 60). Altruism requires a focus beyond the self and is distinguished from resilience by its focus on the development of altruism *because of* suffering. Vollhardt (2009) argues that the concept of resilience limits explanations to how altruism and prosocial behavior are maintained *despite* suffering. Altruism born of suffering addresses the processes by which individuals move from survivorship to an activist quest to help others. Thus, healing from trauma is a fundamental step in developing altruism born of suffering, because it can

encourage openness to experiences that promote altruism and possibly lead to specific actions to help others (Staub & Vollhardt, 2008). Tedeschi and Calhoun (1995, 2004) identified compassion and altruism as possible aspects of posttraumatic growth. These researchers posited that when people recognize their own vulnerability, they may be better able to feel compassion, and that for this reason the experience of trauma may act as a kind of empathy training. After the passage of time since the trauma, it is possible that a need to help others may emerge.

VICARIOUS RESILIENCE

Unlike posttraumatic growth and altruism born of suffering, which are conceptually situated at the client level, vicarious resilience posits that trauma therapists may be positively affected by bearing witness to the trauma of their clients. *Vicarious resilience* is a process “characterized by a unique and positive effect that transforms therapists in response to client trauma survivors’ own resiliency” (Hernández, Gangsei, & Engstrom, 2007, p. 237). It is a term for the positive meaning-making, growth, and transformations in the therapist’s experience resulting from exposure to clients’ resilience in the course of therapeutic processes addressing trauma recovery.

The authors’ study of vicarious resilience evolved in the context of their work with trauma survivors who had suffered politically motivated violence and torture in Colombia and the United States. Three qualitative studies examined if and how work with trauma survivors had the potential to affect and transform therapists in a unique and positive manner (Hernández, Gangsei, & Engstrom, 2007; Engstrom, Hernández, & Gangsei, 2008; Engstrom, Gangsei, & Hernández, 2010). These studies found that the majority of the therapists interviewed in the United States and Colombia were able to identify positive effects within themselves from interaction with clients who had overcome adversity in their own lives. For example, therapists described how witnessing their clients overcome adversity affected or changed their own attitudes, emotions, and behavior in ways that the authors conceptualized as manifesting vicarious resilience. These included (1) reflecting on human beings’ capacity to heal; (2) reaffirming the value of therapy; (3) regaining hope; (4) reassessing the dimensions of one’s own problems; (5) understanding and valuing spiritual dimen-

sions of healing; (6) discovering the power of community healing; and (7) making the professional and lay public aware of the impact and multiple dimensions of violence by writing and participating in public speaking forums.

Vicarious resilience bears some similarity to posttraumatic growth. Like posttraumatic growth, vicarious resilience contends that one's spirituality, personal strength, and life outlook can be enhanced as a consequence of trauma. However, posttraumatic growth remains entirely focused on the transformation of clients; vicarious resilience is concerned with therapists' transformations as a result of witnessing their clients change. Vicarious resilience highlights the process whereby therapists are positively affected by clients' resiliency as they heal in the therapeutic process.

EXAMINING RECIPROCITY IN CONTEXT

The concepts reviewed thus far illustrate the multiple dimensions of, and complexity resulting from, trauma work. In training and supervision, focusing on these multiple dimensions allows therapists to anchor their growth within a universe of coexisting possibilities, with the potential of transcending dichotomies between positive and negative aspects of the work. Underlying each of these concepts is the fact of reciprocity in the therapeutic context.

The idea that client and therapist influence each other in the therapeutic relationship has been expressed in many forms throughout its long history. In the 1980s, systemic therapists integrated cybernetic epistemology in family therapy by developing the following tenets for therapeutic work: an observing system stance and inclusion of the therapist's own context, a collaborative therapy relationship, goals that emphasize the setting of a context for change rather than specification of a change, guarding against too much instrumentality, circular assessment of the presenting problem, and a stance of curiosity (Hoffman, 1985). Likewise, postmodern therapies such as narrative approaches emphasized the mutual construction of meaning in therapy, the multi-storied nature of identity, and related meanings (White & Epston, 1990); postcolonial approaches underscored the need to integrate dimensions of power and social context in therapy (Hernández, Almeida, & Dolan-Del Vecchio, 2005). Thus,

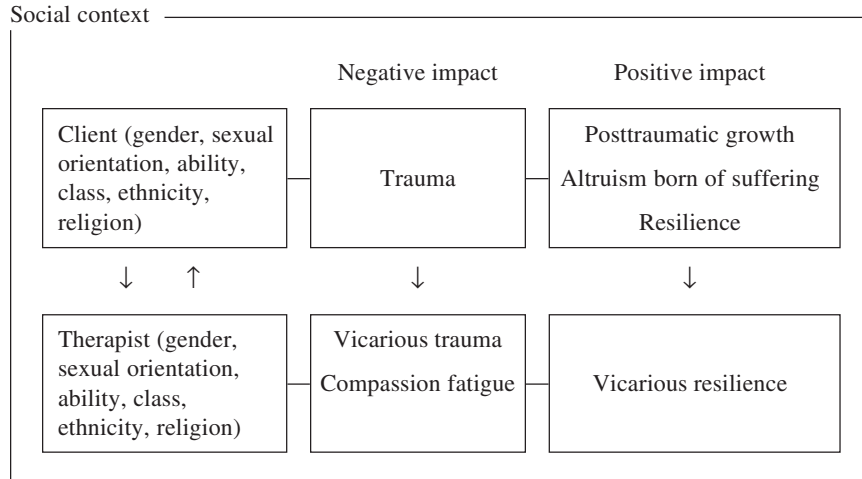
the examination of issues of reciprocity in therapy and social context in training and supervision is founded on longstanding and evolving traditions in the theory and practice of psychotherapy.

Reciprocity opens up the possibility of appreciating, attending to, and making meaning out of the process whereby therapists themselves may heal, learn, and change with clients. Therapists and clients exist in the context of a relationship in which they mutually influence each other and construct meaning; therapists are a part of, or participate in, the therapeutic relationship (Anderson, 2007). This relationship is framed within layers of contexts (organizational, familial, communal, social) and includes dimensions of power inherent in the therapeutic relationship and structured by virtue of the parties' social locations (Hernández, Almeida, & Dolan-Del Vecchio, 2005).

Regarding issues of reciprocity in social context, an often-neglected dimension in training involves making meaning of trauma work by attending to the therapists' and clients' multiple identities in social context. Brown asserts that "[a] psychotherapist's ability to understand how a trauma survivor's multiple identities and social contexts lend meaning to the experience of trauma and the process of recovery comprises the central factor of culturally competent trauma therapy" (2007, p. 3). Equally central is the therapist's ability to recognize her or his own multiple identities and the interaction of these identities with the client's in therapy. As Brown explains, "It also requires the psychotherapist's awareness of her or his own identities, biases, and participations in cultural hierarchies of power and privilege, powerlessness and disadvantage, as well as personal experiences of trauma" (2008, p. 4). In the context of trauma work in the United States and other countries, it is important to encourage therapists to attend to their own development in multiple contexts of marginalization and privilege by virtue of their class, ethnicity, sexual orientation, age, gender, ability, or religion. Often, a lack of examination of areas in which therapists hold unearned privileges by virtue of these dimensions hinders their ability to truly appreciate their clients' change processes and understand how they can learn from their clients.

In sum, paying attention to the processes by which trauma therapists are positively affected by their clients' resilience requires an integration of related dimensions in trauma work. Figure 1 offers a visual illustration of these dimensions, which include the therapist's and client's own experiences of trauma and resilience, trajectories of posttraumatic growth, mul-

FIGURE 1. Relationships between vicarious resilience and related concepts in training.



tiple identities in social context, and altruism born of suffering. These dimensions interact with the emergence of compassion fatigue and vicarious resilience in the therapeutic relationship, and should be interwoven with the reciprocal and differential impact of therapist and client in the therapeutic relationship.

SAMPLE TRAINING EXERCISE

The blueprint presented in this paper has been used in a one-session, five-hour format workshop with a small group of participants, ranging from four to eight therapists. The training leader was the first author (PH). The purpose of this exercise is to assist clinical supervisors and therapists working with trauma survivors in attending to the ways in which they are both positively and negatively affected by their clinical work. Although the leader acknowledges the stressful aspects of the work, the emphasis is on developing and amplifying meaning that strengthens hope and reciprocity. The sample process outlined here can be used all at once, in its entirety, or in segments.

The conceptual foundation previously described in this paper, for understanding the dynamic interplay among resilience and vicarious resilience processes, vicarious trauma and compassion fatigue, and posttraumatic growth and altruism born of suffering in social context, establishes a basis for the training. Within this framework, supervisees can think about themselves and their clients as embedded in systems; the possibility of considering reciprocity in the therapeutic relationship is an integral part of the interactions between these concepts.

The training exercise begins with a general description of and reflection on these concepts using the supervisees' own knowledge and experiences (see Figure 1). Figure 1 is used throughout the training as a guide or map. After these concepts are introduced, supervisees are requested to reflect on a trauma client with whom they have developed a significant therapeutic relationship. The group leader asks a range of structured questions aimed at prompting supervisees to think critically about how a trauma client might describe the therapeutic relationship and the therapist's role in it. Particular emphasis is placed on having supervisees ponder how the therapeutic relationship has affected them and what its most important elements are. Time is spent comparing how client and therapist descriptions may be alike and different. Answers to these questions are discussed and integrated within the framework of the concept of reciprocity. Usually, seasoned trauma therapists have many stories about the feedback they have received from their clients. After hearing these stories, they are asked to reflect on the impact that this feedback had on them. Newer clinicians sometimes have to be encouraged to take the risk of hypothesizing what clients would say.

In the next step, the concepts of multiple identities, privilege, and marginalization are discussed through the use of film clips. For example, *The Visitor*, a 2009 Academy Award-nominated film, illustrates issues of privilege and marginalization by contrasting the position of a white professor with all the other characters in the film. Further comparisons can be made among the characters of color in the film in regard to ethnicity, education, religion, and gender. Issues of privilege in regard to sexual orientation and ability can be hypothesized through scenarios that compare all the characters in the film clip. Supervisees are encouraged to identify dimensions of identity for themselves and their clients, and to reflect on the practical implications of these dimensions with regard to privilege and oppression. Illustrating similarities and differences between therapist and client, and the meaning they see in these similarities and differences, assists in devel-

oping a sense of humility. The objective is to create a framework for understanding that the effects of trauma work, both positive and negative, are also related to meaning derived from context and identity.

The concepts of vicarious trauma and compassion fatigue are discussed next. The following questions serve as a guide (Hernández, Gangsei, & Engstrom, 2007, p. 240):

“Clients who have experienced traumatic events and who suffer from traumatic stress impact us in many ways. Sometimes we identify the impact as vicarious trauma, compassion fatigue or empathic stress. Have you experienced any of these in relation to your work with trauma survivors? How?”

These questions elicit a variety of responses. Sometimes therapists share specific cases. For example, a novice female trainee who worked with rape victims talked about how hard it was for her to listen attentively to a client’s experience and how hearing the story temporarily affected her own personal life. Other times, supervisees share general experiences, acknowledging that they may feel stressed after a long day of work and describing how they use colleagues to process their reactions to get it off their minds. Those who work with refugees and deal with the court system sometimes indicate that the experience itself is stressful, and that they sometimes feel frustrated and hopeless when they witness what survivors have to go through in the process of requesting political asylum, for example.

The next phase of the exercise involves consideration of how therapists benefit from their trauma work. Therapists often have difficulty immediately identifying the multiple ways in which trauma work benefits them (e.g., personal and professional development, documentation of experience (volunteer or paid) for jobs, professional and/or personal credibility, financial gain/employment). After a candid discussion of the personal benefits of trauma work, the concepts of resilience and vicarious resilience are introduced by inviting supervisees to think about their own ways of overcoming personal adversities and to discuss as a group the lessons learned from those experiences. Sometimes supervisees share personal experiences and other times they share experiences related to the work of helping others. For example, some supervisees share stories about the impact of poverty, learning disabilities, car accidents, difficult divorces, personal losses, and racial profiling experiences with the police. Questions invite supervisees to reflect on and explore the potential positive impact that clients have on

them, thus leading them to acknowledge that they may not have thought about these issues before. This creates an opportunity to take a first step toward considering the possibility of vicarious resilience. Specifically, the following questions explore how clients have affected the therapists because of their capacity to overcome adversity:

- What challenges have you witnessed your clients overcoming in the therapeutic process?
- What did your client stimulate in you that you want to nurture and expand?

We then outline the following questions and ask therapists to entertain the ones that resonate with them. In examining how you may have been positively impacted by your clients' ways of coping with adversity, do you:

- Have any thoughts about how your perception of yourself may have been changed by your clients' resilience?
- Feel that your general outlook on the world has changed in some way?
- Identify any impact in your own views about spirituality?
- Have any thoughts about how your views on trauma work may have been positively impacted by your clients' resilience?
- Have any thoughts about how the ways you take care of yourself have been impacted by your clients' resilience?

Finally, we ask: If you were to consider that ethnicity, class, sexual orientation, religion, gender, religion—theirs as well as your own—play a role in shaping your experience, how would they do so? (Engstrom, Hernández, & Gangsei, 2008, p. 22.)

Group responses are discussed with an emphasis on identifying and amplifying the learning processes that occur as a result of witnessing clients overcome adversity during trauma work. Therapists often have not thoroughly articulated these learning experiences; thus, these questions give them an opportunity to begin reflecting on these issues. For example, in responding to the question about change in self-perception in relation to a client's resilience, a young male Latino clinician training at a woman's correctional facility initially shared some of his views (in writing):

My client's motivation in the counseling process was truly remarkable, and this inspired me. I felt more positive about the possible outcome of this rela-

tionship. I was initially hesitant to work here because of my preconceived notions about the type of people who are incarcerated. However, my client's will to change challenged many of these notions. Through our work she has shown me how to take incremental steps to recover from multiple traumas and addiction. Besides, the contrast of my upper middle class, educated background vs. her position as a low income, uneducated African American is so glaringly stark that it has really provoked much reflection in that area. It has reinforced for me the great notion that "with great power comes great responsibility" and that it is my responsibility to help others and contribute to society to the best of my ability.

Others have shared that clients' strong spiritual beliefs have prompted them to take a more serious look at the role of spirituality and religion in recovery. A clinician said that due to her upbringing and professional training, she used to pay little attention to the ways in which spirituality could help someone survive and thrive. This changed when she witnessed one of her clients be helped through very difficult life experiences by a spiritual belief system that gave her strength and compassion. When supervisees were asked if their approach to self-care had changed as a result of witnessing a client's resilience, a variety of themes emerged in the training exercise. However, self-care habits are usually a result of previous trainings and supervision.

The next step involves discussing posttraumatic growth and altruism born of suffering from the standpoint of an active witness—the therapist—who observes and participates in the growth of a client. The first author uses excerpts from Colombian human rights activists' narratives and film clips (Murphy, 2007) as a didactic means to foster reflection. The supervisors conducting the workshop may also use other resources of their own choice. The following question frames this discussion: What are the experiences and meaning-making processes through which you think that trauma survivors may come to care about and help others?

In this phase, one clinician shared the story of a sexual abuse survivor who was relinquished by her father as an adolescent to a boyfriend 10 years her senior. The relationship became abusive over the years, but their migration to another country brought friendships that helped strengthen her desire to leave the relationship. After leaving this relationship, she remarried and had a family. Over time, she became a neighborhood activist, organizing a committee to address safety issues and developing working relationships with the police. Although she risked her safety in this effort, she developed the

strength to act and lead others. The clinician discussed her client's process of reclaiming her voice, the steps she took to heal and rebuild her life, and her decision to help disenfranchised people in her neighborhood.

DISCUSSION

The literature in the trauma training field concerning the impact of traumatic content on the therapist has been dominated by a focus on the stressful and sometimes toxic effects of trauma work. However, although clinicians' own experiences of overcoming adversity, and the positive impact that clients may have as a result of overcoming adversity, may be covert, subjugated stories, these stories have the potential to significantly influence the appreciation of the reciprocal nature of therapy and to further strengthen the use of self as a lens that balances the painful and difficult aspects of trauma work with those that bring hope and promote growth.

In addition to discussing the value of multiple positive and negative aspects of trauma work in training, it is important to continue to integrate overlapping concepts to assist clinicians in addressing the complexities and nuances of this work. In practice, clinical work cannot be accomplished by intellectually dissecting and analyzing the smallest unit of experience. Although such exercises may have academic and scholarly value, practice requires that clinicians develop an eye for and sensitivity to multiple perspectives and connections. We highlight those involving reciprocity in what we gain from doing trauma work—hence the value of using a systemic lens to connect the concepts reviewed in this manuscript.

Further efforts at integrating and refining the ideas presented here may involve addressing the parallels between the therapist's life trajectories and their desire to help others and clients whose life trajectories involve both traumatic experiences and active and sustained efforts to help others. In addition, we underscore the importance of continued emphasis on integrating the processes by which therapists understand how their identities and their clients' identities and social contexts lend meaning to trauma experience. For these ideas to become relevant for practitioners in other countries, trauma and resilience, as well as vicarious trauma and vicarious resilience, must be subjected to the critiques of those who have experience and knowledge of building therapeutic practices outside of the United States (Beristain, 2006).

This training exercise could also be enhanced by using Rothschild's (2006) suggestions to attend to bodily responses and experiences in response to exposure to clients' trauma material. Making a habit of grounding the self by becoming aware of personal reactions and changing body states in the moment may be a significant factor in freeing therapists from compassion fatigue and allowing them to focus on promoting well-being. In addition, a practical consideration in today's mental health service delivery environment involves time constraints: it is often difficult to devote many consecutive hours to training. It is possible to break this training blueprint into components or modules, thereby allowing time in between training sessions for reflection and homework follow-up. Trainers and supervisors may include more experiential components over a longer period of time.

Finally, the first author observes, based on her experience as a clinician and trainer, that both therapists and supervisors must be careful to avoid minimizing the impact of working with complex traumatic stress, and to honor the lengthy amount of therapy that such cases require. Careful attention should also be paid to the ways in which unexamined traumatic experiences may lead persons to become therapists and/or develop activist projects that could harm others.

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