The Lived Experience of Mental Health Workers in a Residential Treatment Facility who Work with Multiply Traumatized Children and Self-Identify as Experiencing Vicarious Trauma and Compassion Satisfaction

Debra Hyatt-Burkhart

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A Dissertation
Submitted to the School of Education

Duquesne University

In partial fulfillment of the requirements for
The degree of Doctor of Philosophy

By
Debra Hyatt-Burkhart

May 2011
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Debra Hyatt-Burkhart

2011
DUQUESNE UNIVERSITY
SCHOOL OF EDUCATION

Department of Counseling, Psychology and Special Education

Dissertation
Submitted in Partial Fulfillment of the Requirements
For the Degree of Doctor of Philosophy (Ph.D.)

Executive Counselor Education and Supervision Program

Presented by:
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February 18, 2011

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ABSTRACT

THE LIVED EXPERIENCE OF MENTAL HEALTH WORKERS IN A RESIDENTIAL TREATMENT FACILITY WHO WORK WITH MULTIPLY TRAUMATIZED CHILDREN AND SELF-IDENTIFY AS EXPERIENCING VICARIOUS TRAUMA AND COMPASSION SATISFACTION

By

Debra Hyatt-Burkhart

May 2011

Dissertation Supervised by Dr. Lisa Lopez Levers

Examination of the work of providing trauma-focused treatment has been, heretofore, accomplished primarily through a lens of pathology. It cannot be ignored that many professionals who work with traumatized individuals suffer negative effects. What has been discounted is the experience of individuals who experience negative effects and also experience psychological benefit and personal growth from their work with trauma survivors. Literature regarding vicarious trauma and secondary traumatic stress is abundant, but few studies have been conducted that have been specifically designed to explore the experience of vicarious posttraumatic growth in providers of psychotraumatology.

In order to add to the insubstantial body of research that examines the phenomenon of vicarious posttraumatic growth, this study sought to illuminate the lived experiences of mental health professionals who work on a day-to-day basis with multiply traumatized children and adolescents, and as a result, experience measurably high levels of vicarious trauma and compassion satisfaction. The study sought to explore benefit
finding and vicarious positive effects of working with traumatized children. Additionally, this inquiry explored the perceptions and attitudes of the workers with respect to job satisfaction, employment longevity, and the meaning they found in their work.

This qualitative, phenomenological investigation was conducted through two individual interviews and two focus groups comprised of a total of 12 people who were employed in a residential treatment facility for children. The results of the study identify themes that address the workers’ role identification, protective factors against vicarious trauma, vicarious traumatization, positive effects of the work, and vicarious post traumatic growth. The implications of the study for the field of mental health treatment and suggestions for further research are provided.
DEDICATION

This dissertation is dedicated to two great men who I carry in my heart; Dr. Victor Adebimpe, who believed I could achieve this before I believed it myself and my dad, Francis L. Hyatt, who taught me how to fly. I wish you were here to see it!
ACKNOWLEDGEMENTS

There are many people who have aided and sustained me throughout this long and arduous journey. Without their encouragement, support, and some much needed brow beating along the way, the trip surely would have been longer if it were accomplished at all. It is only fitting to acknowledge those individuals.

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I am grateful for the Iota cohort. You made what could have been a torturous experience great fun. Whenever I research pedagogy at the library, I promise never to become petulant because, thoughts of you will always make me smile. Your support and friendship are among the best, unexpected gifts I have ever received.

Special thanks to the ladies of F5. You fine women are the most amazing support system that anyone could ask for. You provided me with diversion when I needed it, worked schedules around my classes, fed me Mimosas for my own good, and put up with years of listening to me talk about this work. You are always there when I need you to lend a hand, an ear, or a shoulder. I love you all and can never express how blessed I feel to have you in my life. Now, where are we going next? I have some time on my hands!
There is no way that I would have achieved this without my parents. My mom, Diane Hyatt was a rock. Thank you for all the care that you gave to my little family while I was away at doctor school. You fed my girls, literally and emotionally. You ensured that they got to activities and studied. You worked hard to make up for my absence throughout this whole process. You even took care of that husband of mine, which is no easy feat. Thanks too to you, Dad. You always made me feel special and helped me believe that I could do anything. I am who I am because of you. You are always with me.

Finally, thanks to you, my little family. Pat, your encouragement and support were everything. You let me know it was okay to have a dream and supported me in achieving it. Thanks for being Mr. Mom for a while. I am so glad that you kept them alive; I would have hated to have to make more! We are going to have some fun growing old during our summers off!

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CHAPTER I: THE PROBLEM

Introduction

The examination of the human response, both positive and negative, to traumatic life experiences and tragedy has been a field of interest since the time of the ancient Greeks and early Christians (Tedeschi & Calhoun, 2004a). Yet, extensive scientific study of the psychological consequences of significantly stressful life events did not begin until the last half of the 20th century (Van der Kolk, McFarlane & Weusaeth, 2007). As psychiatrists and physicians were treating soldiers serving in combat posts in World War I, they observed that some of their patients suffered from a distinct pattern of neurotic symptoms that were labeled Shell Shock (Herman, 1997). Shell Shock would later be recognized as a trauma related -illness and be reclassified as Post Traumatic Stress Disorder (PTSD). In 1980, the diagnosis of PTSD was included in the third edition of the Diagnostic and Statistical Manual (American Psychiatric Association, 2000). The formal recognition of the diagnosis of PTSD opened the door to intensive study of the impact of trauma upon its survivors (van der Kolk, Roth, Pelcovits & Mandel, 1993). As the field of traumatology has expanded, research also has been focused upon the effect of working with, or helping survivors of trauma (Steed & Bickel, 2001; Figley, 1995; Pearlman & McCann 1995; Pearlman & Saakvitne 1995; Stamm 1997).

Defining Trauma

For the purpose of this study, trauma was defined broadly and encompassed any event that created disturbance, fear, anxiety, and psychological shock, as perceived by those who had some direct experience of the event (van der Kolk, 1989; Saakvitne, Tennen & Affleck, 1998). Examples of trauma include natural disasters, child abuse, the
witnessing of violent crimes or accidents, deprivation, serious health crises, victimization, and neglect (Bird, 2004; Herman, 1992). An event or experience may be classified as traumatic merely if the individual who experienced it deems it to be so. Survivors’ reactions to traumatic events or circumstances are unique and are based upon their appraisal of the event in combination with their personal characteristics and life history (Stamm, 1999; Lazarus, 1991, Frankl, 1984). There are, however, common conditions that may result from exposure to trauma.

**Negative Effects of Traumatic Exposure**

A significant body of research has explored the negative psychological consequences of traumatic exposure. Although reactions to trauma vary from person to person and from culture to culture, there are certain responses that have been found to be common (van der Kolk, Perren-Klingler, 2000). The range of reaction can be viewed as if on a continuum. A great number of trauma-exposed individuals are able to effectively cope with their experience and suffer only mild disturbance. Such individuals often rely heavily upon spiritual or religious components that enable them to efficiently reorganize the cognitive dissonance created by the event into a functional schema, thereby limiting negative symptoms (van der Kolk, McFarlane & Weusaeth, 2007; Saakvitne & Pearlman, 1996). Mild symptoms may meet the DSM IV diagnostic criteria for adjustment disorders and may include anxiety, depression, and disturbance of conduct that negatively affects performance in multiple life domains (American Psychiatric Association, 2000).

Individuals who find it difficult to make sense of, or derive meaning from, their traumatic experience may develop patterns of negative symptoms that create significant impairment. Acute Stress Disorder (ASD) includes dissociative symptoms,
re-experiencing of the traumatic event, significant anxiety, and impairment in life functioning (American Psychiatric Association, 2000). The symptoms of ASD occur during or directly following a traumatic exposure and must last for at least two days but no longer than four weeks to meet diagnostic criteria (American Psychiatric Association, 2000). Should the symptoms continue to manifest beyond the one month time frame, a change of diagnosis is in order. It is interesting to note that most people suffering from ASD seem to recover from their symptoms without any formal treatment (Breslau, Davis et al, 1991).

Individuals with the most severe and enduring traumatic stress reactions are those who meet the diagnostic criteria for PTSD. These individuals experience long-lasting ASD and have also been found to maintain heightened levels of arousal, debilitating sleep disturbance, and intrusive thoughts that may be so severe as to inhibit daily functioning (van der Kolk et al 1996; Herman, 1992).

Positive Approach to Traumatic Exposure

Trauma research, since its inception, has primarily been focused upon the negative symptoms that result from exposure to horrific events. No real question remains as to the validity of this pathologic view of trauma. What has recently begun to emerge in the research is a trend toward examining traumatic exposure from a positive perspective (Lindley, 2004; Tedeschi & Calhoun, 2004Park, 2006). A growing body of work focuses on the notion of human resiliency in the face of extraordinary circumstances (Bonanno, 2005; Frederickson et al, 2003). It is true that resilience is not a new concept. The idea that humans are resilient abounds in our scholarly and popular literature. From works such as Steinbeck’s “The Grapes of Wrath” (1939) to J.K.
Rowling’s depiction of Harry Potter (1997), the idea that people are able to withstand horrific circumstances without breaking and that we possess the ability to spring back is a central theme in many of our most significant works of literature. The application of human resilience to trauma theory is what is novel. Resilience theorists propose that effective coping and “springing back” are normative to traumatic exposure, not pathology and psychological disturbance as is often the implication of “problem focused” studies (Bonanno, 2004). Rather than assuming a deficit-based approach to the study of trauma, resiliency work examines the strengths and constructs of hardiness and adaptability of those who undergo trauma (Bonanno, 2004; Luthar et al., 2000).

Trauma research has continued to move in the direction of a positive or salutogenic perspective by expanding studies to examine the concept of posttraumatic growth (PTG). Beyond resilience or a springing back, the concept of PTG asserts that suffering and life crises can lead to positive personal change and an improved condition (Tedeschi & Calhoun, 2004; Park, 2004; Zoellner & Maercker, 2006). Post traumatic growth is rooted in the notion that individuals experience the negative effects of trauma, and are able to intellectually and emotionally re-order their assumptive world toward a better functioning as a result (Tedeschi & Calhoun, 2004). Studies have found positive benefit to be perceived by trauma survivors in the domains of enhanced relationships or closeness with others (Affleck et al., 1987; Affleck, Tennen & Rowe, 1991; McMillen et al., 1997), enhanced self-efficacy and sensitivity to others (Affleck et al., 1991), and having a greater concern regarding world issues (Collins et al., 1990).
The Cost of Helping

The rise in research regarding the impact of trauma upon those who experience it, has led to an increase in treatment methodologies focused upon preventing or alleviating negative posttraumatic symptoms (Bober & Regehr, 2005). Helping professionals are increasingly providing treatment that is trauma based or “trauma informed”. Due to cognizance that trauma care comes at a price for those who provide it, there has been a growing interest in the psychological consequences of caring for individuals who have been exposed to traumatic circumstances (McCann & Pearlman, 1990; Figley, 1999; Pearlman & Saakvitne, 1995). Substantial evidence exists to support the proposition that the conditions of burnout (Maslach, 1996), compassion fatigue (CF) (Figley, 1995), and vicarious trauma (VT) (Pearlman & Saakvitne, 1995) can be manifest in individuals employed in the mental health field. In studies focused on severity and rates of occurrence, professionals engaged in work with people exposed to trauma experience significantly higher levels of burnout, CF, and VT than those who are not privy to the traumas of others Figley, 1995; McCann & Pearlman, 1990; Gentry, et al 2002). Greater still, is the negative impact of working with children who have been victims of trauma (Van Deusen & Way, 2006). Often, workers do not recognize their symptoms, or they are reluctant to admit that they are suffering the effects of work-related stress due to feelings of inadequacy or fear of being viewed as incompetent (Stamm, 1999). Individuals who suffer from burnout, CF, and VT may deliver less effective treatment, become inappropriately detached from their work, dehumanize their clients, and may leave the profession (Figley, 1995; Pearlman & Saakvitne, 1995; Joyce, 2004). Worse yet, professionals experiencing debilitating or impairing levels of CF, VT, and burnout...
may remain in the profession and inadvertently cause damage to the very people they sought to help. The following section provides an overview of the possible conditions that may result from working with individuals who have experienced trauma.

**Burnout**

Just as direct exposure to trauma can cause symptoms that appear to be spectrum-like in their variation; the effects of helping individuals with traumatic exposure can be viewed along a continuum of severity as well. Initial explorations of such issues focused on the concept of counselor burnout, which is viewed as a response to the situational, external stressors of the job of helping (Maslach & Jackson, 1981; Gentry, 2002). These stressors can be office pressures, client issues, daily demands, and the like. Burnout is generally understood as a condition that results from a combination of the characteristics of the work environment and its daily pressures, the individual’s personal characteristics and exposure to the difficulties of others (Maslach & Jackson, 1981). Trauma need not be the focus of the work for burnout to occur. Burnout manifests in both physical and emotional symptoms. Workers may experience fatigue, body aches, general malaise, headaches, stiffness, and gastrointestinal distress (Maslach, 1976). Emotional indicators of burnout have been found to be feelings of overextension, frustration, apathy, indifference, cynicism, callousness, and negativity (Maslach & Jackson, 1981). Of import is the centrality of the interconnectedness of the experience of the individual with the work environment (Collings & Murray, 1996). Burnout can be thought of having significantly less spillover into a worker’s personal life than the other resultant conditions to be discussed.
Compassion Fatigue and Secondary Traumatic Stress

Another condition that may be experienced by those employed in the helping profession is compassion fatigue (CF). Figley (1995) defines compassion fatigue and secondary traumatic stress as natural consequences of working with those who have experienced stressful events. He further asserts that the empathetic relationship that is characteristic of counseling and the counselor’s willingness to expose himself to the trauma experience of the client are the foundations of such stress. This empathetic relationship and willingness to hear is inherent in the work of effective counselors and cannot be avoided. Figley (1995) describes compassion fatigue as the price that a member of the helping profession pays for doing the work. Although often associated with trauma work, compassion fatigue is a general term that easily can be applied to the psychological impact upon a counselor as a result of working with a variety of difficult clients. It does not necessitate working with victims of trauma.

Vicarious Trauma

Of further significance for the professional working with the traumatically exposed is vicarious trauma (VT). VT can be equated with the notion of counter transference. Sigmund Freud identified the concept of counter transference in his essays on the technique of psychoanalysis in the early 1900s (Wilson & Lindy, 1994). Defined broadly as emotional entanglement between a therapist and client, Freud viewed the interaction as negative and potentially harmful, but also as a tool that could be used to promote growth through the process of psychoanalysis (Searles, 1979). As the study of therapy has grown, counter transference has come to be understood as a natural part of the relationship between therapist and client, that is a result of the mutual influence
present between people in any relationship (Wilson & Lindy, 1994). VT can spawn from
the workers over identification with, or sympathetic response to the traumatic experiences
of their clients (McCann & Pearlman 1990, Figley, 1995; Stamm 2005). Indeed, it is
often workers who have the strongest desire to help and facilitate change who experience
VT and CF at the most significant levels (Gentry, 2002). Vicarious trauma is of
significant interest, in large part, because of the indirectness of the traumatic experience
for the worker which is manifested in direct negative symptomatology.

Vicarious trauma is, at its core, based upon constructivist personality theory,
which “emphasizes the role of meaning and adaptation, rather than focusing primarily on
a set of symptoms” (Steed & Downing, p. 2). Hence, the focus of VT is upon counselors’
internal shifts in cognitive schemas that happen as a result of the barrage of traumatic
information to which they are exposed. VT is viewed as a normal response to the constant
challenge that exposure to the horrible behaviors in which humans can participate present
to the beliefs and values of the counselor (Baird & Kracen, 2006). VT places an emphasis
on the individual as a whole and attempts to provide a contextual framework for the
symptoms presented. According to Baird and Kracen, the challenges to fundamental
beliefs and values that a counselor may experience, can result in disruptions to five
specific areas of his or her cognitive schema. These areas are safety, trust, esteem,
intimacy, and control (Baird & Kracen, 2006). As constructivist personality theory is
applied, individuals construct their own reality through the development of these
cognitive schemas. Therefore, each person has a different set of constructs. The impact
and severity of vicarious trauma are dependent on the individual person’s constructs,
issues, the traumatic events presented, and the context of the work (McCann & Pearlman,
1990). Each counselor will respond to traumatic events that are presented in a different fashion, depending on his personal characteristics. This is a key concept in the definition of VT as it clarifies that the phenomenon is created by both internal and external stressors, as well as the individual as a whole (McCann & Pearlman, 1990, Dunkley & Whelan, 2006).

Vicarious Trauma is the resulting disturbance in a counselor’s cognitive schema created by the fundamental struggle within the counselor to make meaning out of the stories of human cruelty to which he is exposed (Canfield, 2005). This disturbance is influenced by the counselor’s personal characteristics or attributes, trauma history, and the specifics of the events presented. VT is a normal by-product of working with clients who have suffered traumatic events, and, to some degree, affects all counselors. VT is unique in relationship to other terms that describe the impact of second-hand exposure to trauma on counselors, as it involves both the internal characteristics of the counselor, the specifics of the traumatic events described, and the external factors inherent to the job. VT mimics the symptoms of PTSD and can have far reaching implications for the professional and personal life of the professional.

Positive Effects of Vicarious Exposure to Trauma

There is no doubt that mental health workers can experience negative symptomatology that mirrors that of their clients who directly experience trauma (McCann & Pearlman, 1990; Canfield, 2005; Baird & Kracen, 2006). It is also true that these same workers can experience significant positive symptoms from their experience. The following section provides an overview of the potential positive effects of trauma work.
Compassion Satisfaction

Compassion satisfaction (CS) is the sense of personal achievement, increase in confidence, and sense of humanistic benevolence gained as a result of empathetic engagement with an individual who has suffered a trauma or crisis (Stamm, 2002). In short, CS is deriving personal satisfaction from the work in which a person is engaged, even when that work is with individuals who have suffered horrific events that create cognitive dissonance. Clinicians often report deriving benefits such as an increase in their faith in the resiliency of the human spirit, a positive sense of self-worth and a strong sense of purpose (Herman, 1992; Pearlman & Saakvitne, 1995).

Vicarious Posttraumatic Growth

Just as individuals in the helping professions can develop trauma-related symptoms through the vicarious exposure to the trauma of their clients, I endorse that helpers can experience vicarious posttraumatic growth by observing PTG in those whom they are helping. As with the growing application of positive psychology in work with victims (Seligman & Peterson, 2003) a salutogenic approach toward the examination of helpers is also gaining in favor (Linley et al, 2005; Stamm, Varra, Pearlman & Giller, 2002). Clinicians who experience growth in their clients have been found to perceive personal growth in the areas of relationship skills, spiritual well-being, sense of coherence, value of human life and relationships, and ability to cope with adversity (Brady, Guy, Poelstra, & Brokaw, 1999; Herman, 1992; Pearlman & Saakvitne, 1995)

Statement of the Problem

Examination of the work of providing trauma-focused treatment has been, heretofore, accomplished primarily through the use of a lens of pathology. The
assumption of exclusively negative consequences for those who provide treatment to trauma-exposed individuals has created training and educational approaches that are deficit based and myopic in focus. It cannot be ignored that many professionals who work with traumatized individuals suffer negative effects. What has been ignored, or, at the very least discounted, is that there is a population, of individuals who experience negative effects, and also experience psychological benefit and personal growth from their work with trauma survivors. Calhoun and Tedeschi (1999) organize the positive changes in those who experience trauma into three categories- changes in philosophy of life, interpersonal relationships and self-perception. Vicarious growth in counselors appears to echo the same categorization of benefits as with survivors (Arnold, Calhoun, Tedeschi & Cann, 2005). Additional studies suggest that trauma care can increase counselors’ appreciation for life, enhance their self-awareness, and deepen their personal relationships (Herman, 1992; Pearlman, 1999; Arnold et al, 2005). An increase in spiritual well-being has anecdotally been reported by counselors who work with sexual abuse survivors (Brady, Guy, Poelstra & Brokaw, 1999, Arnold et al, 2005). What is striking is that much of the information regarding vicarious posttraumatic growth has been ancillary information gathered through studies of those who directly experience trauma. Literature regarding vicarious trauma and secondary traumatic stress is abundant, but few studies have been conducted that have been specifically designed to explore the experience of vicarious posttraumatic growth in providers of psychotraumatology (Arnold et al, 2005).

In order to add to the insubstantial body of research that examines the phenomenon of vicarious posttraumatic growth, this study sought to illuminate the lived
experiences of mental health professionals who work on a day-to-day basis with multiply traumatized children and adolescents, and as a result, experience measurable high levels of vicarious trauma and compassion satisfaction.

**Research Questions**

The questions that drove this research study were defined after reviewing the existing literature related to the affects of trauma on individuals in the helping professions. There is a copious amount of empirical research that focuses on the negative experience of vicarious exposure to trauma. While the field of psychology has begun to look more at the potential for growth from direct exposure to trauma, little work has been done to examine the potential for growth from vicarious exposure to posttraumatic growth. The guiding question for this inquiry was: What are the lived experiences of mental health professionals who work in a residential treatment facility for multiply traumatized children? The following subsidiary questions assisted in answering the guiding question:

1. How do mental health workers describe their experience of working with multiply traumatized children?
2. How do mental health workers ascribe meaning to their work?
3. How do mental health workers describe the ways in which they have been affected by their work with trauma survivors?
4. How do mental health workers make sense of their experience of vicarious trauma?
5. What sustains the workers in the field of helping traumatized children?
Significance of the Study

The subject of vicarious growth in helping professionals has received very little attention in the research. As part of our understanding of the process of helping, it is important to consider the positive experiences that permit some professionals to metamorphose their vicarious trauma into a greater appreciation for the resiliency of the human spirit and experience growth in their ability to cope with adversity, engage in relationships and maintain their sense of well being (Saakvitne & Pearlman, 1996). The application of a salutogenic approach to trauma and the examination of the lived experience of workers who experience vicarious posttraumatic growth have significant implications for the field. Avenues for screening of workers, enhanced training, and limiting the exposure of individuals not suited for the work could be developed. These tools could reduce emotional damage to workers, and increase the length of worker retention in the field, which could reduce cost and increases skill levels in the work force, and decrease the potential for inadvertent damage to clients through impaired caregivers.

Through the validation of a salutogenic perspective to the work of counseling, educational methodology could be realigned to a strength based paradigm that would bring the pedagogy of counselor training in line with the rising trend of “strength focused” treatment. The strengths perspective is based on three underlying assumptions about clients. First, clients have personal and environmental strengths and are most apt to employ these strengths when they are supported and validated. Second, the clients are the experts on their own reality and own experience. Third, the counselor, a partner in the therapeutic process, assumes the primary role of supporting, fostering and exposing the strengths of the client (Saleebey, 1992). Counselor educators could apply the strengths
perspective in the classroom by focusing students on efficacy, competence, and the process of healing, instead of adopting the currently accepted deficit or problem based approach (Bell, 2002). Extrapolation of a strength perspective to the developing counselors would focus upon positive reflections, coping strategies, self-care measures, and would validate areas of competence, and the counselor’s positive attributes. An educational culture that focuses on hardiness would have the possibility of affirming the counselor as an individual which could translate into an enhanced ability to empower their clients toward positivist approaches to their work of healing (Bell, 2002).

A shift toward a salutogenic view of psychotraumatology also has implications for counseling supervision. The isomorphic nature of counseling supervision, where the relationship between supervisor and supervisee parallels that of counselor and client, is well researched (Swartz, Liddle & Breunlin, 1988; Frankel & Peircy, 1990; Kaiser, 1992; White, 1997). The incorporation of a salutogenic, strength-based approach to supervision would create opportunities for the co-construction of ideas in the supervisory process where supervisors would approach the supervisees as the experts of their own experience. The supervisor would adopt a positivist perspective toward the supervisee by looking for the benefits of both the therapeutic and supervisory processes without a hierarchical, problems based paradigm. The isomorphic nature of supervision and counseling suggests that such a supervisory approach would cross-pollinate into the therapeutic relationship and enhance a strengths-based application toward therapeutic engagement (Edwards, Mei-Whei, 1999).
The Study

The study sought to elucidate the experience of mental health workers who find psychological benefit in working with trauma. The study was conducted using willing participants employed as mental health workers who were recruited from a residential treatment facility in central, western Pennsylvania. The facility serves adolescents between the ages of 8-18, who are diagnosed with a serious mental illness, and have been exposed to multiple traumas such as child abuse, neglect, multiple out of home placement, and community violence. The facility operates from a philosophy of trauma-informed care using Sandra Bloom’s “Sanctuary Model®”. Bloom’s model is a “full-system” approach designed to “help injured clients recover from the damaging effects of interpersonal trauma” (Bloom, 2008 pp.49). The system approach involves engagement of every level of the participating organization. Ownership of the sanctuary process is shared by clients, line staff, supervisors and management alike. Originally conceived as an approach to working with hospitalized, adult survivors of childhood trauma, the Sanctuary Model® has been adapted for use with adults, children and adolescents across a broad spectrum of interventions (Bloom, 2008). By application, the model guides the organization in the structuring a safe environment that embodies seven dominant characteristics; a culture of nonviolence, emotional intelligence, social learning, shared governance, open communication, social responsibility, and growth and change (Bloom, 2008). Through the development of this culture, it is hoped that the clients, staff, and the organization will benefit from a shift away from a “trauma organized” culture to a safe and collaborative environment with improved outcomes for clients (Bloom, 2008).
Participant Selection

In order to purposefully select the study participants, archival data were used. The residential mental health workers had been administered the Professional Quality of Life Scale R-IV (ProQOL) (Stamm, 2005) as part of the institution’s program to evaluate the efficacy of the Sanctuary Model®. This self-report instrument identifies and distinguishes between compassion satisfaction, VT, compassion fatigue, and burnout. The ProQOL R-IV is the most current version of the Compassion Fatigue Self Test (CFTS) (Figley, 1995). The new instrument is much shorter than the CFTS, which increases the likelihood of participant completion and reduces completion fatigue. The ProQOL is a well analyzed testing instrument. The alpha reliabilities are 0.87 for the Compassion Satisfaction scale, 0.72 for the Burnout scale, and 0.80 for the Fatigue scale (Stamm, 2005). There are small inter-scale correlations. Burnout and Compassion Satisfaction have 5% shared variance, while Compassion Satisfaction and Fatigue share 2% variance (Stamm, 2005). Burnout and Fatigue share variance of 21%, which is noted as most likely due to the similarities in the stressors between the two conditions (Stamm, 2005).

Two of the three scales of the ProQOL were examined in depth. Of keen interest was the vicarious trauma scale, which measures the extent to which individual are disturbed or experience negative consequences as a result of their work with traumatized individuals (Stamm, 2005). The higher the score value on this scale, the greater the level of disturbance. The second scale of interest was the compassion satisfaction scale, which was added to the ProQOL in 1996. This scale measures the positive feelings that individuals derive from their work, which may include feelings of self-worth, altruism,
and personal growth (Stamm, 2005). Higher scores on this scale indicate greater pleasure perceived from work activities.

It was assumed that there would be a relatively small percentage of the sample population that would score low on both the CS and VT scales of the measurement (Stamm, 2005). This combination of scores revealed individuals who do not find their work particularly disturbing or particularly gratifying. Conversely, it was also expected that there would be only a small percentage of responses with high scores on both the VT and CS scales (Stamm, 2005). Respondents with high scores on both scales suggested that they were experiencing some level of emotional disturbance related to the work (VT), and yet were still able to find positive psychological meaning. Individuals with high VT and CS scores were of greatest interest in this study, for this co-occurrence suggested that vicarious posttraumatic growth could be on-going. Willing participants were asked to participate in focus groups or individual interviews regarding their experience.

Data Collection

According to Van Manen (2007), subject interviews, from a hermeneutic phenomenological perspective, serve the purpose of “gathering experiential narrative material that may serve as a resource for developing a richer and deeper understanding of a human phenomenon (p. 66). To that end, the subjects of the study participated in audi-taped focus groups and individual interviews using a semi standardized format. A semi-standardized format permitted flexibility in questioning and provided the participants with the ability to elaborate and direct the content of the interview based upon their own perceptions and identification of individualized notions of the salient factors of their own
experience (Berg, 2007). Each participant was asked to participate in either one focus group interview or one individual meeting. Both settings are important in order to accommodate individuals who may express themselves better one-on-one and those who think and work best in cooperative settings. Additionally, the phenomenological nature of the study compels explication of the “meaning” of the workers experience of vicarious posttraumatic growth both from the view of an organizational or cultural vantage point and from the personal or individual experience of the workers’ everyday lives (Van Manen, 1990). A set of planned questions was developed to start the discussion among the participants. Space was left for the interviews to evolve and be adapted as appropriate and relevant questions emerged (Berg, 2007; Glesne, 2006). I also used a reflective journal and took field notes to enhance the interview data and provide multiple sources of information in order to triangulate the data.

**Theoretical Underpinning**

Van Manen’s (1990) four lived existentials of lived space, body, time, and human relation were used to ground both the interview questions and the examination of the data. Lived space references a person’s feeling or experience of dimension, vastness or lack thereof (Van Manen, 2007). It is the sense of smallness that you may feel while lying in the grass on a moonless, crystal clear night gazing at the vast cosmos above. It is the sense of comfort of the well worn easy chair upon which you settle to read a favorite novel. Lived space is the discomfort we feel when someone invades our personal “bubble” by standing too close to us when they speak.

Lived body, or corporeality relates to our bodily presence. Van Manen (2007) stresses that the phenomenological experience of our bodily presence in this world is a
constant. Our bodies respond to our cognitive and emotional experiences without our volition. Lived body is experienced through perception and action.

Lived time, or temporality is defined by Van Manen (2007) as subjective time. It is the perception that the twenty minutes spent in the waiting room while a loved one underwent a serious medical procedure lasted an eternity. Conversely, it can be the experience of moments accelerating. It is our perception of past, present and future.

Lived other or relationality is our experience of us with others (Van Manen, 2007). It is the physical, emotional, and interactional essence of our relationships and contact with other humans in the world. Each of our experiences of others is highly personalized with none like any other. Van Manen (2007) describes the four existentials as distinct and identifiable elements that are inextricable woven into the fabric of the human existence that combine to form the individuals “life world”. The study examined the essence of the experience of the workers with the separate existentials as a framework, while keeping awareness that one existential always brings forth aspects of the others (Van Manen, 2007).

**Explication of Data**

Once the interviews were transcribed, the transcripts and field notes were explicated using Hycner’s (1999) guidelines for the phenomenological analysis of interview data. Hycner (1999) indentifies fifteen steps helpful to the phenomenological approach to explicating data. In this study, bracketing and phenomenological reduction, delineation of units of meaning, clustering of units of meaning to form themes, summarization of interviews, and extraction of general and unique themes to form a composite summary were used as a structure for analysis. Overlaid with Van Manen’s
(2007) four lived existentials, Hycner’s guidelines helped to ensure that the study remained true to the phenomenological nature of a “lived experience” conceptualization.

Through this inquiry, a nascent understanding of the experience of vicarious post traumatic growth was developed that begins to clarify in what direction further research might proceed. Through this study, I delineated future lines of inquiry that may serve to enhance the field of trauma work and the health of workers employed within it.

**Definitions**

**Trauma**- any event that creates disturbance, fear, anxiety, and psychological shock, as perceived by those who have some direct experience of the event (van der Kolk, 1989; Saakvitne, Tennen& Affleck, 1998).

**Shell Shock**- a stress related disorder thought to be a result of exposure to concussive ordinance (Herman, 1992).

**Battle or Combat Fatigue/War Hysteria/Combat Neurosis**- the pattern of negative psychological symptoms, such as anxiety, psychological shock, exaggerated startle response, and dissociative reactions that occurred as a result of combat related exposure in soldiers (van der Kolk, 1996).

**Acute Stress Disorder (ASD)** - a condition that can occur as a result of exposure to trauma. ASD includes dissociative symptoms, re-experiencing of the traumatic event, significant anxiety, and impairment in life functioning (American Psychiatric Association, 2000).

**Post Traumatic Stress Disorder (PTSD)**- a trauma exposure related condition that results in individuals experiencing long-lasting ASD which may be co-morbid with
heightened levels of arousal, debilitating sleep disturbance, and intrusive thoughts that may be so severe as to inhibit daily functioning (van der Kolk et al 1996; Herman, 1992).

**Counter transference**- a condition which arises in the [physician] as a result of the patient’s influence on his unconscious feelings” (Freud, 1910 p. 144).

**Burnout**- a “state of physical, emotional and mental exhaustion caused by long term involvement in emotionally demanding situations” (Figley, 1995 p. 11).

**Compassion fatigue (CF)**- “the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other and the stress resulting from helping or wanting to help a traumatized or suffering person” (Figley, 1995 p.7).

**Secondary traumatic stress (STS)** - a condition similar to CF that results specifically from work with victims of trauma (Sabin-Farrell & Turpin, 2003; Dunkley & Whelan, 2006).

**Vicarious Trauma (VT)** - “a process through which the therapist’s inner experience is negatively transformed through empathic engagement with client’s trauma material” (Pearlman & Saakvitne, 1995 p. 280).

**Posttraumatic Growth (PTG)** - the concept of positive personal change that results from a crisis or traumatic event (Tedeschi & Calhoun, 1996).

**Compassion Satisfaction (CS)**- “the pleasure derived from being able to do your work well…feeling positively about your colleagues or your ability to contribute to the work setting or even the greater good of society” (Stamm, 2005, p.5).

**Vicarious Posttraumatic Growth (VPTG)**- personal positive outcomes as a result of work with trauma survivors (Calhoun & Tedeschi, 1999).
Overview of the Dissertation

In Chapter 1, I have described the background of the study, the design of the study, the import of the study, and its significance. Chapter 2 offers a review of the literature that includes an overview of traumatology, including a discussion of the pathological constructs of stress related disorders such as ASD and PTSD. Issues related to the professional counselor include burn out, compassion fatigue, and vicarious trauma. Also reviewed are the positive constructs of resilience, traumatic growth, compassion satisfaction, and vicarious resilience and growth, with respect to the issue of counter transference in helping relationships. The chapter concludes with an in-depth discussion of the theoretical grounding for the study.

Chapter 3 explains the methodology and design of the study. Also included is a discussion of the procedures by which the data was gathered and interpreted, the specifics of the methodology of the study, and the approach to research design. The chapter is concluded with a detailed review of the attention paid to considerations of ethical treatment of the subject participants. Chapter 4 provides the results of the data collection. Chapter 5 provides an explication and analysis of the data, the implications for the field of mental health treatment, and suggestions for further study.
CHAPTER II: REVIEW OF THE LITERATURE

Introduction

Understanding the impact of trauma is essential to the theoretical framework that underlies this inquiry. Chapter II provides a review of the related literature regarding the effects of traumatic exposure. While there has long been recognition that trauma can have a psychological impact upon the psychological well being of those who encounter it (Sexton, 1999; Herman, 1992), it has only been since 1980 that a formal diagnosis of a trauma related disorder (PTSD) has been included in the DSM. Since then, the study of human reaction to traumatic events has been ever increasing (Wilson & Lindy, 1994; Sexton, 1999). In a parallel line of inquiry, there has been an increase in the study of the negative effects of helping individuals who are dealing with the after-effects of traumatic exposure (Figley, 1995; McCann & Pearlman, 1990). This research has helped to increase our understanding of the deleterious effects of both indirect and direct exposure to trauma and has informed the field regarding prevention and treatment strategies (Pearlman & Saakovitne, 1995; Figley, 1999; McCann & Pearlman, 1990).

A newer line of inquiry has emerged within the last decade and involves an examination of the potential benefits of traumatic exposure. The so called “salutogenic” or positive approach to trauma concentrates on the positive after-effects of traumatic experiences (Volanti, Patton, & Dunning, 2000; Tedeschi & Calhoun, 1995). Newer still is the line of inquiry that examines the potential benefits of vicarious exposure to these positive effects (Tedeschi & Calhoun, 1999).

Statistics suggest that approximately 90% of individuals, a large majority of the population, will suffer a traumatic event (Breslau, 2002). Approximately 30% of these
individuals will go on to develop stress related symptoms that are significant enough to require intervention (Breslau, 2002; Yehuda, 1992). As those who help these individuals experience the vicarious effects of trauma, it continues to be of import that we focus attention on methods to deal with and prevent pathological reactions. It is essential that the field begin to look beyond the limiting pathological approach to vicarious exposure to trauma and consider a more salutogenic conceptualization. If we desire to provide treatment from a strength-based, positive approach, we must begin to apply those same, salutogenic concepts to addressing the emotional consequences of the work of trauma care.

This review of the literature provides an overview of traumatic exposure and the deleterious and beneficial effects of both direct and vicarious experiences of trauma. There are five foci of this review of the literature. The first is the development and progression of the notion of trauma as a catalyst for emotional disturbance and the history of trauma related conditions. The second is on the cost of caring for individuals who have experienced traumatic exposure and will contain an exploration of burnout, compassion fatigue and vicarious trauma. The third, and most important focus, is on the salutogenic approach toward traumatic experiences for both direct and vicarious exposure. Finally, the theoretical underpinnings of the methodology are examined.

**History and Progression of Trauma as a Catalyst for Emotional Disturbance**

The study of the affects of trauma on the human condition is an endeavor that is rooted in the studies of the mind that were the beginnings of modern psychiatry. In the mid 1800’s, Jean-Martin Charcot studied young Parisian women who were hospitalized at the Salpêtrière. In his consideration of “neurosis,” Charcot examined the repercussions
of lives filled with sexual assault, poverty and violence. Charcot recognized that these women were acting out of their subjective realities and that their conditions were psychological (Herman, 1992). Charcot’s students, Sigmund Freud, Joseph Breuer, and Pierre Janet expanded upon his exploration of hysteria and neurosis, and further hypothesized that these conditions were caused by exposure to psychological trauma (Brooks, 1998). Freud, Janet and Breuer’s conceptualization of what constituted psychological trauma was initially quite narrow and was constrained to the idea that hysteria and neuroses were caused by psycho-sexual events. By 1917, extensive exploration of the subject of traumatic conditions had created an expanded definition of psychological trauma. In his *Introductory Lectures on Psychoanalysis*, Freud proposed a broadened concept of psychological trauma that included “war, railway collisions and other alarming accidents involving fatal risks” (pp. 274). This more inclusive definition would later prove to be foundational in the delineation and classification of trauma related disorders within the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders.

**Shell Shock and Battle Fatigue**

Initial investigations into the psychological consequences of traumatic exposure were not limited to hysterical women. The advent of World War I, with its proliferation of emotionally disturbed soldiers, brought the psychological devastation that could manifest from combat to the attention of the field of psychology. Charles Myers, a pioneering psychologist in the study of combat related disturbance recognized that the soldiers’ symptoms appeared to be similar to behaviors that Freud observed in women who were suffering from hysteria. Myers originally hypothesized that the behaviors had a
physical cause and attributed the behaviors to the intensity of the concussions of exploding ordinance (Herman, 1992). As a result of his hypothesis, Myer labeled the syndrome “shell shock”. Much to the dismay of the military, further study showed that many soldiers exhibited the characteristic symptoms of the syndrome without being exposed to the physical trauma of concussive force (Herman, 1992). Eventually, the soldiers’ neurosis was acknowledged to be the result of the psychological trauma and stress of combat with its constant state of violence, threats to life, and horrific images (Herman, 1992; van der Kolk, 1996).

**Etiology of war hysteria.** By the end of WWI, psychiatric professionals had adopted the position that combat fatigue or, “war hysteria” as it was now known, was a disease created by a lack of “will to be well” on the part of the suffering soldier (van der Kolk, 1996). This view, especially prevalent among professionals serving in the military or in positions with connection to the armed services, followed a similar course of development as the earlier studies of hysteria in women. Soldiers were expected to be brave, heroic, and stoic in their adaptation to the rigors of their war experience. Those who succumbed to psychological distress were categorized as being of poor moral character or of weak temperament (Herman, 1992, van der Kolk, 1996). This view mirrors initial interpretations of women who exhibited neurotic symptoms as internally weak and flawed.

There were those, most notably W. H. R. Rivers, who viewed the affliction of combat neurosis, or war hysteria, as a pathological, traumatic syndrome that was a result of the severity of the stressors of combat, and not a weakness of character (van der Kolk 1996, Herman, 1992). Rivers, who based his treatment interventions upon psychoanalytic
principles, strongly believed that any soldier could be afflicted by combat related hysteria, regardless of his moral character or the height of his bravery (van der Kolk, 1996). When the war was over, veterans’ hospitals continued to serve the psychiatric needs of soldiers who were experiencing persistent disability as a result of their combat experience. These men garnered little attention from the medical community. It was as if the horrors of war and its lasting consequences could be forgotten if they were ignored (Herman, 1992). Between WWI and WWII, the field of traumatic study was quiet during the newly found time of peace.

The study of traumatic exposure did remain of interest to a few professionals within the field of psychology. After a career in psychoanalysis and anthropology, American psychiatrist Abram Kardiner began to study combat related disorders and psychological trauma. Kardiner explored past assessments, theoretical frameworks and studies on combat related hysteria, and synthesized his findings in his 1941 work *The Traumatic Neuroses of War*. Kardiner decried the use of the label hysterical in reference to suffering soldiers as he felt it propagated the impression that the disturbance experienced was a result of weakness or internal flaws (Herman, 1992).

**Development of Trauma Related Disorders in the DSM**

The dawn of WWII, followed by the Korean conflict and Vietnam refocused psychiatry on trauma related illnesses and upon ways to prevent them. War related investigations of trauma eventually piqued the interest of the civilian sector and conditions born from non-combat related trauma began to be examined. In 1952 the American Psychiatric Association released the first *Diagnostic and Statistical Manual of Mental Disorders* as a means to mitigate some of the limitations found in using
nomenclature from the *International Statistical Classification of Diseases, Injuries, and Causes of Death* (ICD-6). In the ICD-6, stress related reactions were labeled as “acute situational maladjustment” (WHO, 1948). The DSM-I labeled stress related conditions under the heading of “Transient Situational Personality Disturbance” (APA, 1952). Included under this heading was the diagnosis of Gross Stress Reaction, which defined psychic disturbance related to combat or civilian catastrophe. Under the same heading, other stress related conditions were given the labels of Adult Situational Reaction, and Adjustment Reaction of; infancy, childhood adolescence or late life (APA, 1952).

**DSM-II.** In 1968, a revised edition of the DSM was released. The DSM II reclassified traumatic experience into a category called “Adjustment Reaction of Adult Life.” There was no longer a description of the diagnosis, and criteria were now explained through the provision of three examples of qualifying experiences. These experiences were unwanted pregnancy, military combat, and being sentenced to death (APA, 1968). There was an asterisk next to the category that directed the reader to the appendices where additional examples of similarly qualifying stressful events could be found. These events included railway, car, boat, and plane accidents (Wilson, 1995). There was cause to wonder about the lack of explication of the various types of trauma and the resultant psychological manifestations, but clearly, the intent of the authors was to provide an inclusive category within which to place reactions related to all traumatic experiences that resulted in anxiety, fear, and feelings of overwhelming loss of control (Wilson, 1995; van der Kolk, 2006).

Until the 1970’s the majority of the work around traumatic disorders centered on combat or disaster related conditions, but with the advent of the women’s liberations
movement, issues related to the “tyranny of private life” of women began to be examined (Herman, 1992). Early exercises of consciousness-raising groups soon led to open, and heretofore unprecedented, discussions of the psychological impact of rape, sexual assault, and the sexual subjugation of women for political purposes (Every & Lating, 1995; Herman, 1992). The field of psychiatry soon acknowledged that sexual assault led to psychological distress that substantially mimicked combat neurosis is its symptom presentation. Psychiatric nurses Lynda Holmstrom and Ann Burgess observed a pattern of numbing, increased startle response, nightmares, dissociative symptoms, nausea, and insomnia in rape victims who presented themselves for treatment at Boston Hospital (Burgess & Holmstrom, 1974). Labeling this pattern of symptom presentation “Rape Trauma Syndrome” Burgess and Holmstrom (1974) spurred the field to consider an even broader definition of traumatic victimization.

A broadened view of traumatic victimization led to studies of chronic victimization, such as those experienced in circumstances of prolonged child abuse or the long-term battering of women. The symptom presentation that manifested in individuals who suffered through these types of experiences was found to resemble those of combat veterans. Further research on family violence validated that traumatic syndromes could, and indeed do arise from violence of an all too everyday nature (Gelles & Strauss, 1979).

**DSM-III.** In 1980, the third edition of the DSM realized another re-categorization of trauma related syndromes within the anxiety disorder section of the manual. The manual contained a new diagnosis, Post Traumatic Stress Disorder (PTSD), which encompassed combat neurosis, rape trauma syndrome, and battered women syndrome. Based substantially upon Kardiner’s 1941 work, the diagnosis was a
compendium of symptoms culled from clinical records, research, and literary explorations of those working within the fields of the various trauma related syndromes (van der Kolk, 1996). The symptoms of PTSD were clustered into three distinct categories from which an individual needed to exhibit four symptoms in order to meet criteria for diagnosis. These clusters encompassed symptoms of re-experiencing the trauma, the display of the effects of numbing and detachment, and changes in personality. In order for diagnostic criteria to be met, the manual further specified the need for the “existence of a recognizable stressor that would evoke distress in almost everyone” (APA, 1980). This statement of the necessity of a recognizable stressor replaced the previously provided list of examples of qualifying traumatic events that were present in earlier editions of the manual. Although there appeared to be tacit understanding that certain types of events would be particularly distressing, there was no discussion of etiology or dissection of how human perception of events as traumatic can vary from person to person (Everly & Lating, 1995). The notion of the variability of human perception of events as traumatic became a salient feature of the diagnosis of PTSD in future iterations of the DSM and will be discussed further in this review.

**DSM III-R.** In 1987 the DSM III-R was published with further revisions to the diagnosis of PTSD. In an attempt to provide clarification of what constituted a traumatic event or recognizable stressor, the phrase “outside of the range of normal human experience’ was added to the criteria (APA, 1987). Further, a list of examples of qualifying events was again provided. These examples included serious harm or threats of serious harm to self, children, spouse or other loved ones, seeing another person killed or seriously injured as a result of violence or accident, and experiencing the sudden
destruction of one’s home (APA, 1987). Of note, traumatic events that were within the realm of normal human experience, such as being the victim of a violent crime or experiencing or witnessing a serious automobile accident, that we now view as highly traumatic and potential triggers for PTSD, were not included in the description (Spitzer, 2007). Additionally, the list of symptoms was expanded to 17 while the number of symptoms necessary for diagnosis was increased to six. The final significant change in the DSM III-R diagnostic criteria for PTSD was the extension of special qualifiers that related to the manifestation of the disorder in children. Heretofore, the field promulgated the assumption that children experienced, processed, and exhibited symptoms of traumatic exposure in much the same way as adults, if at all. The DSM III-R, clarified that children may display disorganized or agitated behavior instead of the fear, helplessness or horror listed as adult symptoms under criteria A (APA, 1987). Under criteria B, definition was provided that children may demonstrate repetitive play with themes related to the trauma instead of having intrusive recollections, and further, that children’s dreams may be frightening but without recognizable content of the trauma as would be present in adult experiences (APA, 1987). Although the revisions were intended to provide clarity and a re-focusing of PTSD as a disorder, debate continued well into the preparation of the DSM IV.

**DSM IV.** The 1994 revision of The Diagnostic and Statistical Manual again brought substantial changes to the PTSD diagnosis. The statements regarding the need of the stressor to “cause distress in most everyone” and to be “outside of the normal range of human experience” were removed from the criteria in an effort to more explicitely define trauma and address the problem of common, yet clearly traumatic events being excluded
from the criteria. There were those who suggested that the stressor be defined in more subjective terms. Most notably were Solomon and Canino (1990) who advocated that qualifying circumstances or traumas should be defined in a sweeping and general manner, such as an “extremely shocking event”, that would speak to the subjective perception of the individual and provide for broad inclusion of experiences. Others advocated for a more objective classification that would further delineate the symptom and response presentation necessary for differential diagnosis (Lasiuk, 2006; van der Kolk, 2007). Eventually, a combination of subjective and objective criteria were combined within criterion A. Criteria A1 addressed the subjective nature of traumatic exposure by defining a qualifying event as one in which the individual “experienced, witnessed, or was confronted by an event or events that involved actual or threatened death, serious injury, or a threat to the physical integrity of self or others” (APA, 1994). The addition of criterion A1 mitigated the previous omission of consideration of the subjective or perceptual reality of the individual who experienced the event. The external nature of the event sustained the notion that the etiology of the disorder is external to the individual. Criteria A2 addressed the need for an objective component of the definition by describing the individual’s response as one that demonstrated “intense fear, helplessness, or horror (APA, 1994).” These changes propagated the controversy surrounding the diagnosis by, perhaps, going too far with the notion of perception with the wording “confronted with” in criteria A1. As a broad concept open for significant interpretation, the addition of this wording substantially expanded the number of individuals that met the criteria for the disorder and allowed for conceptual bracket creep or a stretching of the boundaries of the diagnosis beyond categorical limitations of earlier
definitions (McNally, 2003). The last substantive change to the diagnostic criteria of PTSD in the DSM-IV was the addition of specifications regarding the duration of symptoms. Delimited were timeframes of acute, which was defined as duration of symptoms of less than 3 months, chronic, with duration of symptom presentation of 3 months or more, and delayed onset with a symptom presentation that did not appear until 6 months or more after exposure to the stressor (APA, 1994).

In an attempt to separate what could be viewed as an early, simple reaction to traumatic exposure from the more chronic, debilitating sequelae of PTSD, a new trauma related disorder was included in the DSM IV. Placed within the anxiety disorder category, Acute Stress Disorder (ASD) had many of the same diagnostic criteria as PTSD, but had an onset of occurrence of symptom presentation within one month of the traumatic exposure and was described as lasting for at least 2 days and for a maximum of 4 weeks (APA, 1994). Additionally, ASD criteria included the presence of three of more dissociative symptoms from a list of 5 provided (APA, 1995). Some have argued that the high rates of individuals who progress from ASD to PTSD and the shared symptom profile of the two disorders strongly points to ASD as an early form of PTSD, not a separate condition (Koopman, Classen, Cardena, & Spiegel, 1995; Marshall, Spitzer, & Liebowitz, 1999). By extension, PTSD can be viewed as an interrupted or impaired recovery from an early, intense stress response or ASD. The controversy regarding the validity of ASD and PTSD as separate conditions has prompted some in the field to advocate for a spectrum based view of PTSD and trauma related disorders (Lasiuk & Hegadoren, 2007).
**DSM IV-TR.** In 2000, the American Psychiatric Association released the DSM IV-TR. There were no substantive changes to the diagnostic criteria in this edition. Rather, as the last edition was published some 16 years prior and the next full revision was not expected until 2012 at the earliest, changes in the descriptive text were made to reflect the current state of research and empirical literature. Debate continued to rage regarding trauma related disorders and there were many proposed changes for the DSM V. Today, events such as the terrorist attacks of 9/11, the Oklahoma City bombing, the shootings at Columbine High School and the University of Tennessee, and the 2010 earthquakes in Haiti and Chile, have again brought the exploration of the human response to extraordinary circumstances to the forefront of social science.

**DSM V, proposed changes.** According to the American Psychiatric Association, proposed changes to the diagnostic criteria for PTSD in the DSM V are numerous. All of the following information is available on the APA web site. Possibilities listed for changes in criterion A include an expansion of the section to include 4, more clearly defined ways an individual may experience a traumatic event. In addition to personal experience and witnessing the experience of others, proposed are learning that an event happened to a close relative or friend, and experiencing repeated or extreme exposure to aversive details of the event as in the situations of police officers, social workers and first responders. Clarification is proposed that witnessing or re-experiencing of aversive details does not include exposure through electronic media. The exclusion of electronic media brings into question such occurrences as the experience of 9/11 when people repetitively watched televised images of the planes flying into the World Trade Center.
towers. I would argue that there are individuals that suffered stress reactions from that electronic exposure.

The APA lists the potential changes to criterion B as clarification in the wording of symptoms, such as adding that recollections may be cued or be spontaneous. Criteria B3 faces potential amendments that delineate dissociative reactions may occur along a continuum of severity with the most severe being complete loss of awareness of present surroundings. Additional changes in this criterion are the removal of the mention of symptom presentation related to awakening or substance abuse issues.

Criterion C is slated to focus primarily on avoidance of stimuli that are associated with the traumatic event. There a 3 proposed items that differentiate types of avoidance. C1 describes thoughts, feeling or physical sensations that arouse recollection. C2 addresses activities, places, physical reminders, or times that arouse recollections. C3 is proposed to refer to people, conversations or interpersonal situations that arouse recollection. These criteria are proposed to be separated from criterion D which would now address negative alterations in cognitions and mood.

Criterion D is slated to include the following new items; inability to remember an important aspect of the traumatic event(s) (typically dissociative amnesia; not due to head injury, alcohol, or drugs). Persistent and exaggerated negative expectations about one’s self, others, or the world (e.g., “I am bad,” “no one can be trusted,” “I’ve lost my soul forever,” “my whole nervous system is permanently ruined,” “the world is completely dangerous”), persistent distorted blame of self or others about the cause or consequences of the traumatic event(s), pervasive negative emotional state - for example: fear, horror,
anger, guilt, shame, or a persistent inability to experience positive emotions (e.g., unable to have loving feelings, psychic numbing) (APA, 2010).

Criterion E is proposed to encompass the changes trauma exposed individuals may experience in their general state of arousal and reactivity. The items listed are the same as under criterion D in the DSM IV-TR, but include the addition of “engagement in reckless or self-destructive behavior.” It is important to note that a suggested change of significance is the reorganization of the symptoms of PTSD into 5 distinct criteria that differentiate between the experience or stressor, intrusive symptoms, avoidant symptoms, cognitive and mood changes, and alterations in arousal or reactions. Additionally, there are proposed clarifications in symptom presentation of children, such as the inclusion of language related to the loss of a parent. Still in discussion are the developmental manifestations that refer to age-specific criteria.

**Rates of Occurrence and Controversy**

There are myriad studies that attempt to examine the correlation of traumatic exposure and the development of PTSD. The DSM IV-TR delimits PTSD rates as being between 1% and 14% of the general population (APA, 1994). Many studies have looked at the epidemiology of PTSD with respect to specific populations such as war veterans, sexually abused children, and disaster victims, but few have examined the general population and rates of occurrence PTSD. States rates are, therefore, and extrapolation from studies of specific populations.

There have been disparate findings regarding the prevalence of exposure to qualifying traumatic events. It is widely assumed that a large percentage of the population has at least one traumatic exposure during their lifetime (Breslau, 2002, Green et al.,
1994, Canckwerts & Leathem, 2003). Epidemiological studies have produced traumatic exposure rates that range from 40% to 90% of the general population (Breslau, 2002). Studies suggest that although the rate of traumatic exposures that meet the DSM IV definition is quite common, and between 23% and 33% of trauma exposed individuals go on to develop some PTSD like symptoms, only 5% to 14% of individuals develop symptoms with significant enough severity to meet diagnostic criteria for PTSD (Breslau, 2002; McCarroll et al 1997; Yehuda, 1992). Questions remain regarding the interpretation, expansion, and potential revisions to the diagnostic criteria, the classification of “traumatic events”, and the accuracy of reported rates of occurrence.

Since its conception and inclusion in the DSM, the diagnosis of PTSD has spawned controversy and disagreement among experts in the field of traumatology. Of concern has been the difficulty in delineating the disorder from other diagnosis and comorbid conditions (Davidson & Foa, 1991). Early epidemiological studies found that almost 80% of people diagnosed with PTSD had a concurrent or previous psychiatric disorder (Lasiuk & Hegadoren, 2006; Helzer et al, 1997). Later studies confirmed rates of comorbid occurrences of psychiatric disorders of 83% across genders (Breslau et al, 1991) with 79% of women and 88% of men (Kessler et al, 1995) meeting criteria for another psychiatric diagnosis. Among the general population, the rate of occurrence of psychiatric disorders is estimated to be 20% (U.S Surgeon General Report 2009). Symptoms of major depressive disorder, generalized anxiety disorder, dissociative disorder, and psychosis can all be part of the diagnostic features of PTSD. It remains difficult to ascertain which condition came first. Further, the symptom presentation of PTSD is quite varied in severity as well as duration. Some suggest the perhaps the best
and most efficacious approach is to re-conceptualize the diagnosis as a spectrum disorder rather than a single entity (Lasiuk & Hegadoren, 2006). Regardless, with the examination of the criteria remaining under scrutiny for the coming revision of the DSM, the controversy is likely to continue to that edition and beyond.

**Helping at a Cost**

A significant body of research documents and explores the potential costs or hazards of providing mental health treatment to individuals who have suffered traumatic exposure. Just as those who directly experience trauma can be psychologically impaired, so too can be the helper who participates in the treatment of traumatized individuals. This vicarious or secondary exposure can take a variety of different forms that may be present co-morbidly or alone.

**Counter Transference**

The reactions of individuals treating traumatic syndromes were first viewed through the lens of the construct of counter-transference. Freud first illuminated this phenomenon in his 1910 essays on the techniques of psychoanalysis: “we have become aware of the ‘counter transference,’ which arises in the [physician] as a result of the patient’s influence on his unconscious feelings” (Freud, 1910 p. 144). The process of counter transference was, and has been, explored extensively as a possible interference with the therapeutic process that must been addressed, managed and harnessed (Wilson, 1995; Hayes, 2004; Schneider, 2005). More modern theoretical interpretations define counter transference from a broader perspective as a normal part of the joint relationship between helper and client. The empathetic reactions within the helper can be a source of
information about the client’s experience and can be used as a tool in the therapeutic process (Gabbard, 1995, 1999; Abend, 1989).

The primary development of counter transference lies within the personal characteristics of the professional. Hayes (2004) describe the phenomenon as being elicited by the client’s traumatic material, but being based upon the clinician’s pre-existing self, such as childhood issues, inner conflict, and unconscious processes. Counter transference issues arise when the helper cannot manage identification with the client and the client’s experience (Harrison & Westwood, 2009). Wilson and Lindy (1994) discuss counter transference over identification as excessive advocacy, enmeshment and idealization of the client by the clinician, which may be accompanied by perceived shame or guilt and feeling of inadequacy regarding treatment efficacy. Wilson and Lindsay (1994) further describe avoidance counter transference which is characterized by denial, detachment, disengagement from an empathetic response, and minimization of the clients’ issues. The primary concern regarding counter transference is the potential for the phenomenon to interfere with the therapeutic process and negatively influence the outcome of treatment (Harrison & Westwood, 2009). The subject of counter transference is written about in voluminous detail that is well beyond the scope of this review. There are on-going debates as to whether or not all vicarious reactions to trauma are essentially variation on the theme of counter transference. The phenomenon is the start of the notion that a helping professional can be emotionally and cognitively affected through the work of sitting with the distress of another. Because the essence of counter transference is born from the empathetic response created by the helper projecting themselves into the phenomenological experience of the client (Winnicott, 1960), it is the foundational
construct of the notions of burnout, compassion fatigue, and vicarious trauma/secondary traumatic stress.

**Burnout**

Burnout is a concept that has been well researched and discussed in the literature since the 1970s (Gentry, 2002). Not a trauma specific condition, burnout is, nonetheless, a phenomenon related directly to the cost of caring for others and demands an overview in this discussion. Pines and Aronson (1988) defined burnout as a “state of physical, emotional and mental exhaustion caused by long term involvement in emotionally demanding situations” (Figley, 1995 p. 11). Figley (1995) further asserts that the condition is primarily in relation to the stressors of the workplace. Others define burnout as a “syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who ‘do people work’ of some kind” (Ackerley, Burnell, Holder, & Kurdek, 1988, p. 73). Although the definitions of burnout vary, there is a constancy that burnout is the negative emotional response on the part of the helper as a result of working with people in stressful and emotionally charged situations (Maslach, 1982; Kottler, 1993; Norcross, 2000). Burnout can be interpreted as a job stress that stems from the emotional strain of working with the negative or distressful circumstances of others (Everall & Paulson, 2004).

**Characteristics and measurements of burnout.** Maslach, Jackson, & Leiter (1996) developed the Maslach Burnout Inventory- Human Services Survey (MBI): the most widely accepted validated measure of burn out. Designed to evaluate levels of affect, the MBI assesses the three primary aspects of burnout. The emotional exhaustion sub-scale measures the extent to which clinicians feel emotionally overextended and
exhausted by their work (Maslach, Jackson, & Leiter, 1996). The depersonalization sub-scale measures impersonal responses or numbing towards clients and their circumstances (Maslach, Jackson, & Leiter, 1996). The final sub-scale assesses the clinicians’ feelings of competence and sense of successful achievement at work (Maslach, Jackson, & Leiter, 1996). The characteristic presentation of burnout in clinicians generally manifests in emotional exhaustion and a lack of self-efficacy (Ruysschaert, 2009; Maslach & Jackson, 1981). There may also be issues related to role confliction and ambiguity, and frustration regarding a lack of control over the work environment or institution (Putterman, 2008; Collins & Murray, 1996). Swearingen (1990) describes anger, boredom, loss of confidence, paranoia, rigidity of perception, somatic complaints, and irritability as additional symptoms common to individuals who are experiencing burnout.

One of the most problematic issues related to burnout is the propensity for helpers to be reluctant to acknowledge that they are experiencing the condition (Corey et al., 1998; Kottler, 1993). There is often a perception that experiencing burnout somehow indicates a weakness within or incompetence on the part of the helper who “should” know how to engage in sufficient self-care to prevent vicarious affects from occurring (Corey et al., 1998; Swearingen, 1990; Kottler, 1993). The perception of the burnout as a type of failure often promotes denial on the part of practitioners. Denial can lead to impairment in the provision of treatment (Everall & Paulson, 2004; Pearlman & Saakvitne, 1995; Corey, 1998). According to Sheffield (1998) over 6000 impaired counselors are currently providing services of a reduced quality to clients due to the negative effects of workplace stress.
Risk and protective factors of burnout. Substantial research has been conducted to attempt to elucidate what factors place helpers most at risk for the development of burnout. Bride (2004) identified age, gender, exposure levels, training occupation, personal trauma history, and trauma symptoms as the most commonly studied demographic variables with respect to burnout and other vicariously acquired syndromes. There appears to be little evidence to suggest that demographic variable play any major role in the development of burnout, save one, the personal trauma history of the helper (Bride, 2004; Emery, Wade & McLean, 2009). Characteristics that do seem to play a significant role in an increased risk for the development of burnout include perfectionist expectations and rigid expectations of progress (Pearlman & Saakvitne, 1995), the need for therapeutic and emotional control (Deutsch, 1984), intolerance for client emotional distress (Farber, 1983; Deustch, 1984), experience level of the clinician (Ruysschaert, 2009), and an inability to leave work issues at work (Killian, 2008; Ruysschaert, 2009).

Burnout is a condition that appears to have a strong correlation with the work environment and institutional climate (Figley, 1995). Research indicates that the pressures and everyday stressors of any job may be sufficient to cause burnout, but work with troubled, or difficult populations increases the risk (Bride, 2004; Maslach, 1982). Left unacknowledged and untreated, burnout can be expected to intensify into more severe impairments (Everall & Paulson, 2004; Mclean, Wade & Encel, 2003). It is of ethical concern for professionals to self-monitor for emerging symptoms of burnout and it is of equal importance for supervisors and other clinicians to monitor their colleagues. The American Counseling Association’s code of ethics C.2.g stresses the responsibility of the
association’s members to assist their colleagues and supervisors in recognizing their own impairment.

There are preventative strategies that have proven to be quite effective in staving off or reducing the incidence of burnout. Self-care strategies, such as meditation, hypnosis, taking naps, and positive visualization exercises serve to reduce work related stress and provide a necessary means of letting go (Figley, 1995; Backman, Arnetz, Levin & Lublin, 1997; Ruysschaert, 2009). Helpers also need to be provided with on-going, quality supervision. Supervision should provide a safe place to explore emotional distress related to the work and should assist the supervisee with the identification of appropriate outlets and resources for stress management (Figley, 1995; Maslach, 1982; Corey, 1998). Finally, education regarding the risks for the development of burnout, common symptoms, prevention strategies, and treatment should be incorporated into curricula for those entering the helping professions. Institutions and social service agencies should provide opportunities for professional development, peer-consultation, and group supervision to help normalize burnout as an expected result of the work to which no one is immune (Everall & Paulson, 2004; Pearlman & Saakvitne, 1995).

**Compassion Fatigue and Secondary Traumatic Stress**

As the research into the vicarious experiences of those in the helping professions moved forward, the terms compassion fatigue, secondary traumatic stress, and vicarious trauma began to appear in the literature. Often used interchangeably, there continues to be a lack of clarity regarding these constructs. Recently, attempts have been made to delineate these syndromes from one another so as to provide a mechanism by which to
organize the current research so the profession can effectively use it (Baird & Kracen, 2006; Dunkley & Whelan, 2006).

Figley (1983) first began his examination of vicarious reactions to traumatic stress by looking at the responses of concerned family members who had secondary exposure to the trauma of a loved one. Figley (1995) found that caregiver responses often mimicked the PTSD symptoms of the individual who had directly experienced the trauma. Labeling this phenomenon secondary traumatic stress (STS), Figley (1995) went on to broaden his research by including professional caregivers into his explorations. With a focus on mental health professionals who work in the exclusive environment of trauma care, Figley (1995) found that the task of empathizing with, and providing emotional support to victims of trauma placed a unique psychological strain upon the practitioner. Figley (1995) referred to this construct as compassion fatigue (CF) and defined it as “the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other and the stress resulting from helping or wanting to help a traumatized or suffering person” (Figley, 1995 p.7). The change in nomenclature from STS to CF resulted from Figley’s contention that the condition is a normal, occupational hazard for those who work with trauma survivors and CF provides a less stigmatizing label than STS (Jenkins & Baird 2002; Figley 1995). There are those who suggest that these terms can be used interchangeably (Figley, 1995; Baird & Kracen, 2006; Harrison & Westwood, 2009) and those who find subtle differences between the two constructs (Sabin-Farrell & Turpin, 2003; Dunkley & Whelan, 2006). Central to this disagreement seems to be the notion that STS is a condition that results specifically from work with victims of trauma while CF, like burnout, can occur with any type of client work (Sabin-
Farrell & Turpin, 2003; Dunkley & Whelan, 2006). For the purposes of simplicity, the term CF will be used throughout the remainder of this work, bowing to the current convention of Figley, the father of the construct (Figley, 1995; Adams, Boscarino & Figley, 2006).

**Characteristics and measurement of compassion fatigue.** Focusing little attention on etiology or context, the construct of CF is primarily centered on observable symptoms of distress based on the diagnostic conceptualization of posttraumatic stress disorder (Dunkley & Whelan, 2006; Jenkins & Baird, 2006; Figley, 1995). Figley (1995) categorized the domains of the symptoms of CF according to DSM criteria for PTSD. The domains, consistent with PTSD, were re-experiencing the primary survivor’s traumatic event, avoidances of reminders and/or numbing in response to reminders, and persistent arousal as the organizational framework for CF symptom presentation (Figley, 1995; Jenkins & Baird, 2002). As with PTSD, clinicians can be observed to exhibit symptoms including intrusive and disturbing imagery related to the client’s traumatic disclosures (Herman, 1992; McCann & Pearlman, 1990), somatic complaints (Herman, 1992), and compulsive or addictive behaviors (Pearlman & MaIan, 1995). Unlike burnout, which is most commonly a lengthy process that builds gradually through prolonged work, persistent job strain, and loss of self-efficacy related to job performance (Maslach, 1982), CF generally presents quite suddenly as result of the trauma described by clients, rather than occupational stress or pressure (Figley, 1995; Sabin-Farrell & Turpin, 2003). If untreated, the normal reaction of a clinician who is experiencing CF may become pathological and progress to a condition now referred to as Secondary Traumatic Stress Disorder (STSD). Similar in symptom presentation to CF, and having a
nearly identical diagnostic presentation as that of PTSD, STSD is characterized by symptoms that persist for six months or more post the triggering event (Canfield, 2005: Figley, 1999).

There are a number of instruments, such as the Compassion Fatigue Self-Test (Figley, 1995), Professional Quality of Life Scale (ProQOL) (Stamm, 2005), and the Trauma Symptom Checklist (Elliot & Briere, 1991) that have been designed to measure the presence and severity of CF or STS in helping professionals. Throughout the past two decades, these instruments have been modified in attempts to improve content validity. The validity of the instruments remains problematic due to the lack of clarity in definition between the multiple constructs that describe vicarious exposure to trauma (Sabin-Farrell & Turpin, 2003; Harrison & Westwood, 2009; Jenkins & Baird, 2002). Instruments such as The Secondary Trauma Questionnaire (Motta, Kefer, Hertz & Hafeez, 1999) have been specifically designed to attempt to elucidate and narrow the construct of STS/CF, but questions remain. There continues to be debate as to the veracity of CF, STS, vicarious trauma (VT) and burnout as separate constructs versus they idea that they are merely components of the same syndrome (Jenkins & Baird, 2002, Harrison & Westwood, 2009; Baird & Kracen, 2006).

**Risks and protective factors of compassion fatigue.** Related to the measurement of CF are studies that have been conducted in order to attempt to identify individual characteristics in clinicians that create a propensity for the development of CF. It is of particular interest that some clinicians seem to be able to withstand the emotional stress of trauma work without symptom development, while some experience mild, but manageable symptoms, and still others develop full-blown debilitating STSD. If the
etiology of CF is due to vicarious exposure to the traumatic experiences of others and is not due to internal flaws, weaknesses or deficits within the helper, then what factors contribute to the development of CF? There appears to be a correlation between increased CF and helpers with personal trauma histories (Good, 1996) and to the amount of training and education a helper has received (Rudolph, Stamm, & Stamm, 1997). As with burnout, there are few studies that identify demographic variables as significant influences.

There have been explorations of what types of environmental factors may increase the risk for the development of CF. Findings indicate that working exclusively with a traumatized population, and being a novice practitioner appear to be factors consistent with an increased risk for CF (Harrison & Westwood 2009). Further research needs to be conducted to explore the personal characteristics of those who experience CF and STSD to ascertain the salient risk factors. As the primary mechanism for gathering data is self-report, via questionnaire or interview, this may be a difficult endeavor. Significant stigma is present in admitting that one has been negatively affected by the work. Efforts need to continue to be made to normalize the experience of CF in clinicians in order for accurate data to be collected.

As with burnout, the implication of studies regarding CF for those in the helping professions also points to the import of preventative strategies and education as a vital part of ensuring helper wellness (Pearlman & Saakvitne, 1995; Figley, 1995; Stamm, 1995). Education, on-going clinical supervision, and self-care strategies are all important in the minimization of risk factors for developing CF.
**Vicarious Trauma**

Vicarious trauma, a term first coined by McCann and Pearlman (1990) is a construct that is related to counter transference, burnout and compassion fatigue as its etiology is found in the experience of the stress of helping others. Unlike counter transference, where the emphasis is on the helper’s personal characteristics in response to the client’s trauma (Dunkley & Whelan, 2006), and burnout, where the emphasis is placed on the general stressors of the work environment (Maslach, 1982), vicarious trauma emphasizes the psychological effects of working specifically with individuals who have experienced trauma (McCann & Pearlman, 1990). Unlike CF or STS, vicarious trauma does not focus on the observable, PTSD-like symptoms that a helper may manifest as a result of being secondarily exposed to trauma, but rather, VT concentrates on the inner experience of the helper (Pearlman & Saakvitne, 1995; McCann & Pearlman, 1999; Steed & Downing, 1998).

McCann and Pearlman ground the concept of VT in what they called Constructivist Self-development Theory (CSDT) (McCann & Pearlman, 1990). CSDT suggests that individuals actively construct their reality through the on-going development of cognitive schemas or mental frameworks (Iliffe & Steed, 2000; Pearlman & Saakvitne, 1995; McCann & Pearlman, 1990). A mechanism by which to make sense of one’s experiences, cognitive schemas include expectations regarding the world and self, beliefs, and assumptions (Iliffe & Steed, 2000; Pearlman & Saakvitne, 1995; Fiske & Taylor, 1984). According to Pearlman & Saakvitne (1995 p.31), VT “is a process through which the therapist’s inner experience is negatively transformed through
empathic engagement with client’s trauma material.” Pearlman and Saakvitne (1995 p. 280) further describe the disruptions in the helper’s frame of reference as follows;

Multiple aspects of the therapists and their life are affected, including their affect tolerance, fundamental psychological needs, deeply held beliefs about self and others, interpersonal relationships, internal imagery, and experience of their body and physical presence in the world.

McCann and Pearlman (1990) argue that these changes to a helper’s world view or cognitive schema are cumulative, pervasive, and permanent (Baird & Kracen, 2006). A strength of CSDT is that it stresses that the development of a person’s foundational cognitive schema is a result of his or her interactions in the world, and is, therefore, highly individualized. This individualization of experience helps provide explanation into the variation in responses among people who experience the same traumatic event (Dunkley & Whelan, 2006; Pearlman & Saakvitne, 1995; McCann & Pearlman 1990).

Through a review of the literature, McCann & Pearlman (1990) identified seven fundamental psychological needs that may be challenged through working with trauma survivors including: safety (feeling safe from harm), intimacy (feeling a sense of connectedness to others), esteem (feeling valued and to value others), power/control (feeling able to direct or manage one’s experience, both internally and externally), trust/dependency, independence and frame of reference (ability to make attributions as to why events occur) (Dunkley & Whelan, 2006; Iliffe & Steed, 2000; Steed & Downing, 1998). Vicarious exposure to trauma disrupts these schemas with severity in accordance with those schemas that are most salient or central to the individual’s world view (Iliffe & Steed, 2000; Pearlman & Mac Ian, 1995; McCann & Pearlman, 1990). There is
evidence to suggest that the type of trauma with which a helper works may influence upon what schema changes are affected. For example, individuals who work with victims of violence, and natural disasters may be most affected in schemas that pertain to safety, trust, and control (Dunkley & Whelan, 2006; Iliffe, 2000).

McCann & Pearlman (1990) identified three conditions that promote the experience of vicarious trauma which are specific to helping work with individuals who are trauma survivors. These include: empathic engagement with exposure to graphic and traumatic subject matter, empathic engagement to the reality of the capabilities of human cruelty, and the helper’s participation, through therapeutic interaction, in traumatic reenactments of elements of the client’s trauma experience (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). It is these trauma specific elements that lead to cognitive dissonance and symptom development.

Although the concept of VT emphasizes the role of meaning and adaptation rather than symptoms (Canfield, 2005) there are common, observable symptoms associated with the experience of VT. As with CF, those who suffer from VT may experience symptoms of flashbacks (Ilffe & Steed, 200), intrusive imagery (Way et al, 2004; Pearlman & Mac Ian, 1995), hyper-vigilance (Steed & Bicknell, 2001), psychic numbing, avoidance, decreased libido, and increased substance abuse (Pearlman & Mac Ian, 1995; Rich, 1997) that mirror the diagnostic criteria for PTSD. Emotional distress may be evidenced by anger, irritability, and feelings of shame, guilt, fear, shame and grief which the helper may have difficulty controlling (Steed & Downing, 2000; McCann & Pearlman, 1990).

**Characteristics and measurement of vicarious trauma.** As with CF and burnout, VT is generally measured through self-report and questionnaires which are
focused on changes in beliefs and symptom presentation. It is this blending of symptoms related to changes in schema and behavioral symptom manifestation that contributes to the on-going confusion between the constructs of CF and VT. In order to attempt to keep a narrow focus, Pearlman, Mac Ian, Johnson, & Mas (1992), developed the Traumatic Stress Institute (TSI) Belief Scale. This instrument is designed to assess the possible changes in the cognitive schemas of safety, independence, trust/dependency, intimacy, control/power, and esteem (Sabin-Farrell & Turpin, 2003; Pearlman, Mac Ian, Johnson, & Mas, 1992). There continues to be controversy as to the efficacy of these tools and their ability to distinguish between the emotional fatigue, exhaustion, and depersonalization that defines CF and the reduced sense of personal achievement and purpose that define burnout appears to be somewhat limited (Betts et al, 2001; Kadambi & Truscott, 2003).

**Risks and protective factors of vicarious trauma.** For the past decade, a significant body of research has focused on the specific factors that lead to the development of VT. As much of the empirical data seems to conflict, there is agreement within the field that the current literature is insufficient in scope to provide definitive conclusions regarding what factors lead to the development of VT and what practices may reduce its potentially harmful effects (Harrison & Westwood, 2009; Arvay, 2001; Figley, 2004; Pearlman, 2004). Research into the influence of different types or specifics of trauma on the development of VT has proven to be inconclusive (Kadambi & Truscott, 2004; Schauben & Frazier, 1995). Also inconclusive have been the studies of the influence of the personal trauma history of the helper (Sabin-Farrell & Turpin, 2003; Jenkins & Baird, 2002). It does appear that the helper’s level of experience and education
(Adams et al, 2001; Pearlman & Mac Ian, 1995), the number or percentage of trauma cases on a helper’s caseload (Bober and Regehr, 2006; Kassam & Adams, 1995), and the availability of social support (Ortlepp & Friedman, 2002) all play a role in the development of VT.

Another area of research interest is the elucidation of what protective strategies can be employed to help ameliorate the potential for VT. There has been a focus on including curricula on VT in counselor training programs, the development of specific self-care strategies for helpers, and the importance of quality clinical supervision (McCann and Pearlman, 1995). Of significant interest is the growing movement that suggests a more positive approach toward the work of trauma care as the best preventative strategy. The salutogenic approach to trauma work will be discussed later in this chapter.

Of final importance, there is also a body of research that suggests the impact of vicarious trauma on counselors is negligible (Kadambi, 2005, Sabin-Farrell & Turpin, 2003). These studies conclude that the means previously used to assess the development of symptoms attributed to VT were limited in scope and therefore, limited in interpretability (Kadambi, 2005). Although there is not contention that the work of trauma intervention can have negative implications for the care giver, there is contention that the resultant symptomatology is typical and not pathological, that VT is rare not widespread, and that it is of a separate nature than counter transference reactions and burnout (Adams, 2001; Kadambi & Truscott, 2003).
Salutogenic Approach to Trauma Care

Referred to as Positive Psychology (Seligman, & Csikszentimihalyi, 2000), Salutogenics (Volanti, Patton, & Dunning, 2000), and stress related or Post Traumatic Growth (PTS) (Tedeschi & Calhoun, 1995), a positive approach to the study and treatment of the effects of traumatic exposure has been increasing in favor over the past decade. Not a new concept, the idea that individuals can, and do, derive benefit and positive change from adversity is present in the works of Aristotle, the religious tenants of Christianity, Judaism, and Buddhism, and the writings of many of history’s greatest philosophers. Existential human dilemmas, as described by Erich Fromm (1947) and Victor Frankl (1961), produce growth as people face the tragedies of life and find meaning within them. In his 1977 work “Healing and Wholeness,” Sanford (p. 20) describes the existential psychology of growth or individuation as follows:

Individuation is a work, a life opus, a task that calls upon us not to avoid life’s difficulties and dangers, but to perceive the meaning in the pattern of events that form our lives….It does not necessarily mean happiness, but growth. It is often painful, but fortunately, it is never boring. It is not getting out of life what we think we want, but it is the development and purification of the soul.

It is this notion of growth, adversity and meaning making that forms the foundation of a salutogenic approach to traumatic exposure. There are a number of distinct constructs within the field of trauma-related positive change. What follows is an overview of the constructs currently being examined through empirical studies.
Resilience

The word resilience is from the Latin root resilere, which means “to jump back”. It is defined as “the power or ability to return to the original form, position etc., after being bent, compressed, or stretched; elasticity” (Webster’s, 2009). When applied to the psychology of trauma, resilience has been defined as emotional stamina (Wagnild & Young, 1990), a buffering factor which protects the individual from psychopathology (Rutter, 1987), and protective factors that foster the development of positive outcomes (Luthar, Cicchetti, & Becker, 2000). These definitions imply that resilience is the ability to adapt or overcome extreme adversity or stress without suffering long lasting pathology or debilitating effects (Garmezy, 1991, Masten, 2001). According to Bonanno (2008, p.2) resilience is not the simple absence of a pathological response to trauma, but the demonstration of “transient perturbations in normal functioning (e.g., several weeks of sporadic preoccupation or restless sleep) but general exhibition of a stable trajectory of healthy functioning across time, as well as the capacity for generative experiences and positive emotions”. Resilience theorists propose that resilience, rather than pathology and distress is the normal human reaction to the experience of traumatic exposure (Russ, Lonne & Darlington, 2009; Bonanno, 2004).

Resilience in children. A large portion of the research conducted regarding resilience has been focused on children who experience sexual abuse (Moylan, 2010), exposure to domestic violence (Moylan, 2010; Howell, 2010; Kitzmann, Gaylord, Holt, & Kenny, 2003), poverty (Abelev, 2009; Garmenzy, 1991), and war (Bentacourt, Kahn, 2008; Berk, 1998). Primarily centered on the exploration of what factors enable children to “bounce back” in the face of adversity, the empirical research available provides a look
into both the internal and external conditions ripe for hardiness. Additionally, significant research has been conducted to determine methodology and constructs by which to measure the notion of resilience (Wagnild, 2009; Smith, Dalen, Wiggin, & Tooley, 2008; Madsen & Abell, 2010).

**Factors that contribute to resilience in children.** In the middle of the last century, Werner and Smith (1982) conducted one of the premier studies to examine the construct of resiliency in children. In a longitudinal study that followed 698 children born on the island of Kauai in 1955, Werner and Smith (1982) evaluated the influence of the stressors of poverty, parental psychopathology, and unstable family units upon the successful functioning of the children as adults (Werner & Smith, 1982). The results showed that out of the 200 children who had been identified as “high risk” due to the severity of the stressors present, 70 developed into healthy adults (Werner & Smith, 1982). Labeled as “resilient”, healthy adults were identified as those who accomplished achievements that were comparable to that of children in the low risk group and who exhibited no legal entanglements, and no learning, or behavior problems (Werner & Smith, 1982). Further empirical studies have shown that external protective factors in the face of such stressors can help ameliorate the affects of trauma. The ability of mothers to promote effective coping and conflict resolution skills (Hines & Savdino, 2002), maternal mental health (Levendorsky, Huth-Bocks, Shapiro & Semel, 2003), effective, solid parenting (Levendorsky et al., 2003), and positive attachment to caregivers (Grych, Raynor, & Fosco, 2004) have all been identified as factors in the development of resiliency in children. Conversely, there seems to be a correlation between the amount and severity of the trauma, and the ability of children to display characteristics of
resilience (Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003). It appears that the more severe and lasting the traumatic condition, the less likely children are to be able to adapt and spring back (Wolfe et al., 2003).

But what of children who, like those in the high risk category of the Werner and Smith study, come from home lives lacking in support and external protective factors? From where does resiliency in these children stem? Recent studies have begun to focus on internal aspects such as emotions, attitudes, beliefs, and cognitive processes that may foster resilience (Jew & Green, 1998; Dumont & Provost, 1999). In her 2001 review of the literature, Adrian Van Brenda discriminated the following characteristics contributing to resiliency in children; they had an outgoing, socially open, cooperative, engaging, likeable personality, they were able, from infancy on, to gain other people’s positive attention, their behavior was open, kind, and calm, they had good positive coping skills, had an active, evocative approach towards solving life’s problems that enabled them to negotiate emotionally hazardous experiences, and they tended to perceive their experiences constructively, even if the experiences caused pain or suffering (Benard & Marshall, 1997; Bogenschneider, 1996; Butler, 1997; Cederblad et al., 1994; Hawley & De Haan, 1996; Parker, Cowen, Work, & Wyman, 1990; Rutter, 1979; Werner, 1984, 1990).

**Resilience in adults.** Studies regarding resiliency in adults have been focused on specific areas of interest as well. Exploring topics related to health crisis (Affleck & Tennen, 1996), bereavement (Bonanno, Moskowitz, Papa & Folkman, 2005; Yalom, 1991), and a variety of traumatic exposures such as 9/11(Swickert, 2006; McTighe, 2000), the field of resiliency with respect to adult functioning has grown exponentially.
over the past decade. As with studies of children, adult resiliency studies have attempted
to broaden the notion of “bouncing back” as more than just the opposite of distress or
pathology (Russ et al., 2009). To date, most of the adult research has examined internal
variables, such as “hardiness” (Bartone, 1999) or self-enhancement (Bonanno; 2007;
Bonanno, Rennicke, & Dekel, 2005). In 1993, Waginold & Young published the
Resilience Scale. This instrument attempted to assess levels of resiliency based on five
characteristics that were identified by Waginold & Young in their 1990 study of women
who had adapted successfully to a major life event. The five characteristic of resilience
were: perseverance (willingness to continue to struggle in the midst of adversity),
equanimity (being able to take what comes and moderate extreme responses to adversity),
meaningfulness (the idea that life has a purpose), self-reliance (trust or belief in one’s self
and abilities), and existential aloneness (the idea that everyone is unique and experiences
and lives life on their own) (Waginold & Young, 1990, 1993; Waginold, 2009). These
internal cognitive processes appear to be strongly correlated with adults’ abilities to
experience significant life stressors and return to previous levels of functioning.

Factors that contribute to adult resilience. External components have also been
explored with respect to adult resiliency. As with children, level of social support has
been found to be a factor that contributes to resiliency in adults (Call, 2009). Individuals
that have attachments to others and their community seem to face adversity with a much
greater chance of avoiding pathological responses than do their isolated counter parts
(Call, 2009; Norris, Stevens, Pfefferbaum, Wyche, Pfefferbaum, 2008). Attachments to
others appear to play a major role in the development of resiliency in adults (Fraley,
Bonanno, 2004; Roche, Runtz, & Humter, 1999; Runtz & Shallow, 1997). Other
interesting findings regarding the propensity toward resiliency have found that males, rather than females, Asians rather than Caucasians, and those free from chronic disease and pain are more likely to exhibit resiliency (Bonanno, 2007). Additionally, and somewhat surprisingly, individuals with higher levels of education and a greater potential for significant changes in income as a result of adversity were less likely to be measured as resilient (Bonanno, 2007).

**Controversy regarding resilience.** There is disagreement in the field of psychology as to the definition of resilience, the commonness of the experience, and the limitations of the construct (Linley & Joseph, 2005; Kelly, 2004; Bonanno, 2004). Although there seems to be little controversy regarding the existence of human resilience related to traumatic exposure, the notion that resilience is commonplace continues to be in dispute (Bonanno, 2004; Litz, 2005; Roisman, 2005). Both Litz and Roisman (2005) point to decreased resiliency responses in individuals who suffer extremely aversive events as evidence that a more delineated factorial analysis should be conducted before resilience can be patently called “normative”. Still others dispute the limitations presented by the construct and validate that resiliency should be placed more along a continuum that stretches from pathological response, to adaptation, and beyond to growth (Linley & Joseph, 2005; Tedeschi & Calhoun, 2008; Parke, 2008).

**Post Traumatic Growth**

Beyond the construct of resilience is the notion that rather than merely “bouncing back” following a traumatic event, some people experience personal growth and positive change. In the recent psychological literature, these positive changes have been labeled stress-related growth (Park, Cohen, & Murch, 1996), adversarial growth (Joseph &
Linley, 2005), thriving (Carber, 1998), and flourishing (Ryff & Singer, 1998). Most currently, the concept of positive personal change that results from a crisis or traumatic event has been called posttraumatic growth (PTG) (Tedeschi & Calhoun, 1996). The concept of PTG does not discount the negative psychological experience of traumatic exposure, but emphasizes that in addition to negatives, the experience can lead to an enhanced sense of meaning and purpose in life that promotes personal change and growth (Smith & Cook, 2004).

**Domains of posttraumatic growth.** There is a significant body of literature that examines the phenomenon of PTG in relationship to specific types of trauma such as heart attacks (Affleck, Tennen, Croog & Levine, 1987), death of a loved one (Lehman et al., 1993), natural disasters (McMillen, Smith, & Fisher, 1997; Coffman, 1994), and rape (Burt & Katz, 1987; Frazier & Burnett, 1994). In these studies, between 10% and 90% of individuals reported that they experienced benefit from coping with a traumatic event (Tedeschi, Calhoun, & Engdahl, 2001). Empirical evidence suggests that those who endorse PTG experience that growth within five broad domains (Tedeschi & Calhoun, 1995).

**Strength.** The first domain encompasses changes in the perception of self with respect to strength. The most common change in the perception of self is that although there may be an increased sense of vulnerability, there may also be an increased sense that the individual is stronger, more capable, and better able to survive than they had previously believed (Janoff-Bulman, 1992; Tedeschi & Calhoun, 1992; Collins, Taylor, & Skokan, 1990). This shift can be readily observed in the studies of widows who report that upon the death of their spouse they had to assume new roles and responsibilities,
such as dealing with financial concerns and cars, and handling home repairs. These women reported an increased sense of self-efficacy as a result of their new accomplishments (Znoj, 2006; Calhoun & Tedeschi, 1990; Lund, Caserta, & Dimond, 1993). This increased sense of self-efficacy did not supplant their grief, but existed simultaneously. Examinations of the experience of individuals who suffer serious health crisis produce evidence that such experiences can create a sense that the individuals are “tougher” or more tenacious than they previously perceived themselves to be (Stanton, Bower, & Low, 2006). Individuals who report these changes express seeing them as positive results of their struggle.

**New possibilities.** The second domain is related to an increased sense that there are new possibilities for the future. It is common for individuals who have suffered a significant trauma to realign their everyday lives as a result of their experience (Tedeschi & Calhoun, 2006, 1990; Cadell, Regher, & Hemsworth, 2003). Many people adopt a new, enthusiastic, “carpe diem” attitude toward life that was previously absent. Others may change career paths or even choose to dedicate their lives to helping others who have experienced similar trauma. People such as John Walsh who spearheaded efforts around law enforcement and child abduction as a result of the kidnapping and subsequent murder of his son Adam, Cristy Lightner, founder of Mothers Against Drunk Drivers, which she began after her child was killed by a drunk driver, and Jim and Sara Brady who dedicated much of their lives to lobbying for gun control legislation after Jim was shot, all found a new calling or passion as a result of their traumatic experiences (McMillen, 1999).
**Relationships.** The third domain is changes in how the individual perceives and experiences relationships with others. The most consistently reported positive change that results from a traumatic exposure is improvement in human relationships (Affleck et al., 1987, 1991; Beach, 1997; Collins et al.; Curbow et al., 1993; Fontana & Rosenheck, 1998; Frazier & Burnett, 1994; McMillen & Fisher, 1998; McMillen et al., 1997; Tedeschi & Calhoun, 1996). Those studied reported having a deeper appreciation for family and friends, which resulted in closer relationships that were of a more meaningful nature (Tedeschi & Calhoun, 1990, 2006, Park 2008; Janoff, 2006). Further reported was an increased sense of how quickly relationships or people could be lost, which created an enhanced sense of the value (Affleck, Allen, Tennen, McGrade, & Ratzan, 1985, Znoj, 2006). Many people have experienced this exact phenomenon when faced with the sudden death of a loved one. Being confronted with the reality that life is finite and that the amount of time we have with a loved one is unknown seems to make other significant relationships all the more precious. The “wake up call” that life is short can alter an individual’s cognitive processes about the value of connectedness and change how they go about creating and maintaining relationships with others (Anderson & Lopez, 2008; Tedeschi & Calhoun, 2006, 1999).

**Appreciation of life.** The forth domain involves changes in the appreciation a person has for life. This can involve a change in perception about the general value of life (Affleck, Tennen & Gershmann, 1985; Putterman, 2008; Klass, 1986, 1987), or a feeling that one has been given a second chance that should not be wasted. There may be a significant shift in the priorities of life. Changes in behaviors such as spending less time at work and more time with family, focusing less on what one doesn’t have and more on
what one does have, and adopting more “don’t sweat the small stuff”, “take time to smell the roses” attitudes have all been found to be commonly reported areas of post-traumatic growth (Jordan, 2000; Calhoun & Tedeschi, 2006, 1995; Park, 1998).

**Spirituality.** Finally, the fifth identified domain is spiritual change. Although there is no dispute that traumatic exposure can have negative ramifications upon spiritual beliefs (Schwartzberg & Janoff-Bulman, 1991), people have been found to report that they have a renewed or strengthened sense of their religious beliefs as result of their struggle with trauma (Andrykowski, 1992; Calhoun & Tedeschi, 1989, 1999; Schwartzberg & Janoff-Bulman, 1991). Although it may seem somewhat paradoxical to have one’s belief in God strengthened through adversity, studies find that meaning making is often tied to religious constructs (Park & Folkman, 1997; Cadell, Regeher, & Hemsworth, 2003; Tedeschi & Calhoun, 2004). Individuals may express a sense that a higher power helped them through the struggle, that the struggle was a gift designed to promote growth, or even that the journey was part of a plan to be revealed later.

**Theoretical foundation of posttraumatic growth.** The theoretical foundations of PTG are a growing area of scholarly focus. There appear to be two basic conceptualizations of the phenomenon. Affleck & Tennen (1996) conceptualize PTG as a coping strategy employed to deal with extreme stress. Encompassed by an adaptive response view, coping theorists suggest approaches based on, meaning making (Park & Folkman, 197; Davis, Nolen-Howksema, & Larson, 1998), information processing (Filipp, 1999), and positive appraisal of self or positive illusion (Taylor, 1983). These views of PTG as coping mechanism suggest that it is an adaptive function for psychological adjustment after traumatic exposure.
Schaefer and Moos (1992), and Tedeschi and Calhoun (1995, 2004) originally conceptualized PTG as an outcome born from the struggle with traumatic events (Zoellner & Maercke, 2006). By revising their theory and relating it to constructivist self development theory, Tedeschi and Calhoun (2004) posit a theoretical conceptualization that validates PTG as both process and outcome. Tedeschi and Calhoun (2004) endorse that people actively construct their internal realities through external experiences. When exposed to traumatic events that are challenging to the person’s world view and established schemas, a cognitive processing occurs that can change the basic assumptions a person hold to be true (Tedeschi & Calhoun, 2004). Called rumination by Tedeschi & Calhoun (2004), this cognitive process can either lead to the construction of adaptive schemas and positive meaning (PTG) or to dysfunctional negative schemas, such as PTSD symptoms. It is this process that is illustrated in figure 1.

PERSON PRETRAUMA

SEISMIC EVENT

CHALLENGES

MANAGEMENT OF EMOTIONAL DISTRESS

FUNDAMENTAL SCHEMAS, BELIEFS & GOALS

LIFE NARRATIVE

RUMINATION-MOSTLY AUTOMATIC & INTRUSIVE

REDUCTION OF EMOTIONAL DISTRESS MANAGEMENT OF AUTOMATIC RUMINATION

DISENGAGEMENT FROM GOALS

RUMINATION-MORE DELIBERATE SCHEMA CHANGE NARRATIVE DEVELOPMENT

SOCIAL SUPPORT MODELS FOR SCHEMAS, COPING, POST TRAUMATIC GROWTH

ENDURING STRESS

POST TRAUMATIC GROWTH (5 domains)

WISDOM
Characteristics and measurement of PTG. There are a number of psychometric instruments that have been designed to assess positive changes in the aftermath of trauma. The Changes in Outlook Questionnaire (Joseph et al., 1993) was the first of these instruments. A number of other tools, such as the Stress Related Growth Scale (Parke et al., 1996), the Post Traumatic Growth Scale (Tedeschi & Calhoun, 1996), the Perceived Benefit Scale (McMillen & Fisher, 1998) and the Thriving Scale (Abraido-Lanza et al., 1998) have followed. Additionally, many qualitative studies have been conducted to ascertain adversarial or PTG (Affleck et al., 1987; Petrie, Buick, Weinman & Booth, 1999; Sears, Stanton, & Danoff-Burg, 2003). Debate is on-going as to which type of assessment, quantitative or qualitative, holds the most merit with the theoretical constructs. McMillen (2004) suggests that quantitative measures do not provide the richness of description that can be provided through qualitative measurement. Others (Parke, 1996; Tomich & Helgeson, 2004; Tedeschi & Calhoun, 1996) find value in quantitative assessments as they provide allowance for larger-scale studies with a more narrow set of constructs. There are also concerns regarding the unipolar design of many of the quantitative measures and the possibility that qualitative measures are tainted by leading questions or telegraphed expectations that growth “should” occur (Park, 2006). A significant body of work has been conducted in an attempt to ascertain what characteristics do or do not foster posttraumatic growth. Studies suggest that a person’s level of spirituality is related to PTG (Cadell, Regehr, & Hemsworth, 2003; Pargament, Kavita, McConnell, 2006; Anderson & Lopez-Baez, 2008). Religious conviction and spirituality were moderately to strongly correlate with PTG. The amount of perceived social support is also a factor that has been positively correlated with PTG (Cadell et al.,
Interestingly, the severity or amount of stress has also been found to have a direct positive effect upon PTG (Cadell et al., 2003; Tedeschi & Calhoun, 2004; Cordova, Cunnigham, Carlson, & Andrykowski 2001). Empirical data suggests that, somewhat paradoxically, the greater the stressor or perceived risk or threat, the greater the potential for PTG.

Controversy PTG. There are those that dispute that PTG is authentic (Cohen et al., 1998; Maercker & Zoellner, 2004; Nolen-Hoeksema & Davis, 2004). Problems with obtaining pre-stressor data from those who go on to suffer a traumatic exposure result in suspicious post-stressor data (Ransom, Sheldon, & Jacobsen, 2008). Additionally, barring a few exceptions (Manne et al., 2004; Milan, 2004; Sears et al., 2003; Tennen & Affleck, 2002) the literature relies upon studies based upon cross-sectional data gathered through retrospective self-reports (Ransom et al., 2008). There are a number of postulates as to why people may report or exaggerate successful coping after traumatic exposure. Carver, (2005) suggests that people want to be perceived as coping well or that they hold the belief that their supportive network wants to hear that they are doing fine (Linley & Joseph, 2004; Wortman, 2004; Frazier & Kaler, 2006). Further, there may be cultural expectations for growth in the face of adversity as a societal norm (Frazier & Kaler, 2006; Calhoun & Tedeschi, 2004; Maercker & Zoellner, 2004).

Other critics point out that self-reported PTG may actually be a result of positive illusions adaptively employed during stressful periods (Tayler et al., 2000, Ransom et al., 2008). In research born from temporal self-appaisal theory (Ross & Wilson, 2002), evidence suggests that people tend to see growth in themselves even when evidence of growth is not present. Further, a biased, negative assessment of one’s past self when
compared to a biased, positive assessment of one’s current self, lead to an inflated notion of positive change or growth (McFarland & Alvaro, 2000). That is to say, people may put down their past selves in order to enhance their esteem related to the current self and alleviate the stress of the current trauma (Wills, 1982; Wood, 1989). When examined longitudinally, the stability or sustainability of PTG has also been found to have mixed results. Over time, some of those individuals who had previously endorsed growth report decreases in their growth levels, calling into question whether or not their experience represented actual growth (Frazier et al., 2001). Finally, Davis & McKearney (2003) suggest that the exaggerative quality of growth finding after traumatic exposure may be a self-protection strategy that is, indeed, an integral part of the growth process. Davis & McKearney (2003) also postulate that perhaps some of the controversy and difficulty in assessing PTG comes from the fact that researches are trying to conceptualize a process as a state, a notion that resonates with this author.

**Salutogenic Approach toward “Helping”**

As the field of psychotherapy has begun explore a more positive approach to the conceptualization of the affect of traumatic exposure upon those who experience it, studies have also begun to explore a more positive or salutogenic approach toward working or helping those exposed trauma. McCann and Pearlman (1990) presented vicarious traumatization reactions as “an area of potential growth for the helper” (p.146). Investigators have recently begun to examine reported benefits of working with trauma, such as gains in relationship skills, appreciation for the human spirit, a sense of being part of the solution, and personal growth (Arnold, Calhoun, Tedeschi, & Cann, 2005; Brady Guy, Poelstr, & Brokow, 1999). Studies have looked at a number of professions in an
effort to elucidate the phenomenon of benefit from vicarious exposure to trauma. Proffitt, Calhoun, Tedeschi, and Cann (2002) explored vicarious exposure to bereavement and found that this exposure can lead to PTG. Research psychologists (Radeke & Mahoney, 2000), funeral directors (Linley & Joseph, 2005), disaster response workers (Linley & Joseph, 2006) and therapists (Arnold et al., 2005) have all been the subject of investigations into a salutogenic view of vicarious traumatization. What follows is a discussion of the major constructs of this salutogenic approach toward helping.

**Compassion Satisfaction**

Perhaps the conceptual opposite of burnout, compassion satisfaction (CS) is defined by Stamm (2005) as “the pleasure derived from being able to do your work well…feeling positively about your colleagues or your ability to contribute to the work setting or even the greater good of society” (p.5). A process of empathetic engagement, Stamm (2002) contends that CS involves the development of a stronger sense of self, self-knowledge, confidence, meaning, spiritual connection, and respect for human resiliency. Often described as an antidote to compassion fatigue, burnout, and VT, Stamm (2002) has suggested that helpers can experience CS while experiencing the deleterious effects of working with trauma exposed individuals. Pearlman and Saakvitne (1995) endorse CS as a positive effect of the work and suggest that it may enhance resiliency.

The Professional Quality of Life Scale (ProQOL) is a revision of Figley’s 1995 Compassion Fatigue/Secondary Trauma Scale and the Compassion Satisfaction and Fatigue Test (Stamm & Figley, 1999). This instrument was redesigned in 1996 to include a measure for CS, a positive effect of caring.
**Vicarious Resilience**

Although there is a substantial body of literature that examines the construct of resilience as it pertains to individuals who have survived traumatic exposure, there is a paucity of available research of the potential for vicarious resilience (VR) among helpers. An exhaustive search of the literature revealed only one study that directly examined the phenomenon of VR. Hernandez, Gangsei, and Engstrom (2007) reported on their explorations of VR through a qualitative study of clinicians who worked with individuals who suffered extraordinarily painful (i.e., kidnapping, torture, assault) traumatic events. The study revealed themes that suggest that the study subjects did find positive person effects as a result of their work, and a transformation in their inner experience as a result of their empathetic engagement with the traumatic material of their clients (Hernandez et al., 2007).

It is surprising that with the amount of study done regarding resiliency within individuals that have directly experienced a traumatic exposure, that there is not more work being undertaken to examine the potential for this phenomenon to occur vicariously. It seems to this author that if we, as profession, endorse the vicarious nature of the negative effects of trauma, at the very least, examination into the various constructs of vicarious experience of the positive outcomes of trauma should be undertaken.

**Vicarious Posttraumatic Growth**

Just as there is evidence to support those helpers who experience vicarious exposure to trauma can suffer deleterious effects, a burgeoning body of literature suggests that vicarious exposure can also lead to growth (Linley & Joseph, 2003, 2005; Arnold, Calhoun, Tedeschi, & Cann, 2005). There is a growing interest in examining the
phenomenon of vicarious posttraumatic growth (VPTG), which is central to this study. Presently, there is scant available empirical research that has focused on the construct of VPTG. A search of the major psychological data bases revealed only one article dedicated specifically to the concept of VPTG. Several studies (Linley, Joseph, cooper, Harris, & Myer, 2003; Linley Joseph, & Loumidis, 2005) speak to the potential for positive change in helpers as adversarial growth.

In her 2005 qualitative investigation of 21 psychotherapists, Arnold found 100% of her participant endorsed personal positive outcomes as a result of their work with trauma survivors. The clinicians in the study presented themes of gains in sensitivity, compassion, insight, tolerance, empathy, and interpersonal relationships (Arnold, et al., 2005). As with posttraumatic growth, the small body of available research suggests that vicarious posttraumatic growth in helpers reflects gains in the same three, broad categories that Calhoun and Tedeschi (1999) identified with respect to those who experience direct exposure (Arnold et al., 2005). These categories are changes in self-perception, interpersonal relationships, and philosophy of life (Calhoun & Tedeschi, 1999).

Linley et al. looked at [vicarious] adversarial growth as a function of helpers’ sense of coherence. The construct of sense of coherence encompasses three components: comprehensibility or one’s ability to make sense of one’s world, manageability or being equipped to deal with the challenges of the environment, and meaningfulness or the extent to which a person finds these challenges worth engaging (Linley, Joseph, & Loumidis, 2005). Based on previous validation of the use of the Sense of Coherency Scale (Antonovsky, 1987) as a valid assessment of adversarial growth, Linley (2003)
found that helpers with a higher sense of coherence reported less negative and more positive changes as a byproduct of their work with trauma. In a further study, Lindley and Joseph (2007) explored the possible occupational factors (personal therapy, supervision, amount of training, length of career, workload, personal trauma history, and gender) that might be associated with [vicarious] adversarial growth. Their findings suggest that work related factors do play a part in helper growth. Participation in personal therapy, receiving formal supervision, having a personal trauma history, being female, having a large case load, and having a theoretical orientation of transpersonal counseling were all correlated with [vicarious] adversarial growth (Linley & Joseph, 2007). Additionally, the study pointed to greater length of time in the profession and a cognitive behavioral orientation as correlated with more negative psychological changes (Linley & Joseph, 2007).

The results of the few available studies regarding the notion of VPTG are intriguing. It seems to this author that the body of literature regarding positive changes in the wake of trauma should serve as a catalyst for exploration of the corresponding vicarious phenomenon. To date, so few studies have been conducted that the phenomenon is sketchily described at best. Further Qualitative, phenomenological inquiry is needed in order to elucidate and define the construct.

**Theoretical Foundation of the Study**

The study was a qualitative, exploratory study guided by an interpretive phenomenological approach and utilized Van Manen’s (1990) life world existentials. Phenomena that are not well understood and that have centrality to the lived experience of humans are ripe for phenomenological exploration (LeVasseur, 2003, Carpenter,
It was the nascent understanding and the lack of previous investigation into the phenomenon of VPTG that drove an empirical phenomenological exploration.

**Phenomenology**

Phenomenology had its beginnings with Edmund Husserl (1859-1938), who is seen as the “fountainhead of phenomenology in the twentieth century” (Groenewald, 2004 p.2). Husserl believed that knowledge of the structures of consciousness was not induction or generalization but resulted from a “direct grasp or “eidetic seeing” (Husserl, 1931, p.42). The aim of Husserlian phenomenology was to go “back to the things themselves” (Eagleton, 1983 p. 56). Husserl originally conceived of phenomenology as an eidetic science upon which other sciences would be grounded (Osborne, 1994). Eidos is from the Greek word meaning “essence” and to Husserl, eidetic reduction in order to gain insight into the structure or event being explored, was central to psychological research (Husserl, 1977). According to Husserl (1977, p. 59), the philosopher or researcher must begin with a natural attitude “assuming that the object of an intentional act actually exists in space and time and that the scientific theories concerning the causal relations among objects are valid.” By engaging in the epoche, or abstention, which means refraining from assumptions about the existence, theories or qualities of the entity being studied through a process called “bracketing”, pure phenomenology can be produced (Perry & Westcott, 1994). Husserl can be said to emphasize description in the interest of answering the epistemological question of “what do we know”

Heidegger (1889-1976), a contemporary and colleague of Husserl, shifted the focus of phenomenology with a more hermeneutic or interpretive approach. Heidegger emphasized the idea of the lived world (Heidegger, 1962). He believed that people live
life by “having to do with something, producing something, attending to something, and looking after it, making use of something, giving something up and letting it go, undertaking, accomplishing” (Heidegger, 1962 p. 83). According to Heidegger, reflection was intentional and could never be uninvolved or separated from the world (Perry & Westcott, 1994). Further, Heidegger (1927) asserted that people live in the midst of Being which necessitates that one cannot be without “being-in-the-world”. Put In modern terms, this is the phrase “no matter where you go, there you are!” Heidegger was primarily interested in the ontological question of “what is being?”

Over time, the concept of phenomenology has evolved and has metamorphosed into inquiry designed to describe the lived world (Wrathall, 1993). Welman and Kruger (1999, p. 189) clarify that “the phenomenologists are concerned with understanding social and psychological phenomena from the perspectives of people involved”.

In interpretive, or empirical phenomenological research, the emphasis is focused upon the verbal or written material which is produced by the research subject (Perry & Westcott, 1994). Based on the pioneering works of Adrina van Kaam (1958) and Amedeo Giorgi (1975), this methodology relies upon the gathering of subjects’ descriptions of a particular experience and the subsequent process of indentifying common themes presented by those subjects. The themes are then grouped and integrated to form a description.

**Van Manen’s Life World Existentials**

In this study, the phenomenological constructs of Van Manen’s (1990) life world existentials which were described in detail in chapter I were applied. Van Manen describes the structure of human science research as the “dynamic interplay” between six,
distinct research activities. According to Van Manen (1990), the first activity is turning to the nature of lived experience by digging deeply into something that interests us and causes us to think. The second activity is investigating an experience as it is lived not as it is conceptualized. Third, is reflecting on essential themes and asking ourselves and others what is the true nature or essence of the experience as it is lived. Fourth, is the process of bringing a phenomenon to description or language (logos). The fifth activity is maintaining a strong and oriented relation to the primary wondering. Finally, the sixth research activity is balancing the research context by considering parts and whole. Van Manen speaks of parts and whole as the same notion of being able to see the forest despite the trees and vice versa. These six research concepts grounded the work and gave the researcher a clear focus on the task at hand. Although there is no prescribed or set “methodology” for phenomenological inquiries, this study used Hycner’s (1985) guidelines for the phenomenological analysis of interview data as a means to apply Van Manen’s constructs. Further explanation of this topic is found in the methodology section of Chapter 3.

**Chapter Summary**

The negative effect of traumatic exposure on the human psyche has been the focus of a great deal of study over the past century. From its beginnings in the examination of “hysterical” women in Paris and battle-weary soldiers in World War I, the study of trauma and its affects has grown to include specific diagnostic categories within the DSM. The only diagnosis with an etiology that is external to the sufferer, Post Traumatic Stress Disorder is an accepted, well researched, potential outcome of trauma.
As a counterpoint to the examination of the deleterious effects of traumatic exposure, a large body of work has been conducted to elucidate the experience and impact of indirect or vicarious exposure to trauma. Constructs such as burnout, compassion fatigue, and vicarious traumatization all enumerate the parallel symptomatology that is possible when helping those who have suffered a trauma.

Recently, there has been a movement in the field to shift from a pathological approach toward viewing traumatic exposure and to look at the human response through a salutogenic or positive lens. This approach has led to the exploration of the constructs of resilience and posttraumatic growth.

As the exploration of a salutogenic approach toward direct exposure to trauma has grown, so has the notion of the application of salutogenics to indirect or vicarious exposure. Although not as prevalent a topic in the literature as the research regarding the deleterious effects of indirect exposure, a burgeoning body of work is looking at constructs such as compassion satisfaction, vicarious resilience, and vicarious posttraumatic growth.

This study provided a qualitative examination of the lived experiences of mental health workers who found personal benefit from their work with traumatized individuals. The study elucidated the phenomenon of vicarious posttraumatic growth. Shifting to a salutogenic model of vicarious exposure could have significant implications for the field, but not enough is yet known about this phenomenon. This study provided a deeper understanding of secondary exposure to trauma and its potential for positive dispositions.
CHAPTER III: METHODS

Introduction

From the beginning of the development of the concept of psychological helping as a profession, interest has been present regarding the effect of this work on those who perform it. Extensive research has been conducted into the negative sequelae of vicarious exposure to trauma (Figley, 1995; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). Although limited in scope, within these examinations, there has been a cursory acknowledgement of the potential for gains and perceived benefits from these same secondary exposures (Brady et al., 1999; Herman, 1992; Arnold et al., 2005). As the field has continued to examine the experience of providing trauma related care, only a few studies have directly explored the topic of the benefits of empathetic engagement with trauma survivors (Linley et al., 2003; Radley & Figley, 2007; Ben-Porat & Itzhaky, 2009). This study aimed to add to the scant literature regarding the topic of vicarious posttraumatic growth and, through a qualitative inquiry, help to expand the understanding of the field regarding this phenomenon. In this chapter, I detail the theoretical framework, research methodology, sampling, participant recruitment, research design, data collection and analysis, and the limitations of the study.

Purpose of the Study

The purpose of the study was to illuminate the lived experiences of mental health professionals who work on a day-to-day basis with multiply traumatized children and adolescents, and as a result, experience measurably high levels of vicarious trauma, and compassion satisfaction. There is a capacious body of literature that examines the negative sequelae of direct exposure to traumatic events. Diagnostic criteria are well
established for stress related disorders, such as Posttraumatic Stress and Acute Stress Disorder. There is also voluminous research that has been conducted to examine the potential deleterious effects of secondary exposure to trauma derived through working with individuals who have suffered trauma. The notions of counter transference, burnout, compassion fatigue, and vicarious trauma are well delineated in the professional literature. A burgeoning focus on strengths-based or positive psychology has created a ground swell of support for moving away from pathogenic research in favor of a salutogenic approach. A plethora of studies expound upon the positive changes that people have reported as a direct result of traumatic exposure. What have not been well researched are the potential positive effects of vicarious exposure to trauma.

**Research Design**

Using a phenomenological approach, the study sought to understand the very marrow of the experience of providing mental health treatment to multiply traumatized children and how that experience can manifest itself within the workers. Giorgi (1975) defines the aim of phenomenological research as describing, with as much accuracy as possible and without pre-existing frameworks, the phenomenon at hand. Through naturalistic interviews, the result of the inquiry is a description that is rich with experiential themes that enhance our understanding of the phenomenon of vicarious posttraumatic growth. Employing a phenomenologically based, case study design, the investigation relied upon methods, instruments, and data explication that are traditional to qualitative inquiry. What follows is a description of qualitative design, purposeful sampling, the criteria for subject participation, participant selection, and the sample size for the study.
Qualitative Inquiry

The study was qualitative in design. Unlike quantitative research where the aim is to classify, count, and analyze numerical data, qualitative research seeks to study things in their natural setting and attempts to make sense of, or interpret phenomenon according to the meaning that is assigned to the phenomenon by the people who experience it (Denkin & Lincoln, 1994). In general, phenomena that have not been exhaustively researched, are not well understood, and are axial to human lived experience are suited to qualitative research (Carpenter, 1995). The lack of exploratory studies that address the concept of the positive effects of vicarious traumatic exposure made the topic ripe for qualitative inquiry. Through an exploration of the perceived effects of working with traumatized children upon mental health workers, their meaning making around their work, and how they describe their experiences of vicarious trauma, the essence of the personal gains of trauma work emerged.

Sample

According to Berg (2007), the underlying logic in using a sample of subjects is to be able to make inferences about a larger population. The general intent of sampling is to secure a small number of individuals that are representative of a larger population as it is usually impossible to survey everyone who is affected by a particular phenomenon or topic of interest. In qualitative studies, large, statistically representative, random samples are usually selected from which generalization are drawn (Glesne, 2006). In qualitative research, however, the purpose is not to produce generalizations, but to uncover the meaning and significance of certain phenomena (Van Manen, 1990). As such, the most appropriate sampling techniques for qualitative research are non-probability in nature.
(Berg, 2007; Merriam, 1998). Further, Merriam (1998 p. 61) states that upon considering a sample for a qualitative inquiry the sample must be “based on the assumption that the investigator wants to discover, understand, and gain insight and therefore must select a sample from which the most can be learned.” As I wished to learn specifically about the lived experience of mental health workers, I used purposeful selection to compose my sample.

**Purposeful Selection**

This study used a purposeful sampling design with the intent to find individuals who had experience related to the phenomenon to be researched (Kruger, 1988). Choosing a sample with purpose provided information-rich subjects specific to the study (Patton, 2002). A sample of willing participants was drawn from the population of mental health workers at a residential treatment facility in central western Pennsylvania. This facility was chosen as a result of its practice of “trauma informed care” and focus on working with multiply traumatized children and adolescents. Patton (2002, p. 245) states “random probability sampling typically often used in qualitative research, cannot accomplish what in-depth, purposeful samples accomplish.” It was my aim to carefully select the study participants in order to maximize the probability that the desired phenomenon was experienced.

**Selection criteria.** In order to select the participants for the study, previously collected or archival data was used. The Professional Quality of Life instrument (ProQOL) (Stamm, 2005) was previously administered to staff at this institution as part of an assessment process related to the influence of the Sanctuary Model® upon the
institutional culture. The ProQOL assesses for constructs pertinent to the study and was used as a screening tool.

ProQOL as a screening tool. This instrument contains three sub-scales; compassion satisfaction (CS), burnout and vicarious trauma (VT). According to Stamm (2005), only a small percentage of individuals who complete this assessment score high on measures of both compassion satisfaction and vicarious trauma. High scores on both of these measures suggested that the respondents were experiencing some personal disturbance related to their vicarious exposure to the traumatic experiences of their clients (VT) while continuing to derive some gratification (CS) from the work. The threshold score of 42 was used for the CS scale as only about 25% of people who are administered the instrument score above that level (Stamm, 2005). The threshold of 17 was used for the VT scale as only about 25% of assessed individuals attain that score (Stamm, 2005). Individuals within this population of mental health workers who produced this combination of scores had the greatest potential to be experiencing vicarious growth. Workers who scored high on the burnout scale would, by definition, have been experiencing hopelessness and difficulty in doing their job effectively (Stamm, 2005). Low compassion satisfaction scores would reflect a lack of pleasure being derived from the work (Stamm, 2005). Low vicarious trauma scores would reveal that the worker was experiencing little personal impact as a result of the trauma related stories presented by the clients (Stamm, 2005). Although there were likely to be individuals who would describe positive effects or growth as a result of their exposure to the trauma of their clients who do not score high on the two identified scales, those who do were the most likely candidates to present as having had the desired phenomenological experience.
Participant selection. In order to recruit participants, a general e-mail was sent to all parties who had previously taken the ProQOL (appendix A). This e-mail asked individuals who believed they scored within the desired thresholds, and who were interested in participating in the study to contact the researcher. Score criteria was later verified after permission to view the instrument was obtained. Interested individuals were provided with a clear explanation of the purpose of the study, how their confidentiality and information was to be protected, the activities involved with the study, and approximately how much of a time commitment the activities would involve. Willing participants were asked about their availability and were scheduled for a time to meet with the researcher or participate in a focus group. Prior to the scheduled time, each participant was sent a consent form (appendix B) that explained the study, the study procedures, the voluntary nature of participation, the potential risks, benefits, confidentiality of information, and information regarding the researcher. This consent form is further explained in the ethical consideration section of this chapter.

Sample size. As there is no statistical demand for sample size in qualitative research studies (Munhall, 1989), sample size was determined by the number of workers who meet the ProQOL scoring criteria and agree to voluntarily participate in the study. There is no proposed maximum or minimum number of individuals to be interviewed. According to Lincoln and Guba (1985) it is most prudent for the researcher to expand the sample size until no further explanation or new description of the phenomenon is forthcoming. Twelve individuals responded to my request for participation. All were found to meet the study criteria. These individuals were divided into two focus groups, each composed of 5 individuals. Two participants were interviewed individually. Focus
groups and individual interviews were both used so as to provide a means for triangulating data to improve the trustworthiness of the study. Triangulation and trustworthiness are discussed in the methods and instrumentation section of this chapter.

**Data Collection**

In qualitative research, data collection really refers to the collection or capturing of lived experience material (Van Manen, 1990). Unlike “hard” data or numerical information that is amassed during a quantitative inquiry, qualitative data are the reflections, recollections, and descriptions of the participant and the researcher (Van Manen, 1990). In this study, this information and data was culled in a number of ways, through a number of sources. What follows is an explanation of these sources and the process by which they were mined for data.

**Informant interviews**

One of the methods of data collection was through individual interviews with the study participants. I chose in-person interviews instead of written interviews or questionnaires in order to keep the subjects near to the phenomenon, to enable discussion with the researcher, and to promote spontaneity in expression (Kruger, 1988). Each participant engaged in an interview that was electronically recorded, and lasted approximately 1 to 1.5 hours. The interviews were conducted on the campus of the selected residential treatment facility. Interviews occurred in a private room that was designed for outpatient therapy. This setting, which was away from the client population and other staff, promoted a sense of privacy, confidentiality, and calm while keeping the informants within the therapeutic milieu in which the phenomenon was experienced. Prior to each interview, all consent forms were completed and the informants were
reminded that participation in the study was voluntary, and that their information would be kept confidential. The format for the interviews was semi-structured in nature, an explanation of which appears below.

**Semi-structured interview format.** A semi-structured interview format was used in this study. This format was chosen as the best approach to elicit the greatest response from the participants. When deciding between structured, semi-structured and unstructured formats, I used Berg’s Research Methods for the Social Sciences (2007) as source material. A structured format supposes that the researchers have a somewhat solid concept about the information they wish to explore during the interview (Berg, 2007; Merriam, 2001; Schwarts & Jacob, 1979). The structured approach does not allow for deviations in the question order or content, nor does is allow for clarifications or additions (Berg, 2007). As the phenomenon of vicarious posttraumatic growth is in its infancy and there is little information known, the structured format would have been inappropriate and ineffective. The un-standardized approach involves interviews that are completely unstructured. According to Berg (2007) this format begins with the notion that the researcher does not know what the necessary questions to ask are. An unstructured interview process requires constant adaptation and development of questions throughout the length of the interview (Berg, 2007).

A semi structured interview format allowed me to use beneficial techniques from both of the above mentioned approaches. In a semi-structured interview, the researcher can ask a predetermined set of questions that are designed to focus the interviewee on the specific topic or phenomenon of interest (Berg, 2007). The loose structure allowed for the wording of questions to be changed, for clarifications to be invited, and for questions to
be added or deleted between interviews (Berg, 2007). The notion was to provide a structured foundation from which to continue to use open-ended probing to get to the heart of the matter. A semi-structured format permitted me to provide an initial focus for my interviews and focus groups, have a thread of consistency between sessions, and allowed me the freedom to adapt my interactions to best encourage my participants to elaborate on their experience. The semi-structured interview format was used in both the individual interviews and focus groups.

**Interview questions.** In order to maintain the semi-structured format of the inquiry, there were three semi-structured questions asked of each participant and each focus group;

1. How would you describe your job as a mental health worker? (probe for experiential descriptors not day-to-day tasks, ask for role, meaning)
2. How have you been affected by your work with children who have experienced traumatic events? (probe for positive and negative effects, and lived experience)
3. What sustains you in your work in this field? (explore for meaning, purpose, benefit finding)

Question one was designed to invite the interviewee into the interview process with a general level question that was easy to answer and was non-threatening (Glesne, 2006; Berg, 2007). An experience question builds feelings of competence in the interviewee and was designed to promote rapport between me and the subject(s) (Patton, 2002). The second question was designed to begin to open discussion around the phenomenon of interest. The question of “affect” goes directly to the lived experience of
vicarious exposure to trauma, which was instrumental to the study. The final question sought to illicit a discussion of purpose, and meaning or sense making related to the experience of working with traumatized individuals (Seidman, 2006). Question 3 was also designed to elicit responses related to benefit finding and illuminate the experience of VPTG. As the interview process unfolded, I provided prompts and probes to encourage the participants to expound upon their experiences and provide as thick a description of the phenomenon as possible.

**Focus Groups**

Focus groups were a second mechanism used for the collection of data. Defined as a mechanism by which to learn about psychological and socio-cultural characteristics and processes among a specific group, a group interview can quickly and conveniently collect data from a number of individuals at the same time (Berg, 2007). Focus groups provided me with generalized data that complimented the individual experiences reported in the one-on-one interviews (Morgan, 1998). As the primary goal of a focus group was to have the participants discuss the topic and have an open exchange of ideas, this method raised concepts and issues that I, as an outsider, was unable to foresee (Kvale, 1996). Additionally, the group format provided participants with the ability to hear other, like individuals’ perspectives which enhanced the richness of responses received (Berg, 2007).

Focus groups have been found to be useful in the investigation of phenomena that are not well understood or researched, such as the phenomenon of VPTG in this study (Berg, 2007; Edmund, 2002). Additionally, the nature of a discussion among peers promoted the use of language specific to the group being studied, a more “real”
conversation about the topic, and provided me with an opportunity to observe how the
c participants interact with one another around the topic (Edmund, 2000; Berg, 2007).
Further, the focus groups mitigated the power differential between the participants and
the researcher, which helped to develop a “safety in numbers” perception which, in turn,
led to a deeper and more varied discussion than in my individual interviews (Berg, 2007;
Kruger, 1994; Patton, 2002). There were two focus groups that were comprised of five
participants. This number was chosen to provide an adequate number for lively
discussion, but limit the potential for sub-group discussion (Glesne, 2006; Krueger,
1994).
I used my training as a group leader and supervisor to help effectively facilitate the focus
groups. At the beginning of each group ground rules for confidentiality, turn taking,
objectivity, and a non-judgmental environment were discussed. All necessary consent
forms were obtained prior to the start of discussion. I also used Berg’s (2007, p. 158)
Basic Ingredients in Focus Groups as a guide for conducting my focus group interviews.

Berg’s (2007) basic ingredients for focus groups. The first ingredient for a well
constructed focus group is a clearly defined objective and/or research problem which was
achieved through the proposal approval process for this dissertation. Second, the group
was purposefully selected according the criteria above to ensure that the participants had
information and experiences that were pertinent to the study and the research question.
Third, I created an atmosphere that was comfortable and felt safe for discussion. This was
achieved through giving careful consideration to rapport building between me and the
group members, as well as between the group members themselves, and ensuring that the
group environment was non-judgmental, open, and one in which confidentiality was
maintained to the greatest extent possible in a group setting. Forth, I was an aware facilitator. I used good attending and listening skills as developed through my training as a counselor. I provided a foundational structure for the group, but was flexible in allowing topics that I had not considered to emerge. It was my role as a facilitator to manage the group so that no member dominated the discussion and everyone had an opportunity to express themselves and their opinions (Kress & Shoffner, 2007). Further, I limited my contributions to the discussion and allowed the participants to control the group.

During both of the interview processes, care was taken to establish initial rapport and to create a comfortable, conversational interaction. It was my intent to assume a “learner” role whereby I set aside my assumptions about the topic, my concept of myself as “an expert”, and allow the participants to provide me with the knowledge I seek (Glesne, 2006). I used my considerable training and experience as a clinician to phrase my questions in an open-ended fashion, so as to encourage descriptive responses from the participants.

**Observational data**

In order to provide an additional source of data, I took notes, especially during the focus groups, regarding the participants’ physical behaviors, facial expressions, and any other noticeable items of interest that could have been lost or missed through audio taping and transcription. I fully informed the participants that I would be jotting down brief notes throughout the process of the interview. I went back and completed more descriptive notes at the conclusion of each interview so I was able to recall the setting, interactions, and sequences of each interview in great detail later (Glesne, 2006). All of
the interviews were audio taped and subsequently transcribed verbatim which ensured the completeness of recall of the interaction and made available material for checks of reliability (McMillan & Schumacher, 2006).

Instrumentation

As is generally the case in qualitative inquiries, the researcher is an instrument within the study (Levers, 2006; Patton, 2002; Van Manen, 1990). According to Patton (2002 p. 14) “the credibility of qualitative methods, therefore hinges to a great extent on the skill, competence, and rigor of the person doing the fieldwork-as well as things going on in a person’s life that might prove a distraction”. As I was conducting the individual interviews, moderating the focus groups, providing field and reflective notes, and interpreting the data, it is appropriate for me to provide an overview of my qualifications, experience, and interest in the study.

Researcher as Instrument

I have been working in the mental health field for 20 years. Primarily focusing on working with adolescents and their families, I have been employed in eastern and western Pennsylvania, Virginia, and Ohio. My work settings have included a runaway shelter, a maximum security facility for juvenile, male, persistent, violent criminal offenders, a foster care agency, a hospital for children dually diagnosed with mental and chronic physical health problems, and a large community based social service agency. Through these experiences, I became aware of the prevalence of traumatic exposure across gender, socioeconomic status, ethnic and regional lines. I also was acutely cognizant of the impact that the stories of the traumatic exposures of my clients’ had upon me. I carry with me the memories of people whose faces I can see clearly, but whose names have
long ago faded. I hold memories of clients who told me horrific tales of abuse, neglect, loss, grief, and suffering that staggered my imagination and made me rethink the world. I remember clients that made me cry at night because the pain of their experience touched me so deeply. I remember wondering if this was acceptable. I wondered if I was unprofessional and a “bad” or weak counselor. I was afraid to talk to my supervisor about my experience because might have thought that I was incompetent. It was in my Masters program that I first heard the terms burnout and compassion fatigue. They were only cursorily mentioned, but at least the overview provided with some small sense that I wasn’t entirely alone with my experience.

When I began my doctoral program, I was interested in the phenomenon of vicarious trauma. I planned to complete my dissertation research on that topic and completed a number of literature-based research projects on the subject. As a trainer and educator, I researched and presented seminars and workshops about vicarious exposure to trauma and the potential for deleterious effects. When confronted with my doctoral comprehensive examination, I focused my work on vicarious traumatic exposure. Through a process that, at the time, seemed like a traumatic exposure itself, I was asked to look deeper at my subject matter. I was pushed, thankfully so, to look at the potential positive affects, or the salutogenic approach to traumatic exposure.

I remembered the same clients I talked about above. I remember them as being so brave that they inspired me. I was able to remember their strengths, resilience, and how they could rise above adversity. I remembered that it was sometimes a gift to watch the process of therapy unfold and to see how families and individuals who were crushed could rejuvenate, and rise like a phoenix from the ashes. I remembered what it felt like to
have a client tell you they were done with therapy; that they were “all better” and didn’t need me anymore. I recalled that I work to plan my own obsolescence.

I began to think about the process of therapy and how it had changed me. Yes, I am not naïve. The terrible things that people can do to one another and the way that life experiences can kick a person in the teeth don’t surprise me very often. I know that the world isn’t always a safe place and I watch my own children with a fierceness that might not really be necessary. But I also began to think about how therapy changed me for the better. I am a forgiving person, in large part, because I know how hard life can be and that all of us have had some trauma. The value I place upon relationships, love and family exceeds all else, probably because I know how fragile they really are. I know that humans can survive almost anything and be better for it. It is that notion that comforts me when I fret about my children, my husband, and others who I love, as I am prone to do! It is this experience that makes me interested in VPTG. I believe that I have grown from watching my clients.

I was aware that my experience, education, and personality created the potential for bias to emerge while I was conducting this study and explicating the data. The use of the reflective journal, peer supervision, and consultation with my dissertation chair and committee was intended to mitigate the potential for bias to contaminate the study. It is important to note that while there was a potential for bias, my lived experience also served to enhance the study as I have firsthand experience with the phenomenon examined.
Reflective Journal

After each interview or group, I used a reflective journal as a means to help maintain an awareness of myself in the process, my subjectivity, and any potential for bias present in my interpretation of the interview (Glesne, 2006; McMillan & Schumacher, 2006). The reflective journal contained my thoughts and reflections about how the research was progressing, how it was affecting me, my initial interpretations of the information presented, and how I was integrating into the research (Glesne, 2006). The field notes and reflective journal served as a means of increasing the trustworthiness of my study by making my own assumptions and processes explicit (Patton, 2002).

Ethical Considerations

This study was submitted to Institutional Review Board at Duquesne University for review. In preparation for IRB and in order to ground the study in an ethical framework, I will refresh my memory regarding the American Counseling Association Code of Ethics (Patton, 2002). There are a number of pertinent ethical issues that was considered and attended to as the study is conducted. Of import are the treatment of subject participants, confidentiality, data storage and retention, and the reporting of findings.

Treatment of Subject Participants

According to Glesne (2006) there are five basic principles that require attention in order for a study to meet ethical criteria. First, I ensured that the research members were provided with adequate information to make an informed decision about participating in the study. This included information regarding the purpose of the study, the expectations of participation, where the data was to be collected, how the data was to be collected, and
for what the data was to be used. Second, the participants were provided with an explanation that engaging in the study was completely voluntary and that they could, at any time, withdraw from the study without repercussions or penalty. Third, the potential risk to the participants was eliminated wherever possible. It was possible that the participants in this study could experience negative emotions while participating in this process. This was explained to the participants in advance with provisions made for individuals who wished to terminate their participation while in an interview, or who required follow-up care, such as counseling or debriefing. The risks of this type of inquiry were minimal. Participants were informed that they may or may not find personal benefit from engaging in the study. There could have been emotional gain and validation, but there just as readily might not have been. Participants were made aware that the benefit of this study might be benefit to the mental health profession, other mental health workers and clients. Subjects were told that they would not be receiving any compensation for their participation. This information was contained in the consent form (Appendix A).

Confidentiality

Subject participants were also informed that the information they shared would be kept confidential within the bounds of child protective service law and the ACA Code of Ethics. Participants in this study were aware of mandated reporting laws, and were reminded that any information regarding child abuse or neglect, even third party information, would have to be reported to the authorities. Additionally, the participants were made aware that information regarding the intent to do harm to one’s self or others would require a report to the appropriate authorities. Barring these exceptions, the
participants were told that identifying information would only be available to me. Results are reported in this study in a sanitized format. One caveat that was clearly addressed was that, by their very nature, focus groups are not confidential. As stated earlier in this chapter, the researcher discussed appropriate confidentiality with the focus group members at the beginning of each session (Corey & Corey, 2006; Glesne, 2006)

**Data Storage and Retention**

Subjects were made aware that the audio taped versions of the interviews and focus groups and any notes, or written materials regarding the study would be stored in a locked file cabinet to which only the researcher had access. Any information that was stored electronically was password protected. Password protection included flash drives and other external memory devices, which were encrypted. Audio tapes were destroyed upon the completion of the study. Written materials, such as transcription and field notes will be stored for a period of 5 years, after which time they will be destroyed.

**Report of Findings**

Subject participants were made aware that all findings reported in the study would be made without information that could serve to identify them. Subjects were afforded an opportunity to obtain a summary of the findings of the study should they so choose. This was given to them at no cost.

**Data Analysis**

Once data collection was complete, it was explicated through the lens of Van Manen’s four lived existentials. I followed Hycner’s (1985) five steps of for the explication of narrative data. I first bracketed and engaged in phenomenological reduction. I then delineated units of meaning, clustered units of meaning to form themes,
and that summarized the interviews. Finally, I extracted general and unique themes to form a composite summary.

There is no true step-by-step, approved methodology for the phenomenological analysis of interview data. Keen (1975 p. 41), states that “phenomenology cannot be reduced to a cookbook set of instructions. It is more an approach, an attitude, and investigative posture with a certain set of goals”. Hycner (1985) suggested the following guidelines that were adopted in order to attempt to be true to a phenomenological approach to explicating interview data.

**Transcription**

A professional transcriptionist transcribed all of the interviews and focus groups in order to ensure that the literal content of the sessions was captured. Upon review, interview notes and information contained in my reflective journal were inserted into the margins of the transcript, where appropriate, in order to provide as clear a picture and rich as description of the session as possible. Additionally, I reviewed the interview tapes and videos a number of times to make sure the transcription and notes were an accurate account and reflection of the experience.

**Bracketing and Phenomenological Reduction**

In order to engage in the process of delineating the units of general meaning from the interview data, it was necessary to approach the data without preconceived notions or suppositions and to let the meanings emerge (Hycner, 1985). According to Van Manean (1990, glossary), bracketing is “the act of suspending one’s various beliefs in the reality of the natural world in order to study the essential structures of the world”. It was not possible for me to totally suspend all of my preconceptions, but by listing my biases,
engaging in on-going reflection and dialogue with my dissertation chair and committee, I remained aware of those biases that I could identify and was made more aware of those of which I was not conscious.

**Listening for a Sense of the Whole**

Giorgi (1975) discusses the need to grasp a sense of the gestalt, or whole of the interview once bracketing and reduction have been accomplished. This “whole” was found through listening to the audio tapes and reading the transcripts of each interview or focus group multiple times, paying careful attention to phrasing, emphasis, intonations, and the nuances of language. Impressions and perceptions were noted in my reflective journal and provided context for the emergence of themes and units of general meaning in the next “step” (Hycner, 1985).

**Delineating Units of General Meaning**

The delineation process got at the essence of the meaning expressed by identifying words and phrases (Hycner, 1985; Kruger, 1979). The process was a “boiling down” of the essence of the transcript into more manageable pieces of information. At this point, the bits of information needed not to be related to the research question. The purpose was merely to organize the data into useful general categories.

**Delineating Units of Meaning Relevant to the Research Question**

The research data was examined with respect to units of meaning that specifically illuminated the research questions. Units of meaning previously delineated in step four that did not relate to the research were not included. Those bits of meaning that appeared to be ambiguous were included in order to err on the side of caution. As
phenomenological explication of data is an iterative process (Levers, 2002), greater clarity evolved as the process continued.

**Clustering Units of Relevant Meaning**

Through the process of clustering units of meaning, I continued to bracket my presuppositions. As I read through the units of meaning relative to the study, I attempted to discern which discrete units naturally clustered together by their shared essence or theme (Hycner, 1985). Again, field notes and information from my reflective journal were used to maintain the “whole” of the experience and keep figural the non-verbal and linguistic nuances that could have altered or influenced the meaning of text (Groenewald, 2004; Hycner, 1985). The emerging themes were categorized through Van Manen’s (1990) four life world existentials. The existentials of lived space, lived body, lived time and lived human relation served as a guide to understanding the themes of the particular phenomenon of VPTG (Van Manen, 1990).

**Determining the Central Themes**

The last stage of the explication of the data involved an attempt to determine if there were central themes that emerged from the interview data (Hycner, 1999; Groenewald, 2004). Hycner (1985 p. 290) calls this process “interrogating the clusters of meaning.” Care was taken to ensure that themes were not clustered if there were significant differences between them (Groenewald, 2004). Chapter five contains a discussion of the eight themes that emerged as a result of the explication of the interview data.
Summarization of the Interviews, Validation, and Modification

The summary of the interviews contained a discussion of the main themes explicated from the data, the context or “horizon” from which the themes emerged, and initial theorizing regarding the phenomenon (Hycner, 1999; Groenewald, 2004). Upon completion of the summary, I returned to the subject participants and asked them to review the materials to provide me with a “validity check” (Hycner, 1999). The participants were asked if the interview has been captured accurately and if there was anything that they feel they need to add (Hycner, 1999; Groenewald, 2004). None of the participants had any suggestions or corrections. This validity check helped to increase the trustworthiness of the inquiry.

Trustworthiness

Trustworthiness is defined by Lincoln and Guba (1985) as evidence of the rigor of the study which results from the dependability, credibility and transferability of the data collected. There are a number of methods by which I enhanced the trustworthiness of the findings of this qualitative study.

Dependability of the Data

As mentioned above, I actively sought out the feedback of the participants regarding the accuracy of my explication and interpretation of the data. I chose to conduct both focus groups and individual interviews so as to have separate data sources to triangulate the research (McMillan & Schumacher, 2006). Triangulation was also achieved through the use of field notes which served as source of information separate from the transcribed interviews and focus groups. As mentioned earlier, interviews and focus groups were transcribed verbatim to ensure accuracy and validity of the sessions.
Credibility

I engaged in the reflective activities of journaling, peer and committee consultation, and debriefing in order to facilitate the bracketing of my biases and presuppositions to limit their affect upon the study. I continued to engage in reviewing the literature related to the study in an effort to add validity to the work. Glesne (2006) suggests that the literature review process cannot be completed prior to data collection and analysis. During the process of the study, literature of both a substantive and theoretical nature that is pertinent to the study may emerge. I continued to keep an open mind to reviewing ancillary topics that emerged through the work and set up RSS feeds through the data bases to alert me to new research related to topics of interests already reviewed.

Limitations of the Study

Glesne (2006 p. 169) states “part of demonstrating the trustworthiness of your data is to realize the limitations of your study.” A function of context, delineating the limitations of a study informs the reader and promotes appropriate use of the research findings (Glesne, 2006). The limitations of the study are addressed below.

Generalizability

The largest limitation of this qualitative study was its lack of generalizability. The use of a relatively small sample of mental health workers who all work at the same agency dictates that the findings cannot be unilaterally applied to all mental health workers in all residential treatment centers for children and adolescents. Further, the study occurred in one location in rural, western Pennsylvania where, although there is some diversity in the population of the staff at the RTF, the make-up of the residents is
rather homogenous. Merriam (2002) notes that the uniqueness of setting combined with the individualized nature of subject participants’ experiences and characteristics limit the generalizability and transferability of findings from one group to another.

**Participant and Researcher Concerns**

There were potential issues related to the researcher and the participants. First, as a researcher with a vested interest in the process and the phenomenon, I had an effect on the data collection, analysis, and interpretation of the findings (Patton, 2002). Further, the nature of this inquiry involved data collected via participant self-report. The participants may have reported attitudes, behaviors, and emotions they thought would be desirable to the researcher. Alternatively, the participants, who will all knew each other to one degree or another, may not have wished to present information they felt displayed a lack of competency or weakness. These reporting inaccuracies may have been done intentionally or unconsciously on the part of the participants.

**Delimitations of the Study**

The delimitations of a study were the characteristics that defined the boundaries of the study and were determined by the decisions made by the researcher in the development of the proposal (Cline, 2010). Among these choices was the research question itself, the theoretical perspective, and the variables of interest in an inquiry. In this study, I was only interested in the experiences of mental health workers who work with multiply traumatized children in a residential treatment facility. I intentionally selected a residential facility that works with children and adolescents who have experienced trauma. Further, I chose to purposefully select my participants from a pool of individuals who achieves the earlier specified, threshold scores on the ProQOL. By
delimiting the study in this fashion, I hoped to get to the heart of the matter of the participants lived experience of empathetic engagement with the trauma of children.

Chapter Summary

The aim of the study was to examine the lived experience of mental health workers who, as a result of their work with traumatized children, self-identified as experiencing positive psychological benefit from watching the growth of their clients. As the phenomenon of vicarious posttraumatic growth has only been cursorily examined and only a nascent understanding had been developed, a qualitative inquiry was appropriate. Designed as a phenomenological inquiry, the study sought to elucidate the lived experience of the workers by grounding the work in Van Manen’s (1990) four life world existential. Guiding the development of the study were Van Manen’s (1990) concepts of lived time, relation, space, and body, served to inform the research question, methodology, and explication of the data. By following as true a phenomenological approach to the explication of the data as possible, it was hoped that the “essence” of VPTG would emerge.

Participants for this study were selected purposefully using archival data to help increase the likelihood that selected subjects would have experienced the phenomenon to be studied (Kruger, 1988). Once selected, the participants engaged in focus groups and individual interviews. These interviews were viewed in conjunction with my field notes and observations in order to provide multiple data sources as a method of triangulation (Patton, 2002).

The data was explicated following the guidelines suggested by Hycner (1999). As was hoped, the data revealed themes that could be used to generate further questions
regarding the phenomenon. Such research questions could be used to advance the research base and enhance the understanding of a salutogenic approach to the effects of vicarious trauma. These questions are discussed in chapter five. Chapter four provides case-by-case narratives and a cross-case analysis of the interview data.
CHAPTER IV: RESEARCH FINDINGS

Introduction

The desired end result of qualitative research is to assemble an interpretation of the experiences of other people without allowing prior assumptions about their beliefs, perceptions, and conditions to influence the outcome (Avis, 2003). In order to provide such an interpretation, this chapter provides a case-by-case narrative of the two focus groups and two individual interviews that were conducted for this study. Context is provided through a discussion of the demographic characteristics of the participants. Through the careful use of phrases of significance that have been gleaned from the interview transcripts, the narratives delineate the central categories and clusters of meaning derived from the data.

Following the narrative description of the interviews, the categories are organized into tables that provide a concise view of the phrases of significance and their relationship to the analytic categories. The chapter concludes with a cross-case analysis and summary, which includes the incorporation of my own experience. This analysis serves to provide the reader with a sound contextual understanding of the experiences of the mental health workers, which will act as the footing for the culminating work of chapter 5.

Demographic Information

There were 12 participants, who participated in the two individual interviews and two focus groups of this study. All participants were actively employed as mental health workers in a residential treatment facility for multiply traumatized children. All of the participants had been previously administered the Professional Quality of Life R-IV
(ProQOL) (Stamm, 2005) as part of the facility’s quality improvement initiatives. By using the ProQOL to purposefully select participants most likely to have experienced the phenomenon of study, the chosen individuals all scored above the threshold of 42 on the compassion satisfaction scale and above 17 on the vicarious trauma scale of the instrument. Participants granted the researcher permission to verify their ProQOL scores through the informed consent procedure of the study.

There were seven males and five females, ranging in age from 23-63 years old (with an average age of 33.4) who participated in two focus groups and two individual interviews. In order to protect the confidentiality of the participants, each has been assigned a number by which they will be referred during the discussion of the findings. The experience level of the participants ranged from 1 to 17 years in the mental health field (average of 5.3 years) with a range of five months to 17 years (5.2 year average) of employment within the study facility. The education levels of the participants included one high school completion, three associate’s degree, six bachelor’s degrees, and two master’s degrees. The areas of academic study included psychology, criminology, journalism, business, and therapeutic foci. The participants were also asked whether or not they identified as having a personal trauma history. Five of the participants endorsed a trauma history while seven did not. Table 1 provides a summary of the demographic information of the participants.
Table 1. Informant Demographic Information

<table>
<thead>
<tr>
<th>Participant #, id number and interview type</th>
<th>Age</th>
<th>Gender</th>
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<th>Years in Mental Health Field</th>
<th>Degree</th>
<th>Endorse personal trauma history</th>
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Focus Group and Individual Interviews

All interviews and focus groups were semi-structured in format and were digitally recorded and videotaped in order to ensure an accurate, verbatim account for transcription. Videotaping was especially important during the focus groups in order to ensure that distinction could be made between the voices of the subject participants. Throughout the interview process, I took notes regarding the participants’ non-verbal behaviors. I used a reflective journal to assist in the bracketing of my suppositions and to
assist in the documentation of my own experience of the process. I first conducted an individual interview of approximately 60 minutes in duration in order to get a single, clear voice on the subject matter at hand. This interview was followed by the 2 focus groups, which lasted between 1-1.5 hours in length, and were designed to provide a broader, more conversational exploration of the phenomenon. Finally, the data collection was concluded with a final individual interview of 1.25 hours in length that was designed to provide confirmation of the themes uncovered in the group settings. All interviews were conducted on the campus of the residential facility, in a private room designed for therapy sessions, in order to keep the participants close to the milieu of the phenomenon, and provide them with a sense of privacy and confidentiality.

Presuppositions

I am aware, that as a researcher, I had an influence upon this study. In order to mitigate this influence and reduce the potential for bias to creep into the interpretations of the data, I practiced reflexivity throughout the entirety of the study. According to Patton (2002) reflexivity is the process of evaluating the researchers own voice within the context of the voices of the study participants. A significant part of the evaluation of my voice was to examine my presuppositions as I embarked upon this study.

First, I believed that I would find that all of the participants in my study would describe elements of vicarious traumatization. I expected that, as the literature describes, the workers would express experiencing shifts in their basic cognitive schema related to safety, trust, esteem, intimacy, and control (Baird & Kracen, 2006). I have personally experienced the phenomenon of vicarious trauma. I had read extensively about the issue in the professional literature and fully expected that my subjects would relate similar
effects of their work during the interview process. Vicarious traumatization appeared to
be a given, especially in light of the endorsement of the phenomenon through the results
of the ProQOL. I believed that the workers would point to the trauma stories of the
children as being particularly difficult to assimilate. Additionally, I believed that the
workers would hold that the management of the residential treatment facility did little to
mitigate the negative effects of vicarious exposure to trauma and, in fact, would hold the
management responsible for any deleterious effects of the work.

Second, I believed that the workers would find satisfaction in their work. Again,
the participants’ scores on the ProQOL were highly suggestive that interaction with the
residents of the facility was providing them with personal satisfaction. I expected that this
satisfaction would be derived primarily from the individual cases in which perceived
“success” or positive change occurred. It was my belief that the workers would identify
specific cases that ended with a positive disposition as those that created satisfaction with
their chosen profession and day–to–day work experiences. I also expected that it would
be this perception of success in changing another’s life for the better that kept the
workers in a high stress, emotionally taxing job. I supposed that the workers would
identify themselves as positive influences upon the children which would contribute to
their sense of personal satisfaction.

Third, based on my own experience and the suggestions regarding vicarious
posttraumatic growth in the current literature, I believed that the workers would express
finding personal growth and positive change in their own lives. I believed that they would
directly attribute some change to the experience of working with traumatized children
who demonstrated triumph over trauma. I further believed that the workers would find
personal growth in the domains of strength, new possibilities, relationships, appreciation of life, and spirituality that Tedeschi & Calhoun (1995) describe as occurring in posttraumatic growth.

Finally, I expected that given the pathogenic approach to mental illness that has been pervasive in the mental health field since its beginnings, I believed that the workers would most likely need to be encouraged to examine the positive effects of working with mentally ill children who have been traumatized. My experience as a supervisor and clinician has conditioned me to expect that individuals will tend to focus on the negative aspects of situations, often to the exception of consideration of positive outcomes. I was aware that, as a supervisor and counselor, I make it a priority to provide a positive reframe for individuals with whom I am working. During the interview process, I remained mindful of this tendency so as to not push the participants toward disingenuous descriptions of their experience.

Throughout the study, I used my reflective journal and dialogue with colleagues, and I continually attempted to be aware of my biases and presuppositions in order to bracket my own beliefs so as to allow the meaning of the data to emerge. I consciously remained on the periphery of the discussion in the focus groups and provided only the minimal prompts necessary to keep the content focused and on topic. At times, I became aware of my own thoughts regarding the potential outcome of the interviews. For example, at the start of the initial individual interview, I felt discouraged because the participant was not providing the information that I expected, or wanted. I had to stop myself from feeding the participant leading questions that I thought might push him to give me the responses I desired. On the positive side, during the first focus group, I found
it necessary to restrain myself from allowing my elation to become evident. The group members quickly began to discuss themes that I had hoped would be revealed in the study. I wanted to ensure that my emotional reactions did not interfere with or influence the process or content of the focus group.

**Analysis of Interviews and Focus Groups**

Once the individual interviews and focus groups were completed, the recordings were transcribed to provide an accurate written account of the proceedings. Through this process, I listened to the tapes of the sessions several times and took additional notes regarding nuances of which I was previously unaware. I watched the video recordings of each focus group and interview several times to take note of non-verbal behaviors, facial expressions, and my own reactions to the process. This repetitive viewing allowed me to examine the participants’ behaviors in a more detailed and purposeful fashion than can occur during the heat of the interview process. These notes were inserted into the margins of the transcriptions in order to have as clear a picture and as rich a description of the process as possible. This sense of the gestalt, or whole of the interview, was an essential step in the beginning of the teasing out of the essential themes presented in the data.

When the transcription process and review of the interview sessions were completed, the data were further explicated through the lens of Van Manen’s four lived existentials. I used Hycner’s (1985) steps to accomplish the explication of the data into themes. First, I delineated the units of meaning present in the interview data. I then clustered the units of meaning to form themes through a summarization of the interviews. Finally, I extracted general and unique themes to form a composite summary.
During the process of delineating the units of meaning, I sought to titrate the meaning expressed by the participants down to meaningful words and phrases (Hycner, 1985; Kruger, 1979). Due to the extensive volume of material contained within the verbatim transcripts (well over 100 pages of text), it was essential to reduce the content to more manageable pieces of information. Initially, these bits of information were not necessarily related to the specific research questions, but merely appeared to be thematic, reoccurring pieces of the essence of the interviews.

Next, I examined the data with respect to units of meaning that specifically illuminated the research questions. Previously delineated units of meaning that did not relate to the research questions at hand were not included. These units of meaning provided me with the ability to begin to identify chunks of data, in the participants own words that addressed the research phenomenon.

By examining which discrete units of meaning naturally clustered together by their shared theme or essence (Hycner, 1985), I was able to identify emerging themes. The themes were then categorized within Van Manen’s four life world existentials, which served as a guide to understanding the phenomenon. The final stage in the explication of the data was to “interrogate the clusters of meaning” (Hycner, 1985 p. 290) in order to identify any central themes extant in the interview data. Care was taken not to cluster themes where significant differences were present. The significant themes could be organized into six general categories related to the research questions. Through the process of coding and clustering the data, each of the main analytic categories naturally became segregated into relevant sub-categories. The six major categories were as follows;
1. Lived existential (body, time, relationship, and space)

2. The perceived role of the residential treatment worker

3. The experience of exposure to traumatic stories

4. Negative consequences of exposure to the children’s trauma (vicarious trauma)

5. Protective factors against the negative effects of exposure to the children’s trauma histories

6. Positive results from the work

The iterative nature of the review of the data provided saturation with the final individual interview. The explication of these narratives led to the development of the six main categories that were used to construct the dominant themes that are discussed in chapter 5.

Case-by-Case Analysis

In the following section, I offer a case-by-case, narrative discussion of each of the interviews conducted in the order that they occurred. First presented is individual interview #1, which is followed by the details of the two focus groups. Last presented is the information from individual interview #2. These narratives of the study interviews provide illustration of the six categories discussed above.

**Individual interview #1.** My initial interview was conducted individually with a 24 year old, male worker who had been employed with the facility for two years. This worker reported earning a bachelor’s degree in psychology. His employment at this residential facility was his first position in the mental health field. He did not self-identify or endorse a personal history of trauma on his demographic questionnaire. The interview was conducted in a private therapy room within an administrative building on the campus
of the residential treatment facility. This room afforded a quiet, confidential space in which the participant could feel free to speak, while keeping him immersed in the milieu of the phenomenon to be explored. I first introduced myself to the participant and confirmed that he was fully aware that his participation in the study was voluntary, bore no influence upon his employment with the facility, and that he could choose to not participate without anyone at the facility being aware of this decision. The participant expressed his willingness to participate and voiced that he had a clear understanding of the nature of the study. Although he had previously been provided with a copy of the informed consent document that explained the study’s purpose, procedures, participant rights, and parameters, I reviewed this document prior to beginning the interview. Once the participant expressed his understanding of the study, his signature was obtained on the consent document and I began recording the interview. Initially, the informant appeared to be quite nervous. He spoke quietly, engaged in only sporadic eye contact, and provided only short, minimalistic answers to my inquiries. He seemed to be unsure of what I was asking. He would offer responses and then ask if that response was what I was looking for. For example, when I asked him to describe his work at the facility, his initial response was, “You want me to tell you about the kids? Like why they behave the way they do? Or like how I respond to them? These kids have issues every day. I am not sure what you want me to say.” When I explained that I wanted him to talk about his experiences and that there was not a correct answer to any of my questions, he seemed to relax. During this time, I was aware that I was also feeling anxious. I was concerned that the focus of the study was not clear and that I had erred in my participant selection. I made a conscious decision to begin with non-threatening questions. I asked him to first
tell me a bit about his demographic information, such as where he attended college, where he was from, and what other jobs he had held prior to his current position. It appeared that the casual dialogue about his life experience and my reassurance that his unique point of view was at the heart of the matter helped him to relax and view the interview process in a less intimidating, more informal way. The establishment of a more conversational interaction also served to reduce my own apprehension and make the questioning feel more naturalistic. The interview lasted approximately 45 minutes, at which time the topics at hand appeared to be exhausted and the participant expressed having no further relevant information he wished to share.

Once we had established a comfortable atmosphere, participant #I-1 answered the initial question of how he viewed his role as a mental health worker with respect to function. He indentified that his job was, “to keep the kids in a routine. When they have an issue, not to give them answers, but to try to lead them, teach them to figure it out themselves. Help them find out why they are angry or excited or whatever, and help them work through it without flipping out.” He went on to say that he believed “the ultimate goal, or whatever I do, is to keep everyone safe. I do it differently all the time. I obviously talk to them to see what is up. I ask them what they need from me.” Participant #I-1 further identified the following:

What the kids usually need is for us to just let them know that we are here for them. That there is no reason for them to feel like they need to fight us or be on guard against us because we can provide them anything they need. We are here for them, that’s all. It is all about them and what they need.
As I wanted him to explore the essence of what he meant by “being here for the kids,” I probed further to encourage him to talk more about his role. Participant #I-1 identified that he felt part of his role with the kids was to be an emotionally safe person for them. He stated:

I’m pretty constant. I don’t ever yell. I don’t get mad. I am just flat lined all the time, on purpose. The kids appreciate that. I don’t try to raise my voice. I try to talk to them and explain things. More than explain it, I will go over things five or six times to try and help them understand where I am coming from so they can get a better understanding of what is going on with themselves. That doesn’t work if you are all emotional and worked up about things. It is about the kids and their stuff, not mine.

Later in the interview, participant #I-1 went on to talk about how the children in the facility viewed his role. He described being “thought of as a big brother.” He further described this big brother role as being that of a role model and example of a positive relationship that could be had with a male. Participant #I-1 stated:

Some of the girls don’t have fathers. I was the only male that they were literally allowed to even talk to. So I kind of felt bad, it was kind of weird for me. I want to be appropriate, a good role model. So many of them had never had a positive relationship with a guy before. How wild is that? I was the first safe guy. It makes you think about yourself a lot.

When I felt that I had a solid understanding of how participant #I-1 viewed his role as a mental health worker, I moved to the interview questions relating to the
experience of exposure to the traumatic stories of the children with whom he worked.

When asked to describe his experiences with the children’s stories, he responded:

I guess it, reading their histories, and their stories kind of really opened my eyes to the world that I didn’t know really existed as much, with the kind of abuse that some people go through. It just kind of opened my eyes more to what some people actually go through and maybe, yeah really, how that affects the way they are.

He went on to talk about the initial trainings he received at the facility and how he tried to be, “prepared for whatever might happen, but tried to keep an open mind about what the kids were like. I mean not just reading about them and making assumptions about how they were going to be based on their really f’d up pasts.”

The discussion of the children’s trauma histories and its relationship to their behaviors naturally flowed into participant #1 discussing the behaviors of the children within the facility and how he experienced these behaviors. He began to describe specific events that had occurred with the children and how these events had affected him. He related:

Getting spit on is a big thing for me. It is really unpleasant. Seeing people get attacked by a kid, that is not fun. I got peed on a couple times. It is hard to see two 12 year old girls sexually acting out on each other. There is so much stuff, tons of little stuff that I can’t even remember, that happened. Sometimes it doesn’t seem real. When I first started, this girl, she beat on me. I wasn’t sure if this [job] was something I was really interested in doing. I was pretty shaken up. I mean it was overwhelming. A kid gets so worked up, takes her pants off and starts peeing...
herself right in front of everyone? Then she just launches into staff? Something really, really messed up is going on there. It really affected me for a while. That stuff gets inside of you. Thankfully that doesn’t happen every day or I don’t think I’d still work here.

Participant #I-1 continued to talk about events that he found significant, especially those that occurred when he was a relatively new employee. He discussed how the children’s behavior is much less disturbing to him now than it used to be, “not that you get used to it, but you can learn to deal with it better yourself.” He further stated, “I used to sometimes feel kind of weird when I was coming into work. I had kind of butterflies wondering what was going to jump off that day. I felt kind of wired, “itchy”, at the beginning of my shift. I don’t have that now.” As he discussed his experience, I was conscious that I was focused on the content of his answers and was not attending to the interview process. I realized that I was taking too many notes and not being present enough in the interview. I purposefully relaxed and shifted my focus to participant #I-1 instead of my note pad.

After the discussion of these negative experiences, without prompting, participant #I-1 segued into a discussion of what he believed enabled him to continue to do his job. He began by identifying personal characteristics such as, “I always like to say that I spread positiveness. I just like to be positive. It makes things go better.” When I inquired if he had always been a person who was positive or spread a positive attitude, he cocked his head in a thoughtful manner and replied, “hmmm, no. I guess I wasn’t. I never really had to be. Maybe that change came as a result of the kids. I don’t know why, but the difference is distinguishable!” This insight seemed to be surprising to him and he smiled
broadly as he related this change. Participant #I-1 also identified that he is a person who adapts well to change and stated, “I just roll with the changes from day to day, minute to minute. You can’t try to control things.” He continued to elaborate on his personal approach to the work by discussing his ability to remember that the work is about the kids and not really about him. He stated:

I know a lot of people take it a lot more negative from it. It stresses people out more than it does me. I know their [the kids’] anger is not really towards me. I don’t take it personally. I don’t get mad at them for getting angry with me or being obnoxious, so it doesn’t affect me. I am here to help them. Sometimes they don’t want my help and that is on them. I can’t own that. When kids say this place doesn’t help them, I let that roll off of my back. You have to want to get help.

You have to ask for it.

Participant #I-1 also identified that he has few outside stressors that he brings to work. He discussed that he observes that other staff bring their issues with their spouses, children, and family to the work environment which sets the stage for a stressful day on the job. He reported that, “I think maybe me not having much else going on in my life, like stress wise, is actually a helpful thing for my job. I know it sounds silly, but I don’t come to work wound tight.” When he discussed not having outside issues to bring into work, participant I-1 seemed to feel as if this characteristic was somehow undesirable. I prompted him to talk more about this notion. He clarified that, “That is just where my life is right now. It will change over time I’m sure. I just mean right now, I don’t have those things to get in the way.”
After exhausting the topic of the deleterious effects of the work and the factors participant #I-1 perceived as individual characteristics that help him continue to perform his job, I asked him to talk about the positives or benefits that he finds in his work. He sat quietly for a brief period of time, which had not occurred since the start of the interview. Finally he said, “That’s a hard question.” I allowed him to sit in silence as he continued to ponder the question. I was acutely aware that I was mentally willing him to find something positive to talk about, as benefit finding and personal growth were the central point of my study. I experienced a personal feeling of relief when he finally said, “I think I am really good at relating to these kids and I get satisfaction out of that.” I again waited for him to elaborate without providing additional prompts so as to not influence his thought process or the content of his answer. He continued on by saying:

I mean it is not about the money. They don’t pay us near enough, but it [money] has never been a motivator for me. The jobs I had before I made a lot of money. I didn’t like it or enjoy it though. I guess I like being liked by the kids. I feel like they have been through a lot and then they came here. I feel important to them. You know what I mean? I like that I can be important to them in a good way, maybe a way they never had before.”

He continued to elaborate by discussing a specific case of a resident who had been the victim of a rape. He talked about how this resident was distrustful of males and would often display negative or aggressive behaviors when she was involved in even minor interaction with other males at the facility. Participant #I-1 related his interactions with this girl as an example of the satisfaction or benefit he finds from his job. He stated:
I knew that she felt safe with me. That was really rewarding. She actually asked me to come to the trial with her when she testified against the person who raped her. Because she felt safe with me, the only male she felt safe with. To me, that was kind of cool, to be that person to someone else. Maybe my relationship with her will be the one that changes it for her.

Quite quickly after he made the above statement, participant #I-1 seemed to become a bit embarrassed. He blushed and broke eye contact by looking down. Before I had an opportunity to inquire about his reaction he said, “I know there are 100 people involved in their treatment here. I shouldn’t feel that important. I don’t deserve that much credit.”

As I let him mull over this statement, he continued by saying, “I guess I am important in the process. Sometimes it is easy to just only view yourself as a part of a team and not take credit, but I guess there is importance to what I do. I know there is.” Participant #I-1 also identified receiving follow-up phone calls regarding the progress of discharged clients as a source of satisfaction. He stated:

It always feels good when a kid gets discharged from here and they go back home and you hear that they are being successful. Kids that are doing well let you know! They [supervisors] will give you updates on the kid that was here for a long time, whether she is in danger now or what’s going on. We always like to hear that they are doing well. When they are doing well it kind of fills you up. You know?"

When I inquired further if the successes with the kids were the reason he stayed on the job, participant #I-1 endorsed the successful discharges as a factor, but also pointed to his camaraderie with the other staff as a major influence in his job satisfaction. He said, “I
like the people I work with. The people you work with are really important. If I didn’t have the relationships with these people that I have, I wouldn’t be happy here.” He described a close group of people who work together as a team “to make sure everybody including the staff” is safe. Participant #I-1 continued by saying that the overall administration of the agency didn’t make much difference in his day-to-day work experience, but “the support of your team, your unit staff if what keeps us going. I am loyal to these guys. They, my team, those people are a huge part of what makes me stay here. I like working with the kids, but my co-workers are really just as important to me.”

The conversation easily continued with a discussion of the change process and how participant #I-1 experienced change in the children in the facility. He began by discussing how he believed there was hope for everyone to exhibit change, “I kind of assume that all the kids will change. I don’t have doubts that this person or that isn’t going to. I don’t think that anyone is too far gone.” Through the course of discussion, participant #I-1 explained:

“The change is always gradual. If you are not looking for it, you might let it pass by unnoticed, but if you compare these kids from when they first got here to when they are discharged, it’s usually a 180. Sometimes it just smacks you in the face!”

He went on to mention positive changes in the children’s ability to express their anger appropriately, increases in their coping skills, and improvement in their social functioning as common changes that he identified.

I asked participant #I-1 if there were any positive changes, other than becoming a more positive person as mentioned earlier, that he has noticed in himself since working at the facility. This seemed to require more thought than the other questions. He sat quietly
for several moments stating, “I have never really thought about that.” Finally, he said, “If I had to come up with one, I guess I would say that I am more patient.” As I wanted to understand if this was a general improvement or one specific to the job, I probed as to where he noticed this change. He said, “Little things don’t get to me on the outside. Who cares what some a-hole says to you? I mean, look at what these kids have put up with! I can put up with some jerk flipping me off in traffic!” I asked him to talk more about that and he continued on by expanding on the notion, “my life is easy. I have a good life. I have everything I need-most everything I want. Look at these kids! They are working so hard just to get over the crap. I need to just get over myself! I think about that now from time to time.”

As we were concluding the interview, I asked participant #I-I if there was additional information that he had not had an opportunity to discuss or anything else that he wished to share. He expressed that he thought he could sum up his experience in the following way:

I guess I have learned that you can’t be surprised about the way these kids act, especially given the things they have been through. But that isn’t an excuse for not making changes. No diagnosis, no history is an excuse. They all can make positive changes, even if it is something small. I have seen the worst kids get it together to be better. I know they can all do it. As long as I can keep having hope, keep finding even the little positive change, I can keep doing this job. I have good friends on the staff, I set up good boundaries for the kids and I do make a difference. That is something to hang your hat on!”
I concluded the interview by thanking him for his time and making him aware that I would be forwarding a copy of the transcription of the interview to him for verification of its accuracy. After her exited the interview room, I sat for some time thinking about the interview. I reviewed the notes I had made and entered my thoughts and impressions into my reflective journal. I was feeling quite positive about the results of the interview and felt elation that the information appeared to be useful to the study. I planned to use the lessons learned from this interview when conducting future data collection. I felt of most import was being present and involved in the process and to not bury myself in note taking. Later, when I reviewed the tapes of the initial interview, I was reassured that the recording captured the events in a manner such that note taking need only be minimal and that I should focus on my thoughts and feeling of the moment, not content.

The interview with participant #I-1 provided a number of phrases of significance that related directly to the analytic categories elucidated earlier in this chapter. Table 2 provides a summation of the phrases of significance from the narrative above.
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<tr>
<td>Lived time</td>
<td><em>It really affected me for a while.</em>&lt;br&gt;&lt;br&gt;<em>I roll with the changes day-to-day and minute-to-minute.</em>&lt;br&gt;&lt;br&gt;<em>I need to just get over myself? I think about that from time to time.</em></td>
</tr>
<tr>
<td>Lived relationship</td>
<td><em>What the kids usually need is for us to just let them know that we are here for them...we are here for them, that’s all.</em>&lt;br&gt;&lt;br&gt;<em>They think of me like a big brother</em>&lt;br&gt;&lt;br&gt;<em>So many of them never had a positive relationship with a guy. I was the first safe guy.</em>&lt;br&gt;&lt;br&gt;<em>Maybe my relationship with her will be the one that changes it for her.</em>&lt;br&gt;&lt;br&gt;<em>If I didn’t have a relationship with these people that I have, I wouldn’t be happy here.</em></td>
</tr>
</tbody>
</table>

Table 2 Participant #I-1 Phrases of Significance
### 2. PERCEIVED ROLE

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helper</td>
<td>...help them find out why they are angry or excited or whatever, and help them work through it without flipping out.</td>
</tr>
<tr>
<td></td>
<td>...help them understand where I am coming from so they can get a better understanding of what is going on with themselves.</td>
</tr>
<tr>
<td></td>
<td>I am here to help them</td>
</tr>
<tr>
<td>Teacher</td>
<td>...teach them to figure it out themselves</td>
</tr>
<tr>
<td>Baby sitter</td>
<td>n/a</td>
</tr>
<tr>
<td>Role Model</td>
<td>I want to be appropriate, a good role model.</td>
</tr>
<tr>
<td>Safety officer</td>
<td>The ultimate goal, or whatever I do, it to keep everyone safe.</td>
</tr>
<tr>
<td></td>
<td>I knew that she felt safe with me ....because she felt safe with me, the only male she felt safe with.</td>
</tr>
<tr>
<td></td>
<td>To make sure everybody including the staff is safe.</td>
</tr>
</tbody>
</table>

### 3. EXPERIENCE OF TRAUMA EXPOSURE

<table>
<thead>
<tr>
<th>Description</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>“I never knew that really existed”</td>
<td>...opened my eyes to a world I didn’t know really existed as much.</td>
</tr>
<tr>
<td>Nobody would believe it</td>
<td>How wild is that? I was the first safe guy.</td>
</tr>
<tr>
<td></td>
<td>Sometimes it doesn’t seem real</td>
</tr>
<tr>
<td>Something out of T.V or the movies</td>
<td>n/a</td>
</tr>
</tbody>
</table>

### 4. NEGATIVE CONSEQUENCE OF TRAUMA EXPOSURE

<table>
<thead>
<tr>
<th>Outcome</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoia/hyper-vigilance</td>
<td>n/a</td>
</tr>
<tr>
<td>Concern for outside relationships</td>
<td>n/a</td>
</tr>
<tr>
<td>Negative view/taking it home</td>
<td>I was pretty shaken up. It was hard on me. It was tough. It was kind of overwhelming when I was first here. It really affected me for a while.</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Potential for leaving the job</td>
<td>In my training class, there were about 13 people and there is only me and one other gentleman from our training class left two years later. I probably couldn’t do this long term because it would be really easy to get burnt out.</td>
</tr>
<tr>
<td>Feeling helpless</td>
<td>n/a</td>
</tr>
</tbody>
</table>

5. PROTECTIVE FACTORS AGAINST TRAUMATIC EXPOSURE

<table>
<thead>
<tr>
<th>Accepting the trauma</th>
<th>What some people actually go through and maybe, yah really, how that affects the way they are. I feel like they have been through a lot and then came here. You can’t be surprised how these kids act given what they have been through Not making assumption about how they were going to be based on their f’d up pasts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal characteristics</td>
<td>I am pretty constant. I don’t ever yell. I don’t get mad. I am just flat lined all the time. On purpose. I always like to say that I spread positiveness. I just like to be positive. You can’t try to control things. …try to keep an open mind about what the kids were like I can’t own that. [the children’s “stuff”] I don’t deserve that much credit</td>
</tr>
<tr>
<td><strong>“It is not about me”</strong></td>
<td><strong>It's all about the kids stuff, not mine</strong></td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td></td>
<td><em>I don’t take it personally</em></td>
</tr>
<tr>
<td></td>
<td><em>We are here for them. That’s all. It is all about them and what they need.</em></td>
</tr>
<tr>
<td><strong>Supportive environment</strong></td>
<td><strong>The people you work with are really important</strong></td>
</tr>
<tr>
<td></td>
<td><em>The support of your team, your unit staff is what keeps you going.</em></td>
</tr>
<tr>
<td></td>
<td><em>I have good friends on the staff</em></td>
</tr>
<tr>
<td><strong>Setting boundaries</strong></td>
<td><strong>I set up good boundaries for the kids.</strong></td>
</tr>
</tbody>
</table>

**6. POSITIVE RESULTS OF THE WORK**

**Being the person who makes a difference**

*I was the first safe guy. It makes you think a lot about yourself.*

*I like that I can be important to them in a good way, maybe a way they never had before*

*Maybe my relationship with her will be the one that changes it for her*

*I do make a difference. That is something to hang your hat on.*

**Seeing the smallest change**

*These kids can all make changes, even if it is something small.*

*...keep finding even the little positive change, I can keep doing this job.*

**Changes in outside behavior**

*I never really had to be [positive]. Maybe that change came as a result of the kids. ...the difference is distinguishable*

*I am more patient.*

*Little things don’t get to me on the outside.*

**Benefits of comparison**

*Look at what these kids have put up with*

*My life is easy. I have a good life. I have everything I need-most everything I want. Look at these kids! They are working so hard just to get over the crap. I need to just get over myself!*
Focus Group #1. The first focus group was conducted in a large conference room in an administrative building on the campus of the residential treatment facility. I arrived ahead of the participants in order to set up the recording equipment and make the space conducive for the interview. Five minutes before the interview was to begin, one of the participants stuck his head in the room and stated that there were flu shots being conducted on the units and that he and anyone else that was scheduled to participate would be late for the session. I assured him that I would wait. I was quite anxious as to whether or not the interview would actually take place, but approximately ½ hour after the scheduled start time, participants began to arrive for the group. As I waited for the participants, I chatted with those present about the morning activity and the process by which 117 children were inoculated. I felt this easy conversation would help to build rapport prior to the start of the interview. By the time all of the participants had arrived, the conversation in the room was easy and comfortable, which I felt boded well for positive interactions during the focus group.

When all of the participants had arrived, I provided them with a copy of the informed consent and I reviewed this document with them. Although they had previously
been provided this information, I felt it important to ensure their understanding of the process, purpose and parameters of the study. I was careful to emphasize the need for confidentiality and the difficulty of ensuring such in a focus group setting. I also emphasized the voluntary nature of the study and its separation from any work requirement. When the participants voiced clear understanding of the study parameters, had no further questions or concerns, and signed the consent documents, I began recording the session. Focus group #1 was comprised of five individuals whose demographic information is presented in Table 3.

**Table 3. Focus Group #1 Demographics.**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Gender</th>
<th>Years employed</th>
<th>Years in Mental Health Field</th>
<th>Degree</th>
<th>Endorse personal trauma history</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>51</td>
<td>male</td>
<td>8</td>
<td>8</td>
<td>Associates Business</td>
<td>no</td>
</tr>
<tr>
<td>2</td>
<td>30</td>
<td>male</td>
<td>6</td>
<td>6</td>
<td>Associates Criminal Justice</td>
<td>no</td>
</tr>
<tr>
<td>3</td>
<td>35</td>
<td>female</td>
<td>5</td>
<td>5</td>
<td>MSW</td>
<td>yes</td>
</tr>
<tr>
<td>4</td>
<td>63</td>
<td>female</td>
<td>17</td>
<td>18</td>
<td>MA-Clinical Psychology</td>
<td>yes</td>
</tr>
<tr>
<td>5</td>
<td>23</td>
<td>female</td>
<td>5 months</td>
<td>1</td>
<td>BA - Education</td>
<td>no</td>
</tr>
<tr>
<td>average</td>
<td>40.4</td>
<td>M=2 F=3</td>
<td>7.3</td>
<td>7.6</td>
<td>N=3 Y=2</td>
<td></td>
</tr>
</tbody>
</table>

The participants all knew each other and had worked together across different units of the facility. They appeared to be comfortable with each other and engaged in an easy banter prior to the start of the semi-structured interview. I began by asking the group to describe their roles as mental health workers. They provided answers by going around the table, answering the question in turn. Initially the participants answered with titles. Participant
#4 said, “I am a therapist.” Participant #1 followed with, “I am a senior staff.” Participant #5 stated, “I still don’t know what all my job description is yet.” At this point, I interjected that I was asking them to describe their function or role. I relayed that I was not looking for their day-to-day activities, but more their meaning or purpose with the children in the facility. This clarification seemed to be effective and they began discussing their perceptions with one another instead of merely reporting to me. Participant #3 stated, “I would like to think that I help the kids work through their traumatic experiences…and teach them how to cope with things that they can’t change.” Participant #4 endorsed this statement by following up with, “My day- to- day here is to help the kids cope and deal with their trauma and their families and their stress. I also help the clinicians with their trauma and stress and struggles.” Participant #1 identified himself as, “the kids see me maybe as a parent…my real work is keeping or maintaining everything in a constant routine.” Participant #2 seemed to struggle with the identification of his role. He very concretely described his daily routine and activities with the children. When I followed up with the question again he said, “I am a therapeutic mentor” which caused the other members of the group to endorse that description as very appropriate. Participant #4 continued by saying, “Our job is to try and help. We are here to guide them and teach them, okay, you don’t do this, do it like this.”Participant #5 stated, “I just tell people that I counsel kids and families, that’s all.” This prompted participant #4 to advance, “I just say I help. We help clients and families heal from traumatic events or broken families or whatever. I think help is a great word to describe what we do.” Participant #1 responded with “I like to use the work assist. I assist kids with behavior issues.” At this juncture, I wanted to encourage a discussion of
meaning related to their role. As I probed for purpose, the participants began to discuss
the deeper meaning their work held for them. Participant #4 stated, “I am here to help
kids and families to improve their lives. …I’m here because it’s my mission field and I’m
working here because it is mission work.” Participant #2 responded by saying, “A lot of
us, we’re here to help the kids and want to make sure they are safe. I want to try to keep
the kids safe as much as can be.” Participant #5 agreed, “I try to show the kids I’m here at
[the facility], I’m not going to hurt you. My job is to try to help you learn from your
experiences.” There was then discussion about how hard it is to help the children to learn.
Participant #1 stated, “sometimes we really are just glorified babysitters trying to keep
these kids from going off and hurting themselves or somebody else.” With a chuckle,
participant #4 retorted, “Yeah, worst babysitting job in history. They don’t have cable
and the parents never come home!” This humorous comment caused laughter to ripple
through the participants. Participant # 4 appeared compelled to say, “Sometimes you
really just have to laugh at what goes on with these kids or you would just cry.” I found it
interesting that she seemed to feel the need to defend even this mildly humorous
reference to me. The comment was by no means offensive, but she wanted to clarify the
use of humor as a defense mechanism. I used this opportunity to reflect back to the
participants that her statement made me wonder if there are circumstances that really
have made them cry.

My inquiry was followed by asking them to talk about their experiences with
exposure to the children’s trauma. Participant #5 answered without hesitation. She stated:

It has been hard. It was hard for me the first time I had to go in with a therapist
and talk to a dad who did something horrible to his kid. He was sitting right
across from me, right across the table from me. I took everything in me not to just reach across, grab the guy and slam his head on the thing because what he did to his son was horrible. You wouldn’t believe it. It was awful.

Participant #3 quickly related her exposure to the traumatic stories of the children to her world outside of work. She reported:

I think because of some of the horrible things I’ve seen and the horrible things I’ve heard it makes me very paranoid about my own children. Where they are, who they are with. …I’m very careful about friend’s houses and sleep overs. I think it has affected me because my husband’s perspective is totally different than mine. I have such a heightened, a skewed view of what goes on, that is how it has affected me.

Participant #4 agreed with the notion of hyper-vigilance and related that issue to how she behaves with the children in her church youth group. She related:

I have an increased awareness at church. I’m very conscientious and always redirect kids if I think there is a potential they are doing something they shouldn’t be. They think I’m nuts sometimes when I say, sorry. I’m just making sure everybody is safe. I worry about safety.

Participant #5 nodded in agreement while the previous members were discussing their thoughts. When she spoke, she said, “I am kind of thankful that I don’t have kids yet. They might have made it worse. I am sometimes like holy cow, this shit does really happen, not just on the Lifetime movie special.” Participant #2 continued this thought with, “I think working in the RTF is one of the greatest birth controls. When you see
what has happened to kids- by their families and neighbors- it’s so scary. Stuff you can’t believe.” Participant #1 stated;

   It has heightened my awareness about what the world is really like. I didn’t know that world before. But my kids are grown. I watch my granddaughter, watch her behavior more than I normally would….watch to see if she is growing up in trust with adults and making sure she has a good foundation at home. I am concerned about her safety, but not overly concerned like mothers are. You do get surprised by what is out there. I mean this stuff is for real. It is not joke.

Participant #5 muttered somewhat under her breath, “crap that happens to these kids, not just these kids, any kids; it’s just unreal, unreal.”

Their demeanor during this discussion was quite pensive. I felt they were all thinking about cases that they remembered as particularly difficult. When I asked if this is what their internal process was, participant #4 said, “Sure, those bad cases just float back up to the surface. Sometimes they are hard to think about.”

   I then moved the group into a discussion of what they perceived as the negative effects of their exposure to trauma. Participant #1 responded, “I shouldn’t be taking it home, but I do. So I don’t get to sleep like I should. But I don’t mind it. There is no way to separate it. My lifestyle, there’s no way I can separate life/work.” In response, participant #5 said, “I find when I leave here, I get home, relax, I’m doing good. As soon as my head hits the pillow, I start thinking about everything that has happened.”

Participant #2 stated:
Sometimes you have to leave it at work and I don’t. But you see kids, we had one girl and her trauma, her background was unreal. I’ve never heard of a person gone through what she went through.

Participant #4 then countered with, “I typically don’t take it home with me. I may have, but long ago. When there’s a concerning situation…I will take it to my small prayer group at church. I leave it there.” Another participant then commented to her that she was indeed taking the work home with her even if it was just to take it to her prayer group. This seemed to embarrass participant #4 who nodded, but broke eye contact with the group. She then said, “I guess we learn how to function, how to put things in the right places to allow us to make sense of it. Sometimes things do find ways to get through those protective gates we put up.” At that moment I was concerned that participant #4 was displeased by the interaction, but she did not disengage from the group or seem to hold any negativity after the exchange. Participant #2 then began to tell the story of an experience with an aggressive child whose behavior resulted in his requiring medical attention. Participant #2 stated:

I was feeling like either I’m going to end up quitting this job, or he is going to end up getting hurt because we are going to end up in a restrain and I’m going to snap or something. I didn’t want that to happen. I was kind of hard. I needed to take myself out of that equation. That kid was under my skin.

Participant #3 responded by validating participant #2’s response through discussing how everyone has specific children that get to them. She identified that there are children who individuals dislike and children who staff like more than others. She stated:
I think there have been some who have a special place in my heart. When they go, they take little pieces of you with them, and a piece of me says was there something more that I could have done? You know, those kids that stick with you over time.

I returned them to the previously mentioned issues of hyper-vigilance and worry about their own children. Participants #3 and 4 validated that they believed that their behaviors were a direct result of their experience of the trauma histories of the children with whom they worked. Participant #3 reported:

I do worry about my kids and who they are with. Even if it is someone I know, sometimes I catch myself. I’m very, very, I don’t want to say paranoid, but aware maybe of people around me, people around them.

Participant #2 segued into expressing that, on some level, “they all feel like my children at times.” He continued by saying, “It hurts when you see these kids do the same trauma that was done to them. When I heard that news, it hurt me, like a punch in the gut because I was dealing with that kid.” The participants discussed the relationships and connections with the children and talked about how they sometimes treat their own children like the children in the facility. Participant #3 said:

I sometimes find myself talking to my daughter like a resident, like she needs to be redirected. When it happens and I catch it, I get this jolt, like life isn’t like the inside here. Just be a mom not a therapist!

The idea that the work behavior sometimes bleeds out into life was endorsed by other members of the group with participant #1 saying, “I watch my granddaughter’s behavior
sometimes looking for the stuff that goes on here. I think I watch her behavior because I constantly see the behaviors around here.

As the topic of the negative effects of exposure to the children’s trauma seemed to have been sufficiently addressed by the group members, I then asked them to discuss what sustains them in the work. There was a brief period of silence while the members were obviously in thought and then participant #1 related:

I just fell in love with it when I came here. Just being able to see a difference in some of the children from the time they come until the time they leave and how much they hate me and the rules at the beginning, but respect me when they leave. That is the difference, and it is a difference in the not just how they deal with me, but how they react to other adults, which is good. So that is why I stay. Because I make a difference to these kids. I see the change!

Participant #4 followed up with, “There have been lots of ups and downs for me, but I have constant knowing that God called me here and there is no way I’ll leave until someone kicks me out.” She again talked about mission and the work of helping stating, “Helping the kids is satisfaction enough, it certainly isn’t about the money.” Participant #3 said:

This is the first place I’ve been where I truly believe puts the kids first. It feels like it’s the right place for me to be, so maybe it is a calling like [#4] said. It just feels like this is the place I am supposed to be.

Participant #2 chimed in with, “What keeps me here every day is knowing that I can try to make a difference and show these kids you don’t have to screw up and let your past determine your future.” Participant #1 continued by discussing a particular case where
the child was very aggressive upon arrival to the facility. He discussed the number of restraints that she had been in as a “record that still stands.” He concluded by saying:

She left here at 16, got a job, her driver’s license, stopped taking meds. She did well and you never, never expected it. That’s a success story. You stand back on those kinds of cases and scratch your head and say wow! That kid did it! A kid that messed up did it! We did that. It makes your chest swell up with pride for those kids, not pride in my accomplishments, but what that kid did. All about the kids making it. We did things, change things, but she really wanted help and she really tried and it worked out for her. It makes you have hope to see that.

Participant #4 stated:

I like seeing a change, a change in the family, the kid. Like when a kid doesn’t want his parents near him, but then they work on it and there is a legitimate, honest hug. Things like that stick out in my mind. Those happy discharges, that people are crying but they are happy and then they call you. Those stick with me. The people who keep in touch to share the good things, like the kid getting mainstreamed, making a friend, not getting in trouble. Things we expect from our kids that are just huge from these kids.

Participant #5 continued by saying:

I think the little changes in the kids reminds me that even in the face of horrible adversity, that there is still resiliency and it can still happen, regardless of the horrible, horrible stories you hear. There is always hope. I guess that is what keeps me going, that there always is hope. Those little glimmers, those kids reaffirm my hope, I guess in change, in resiliency and growth.
The discussion continued with the participants recalling specific children that they remembered had been particularly successful. Participant #5 eventually said, “It is about the kids who grow, the kids who change, but it’s also about the kids that don’t, it’s about them too. The ones you have to keeping hoping to reach. I’m a hoper. I think that is why I stay.” Recalling my prior individual interview, I then prompted the group to explore what personal characteristics they believed they brought to the work that enabled them to stay in the job. Participant #1 discussed being tenacious, “I keep trying to figure out what I can do with that program, that kid or the next to make things more successful. I keep working at it even if I fail. I don’t scrap it.” Participant #2 said, “You have to be able to adjust, roll with the punches.” In response participant #5 said, “Yeah, but you have to be consistent with the kids. Same drill every time so they know what is coming. Stick to the rules. No emotion, no anger, just keep it about the kids.” This began a discussion about the need for staff to continually consider that the work is about the children. Participant #1 led the discussion by saying, “Part of the work is reminding staff that they are the adults to keep them out of the power struggle. The kids are the clients, the job is about them, helping them and it will always be that way.” Participant #2 agreed, “If everybody maintains those ideas, staff as adults, kids as clients we work through things.” Participant #3 related an issue about the work environment being supportive. She said:

I honestly believe that everybody who is here has the best interest of the kids in their mind and in their heart. I have strong relationships with the people I work with here. That helps. I feel supported, help up by other staff. I think everybody works really well together here. You’re not an island you’re not all by yourself. There is lots of support.
Participant #4 followed by saying, “Everybody here works together in the best interest of the kids. We also take care of each other. That makes a difference, your relationships with your co-workers. If those are poor, the work is harder.” Participant #5 stated her agreement, but pulled the conversation back to a topic she wanted to further address. She said, “I wanted to say that I also think it is how we look at the kids. Some of these kids have never had a normal childhood. How are they supposed to be able to function without having somebody to help them?” Participant #2 agreed saying, “Sometimes you’re not dealing just with behaviors that are about attention seeking or control. Sometimes the behavior is about the trauma they went through and even they don’t know it.” Participant #1 carried this notion further by saying:

Because of what’s happened to them in the past, the can have such a crust around them, so they can make it through life, but they aren’t enjoying life, they don’t enjoy other people, they thrive, they exist. I’d like to think that we do something to break that crust off, to help them break that crust, to help them be a part of a community so they can love and be loved. To help them break it down, and when they do it’s like warmth spreads across you, you know, like the sun comes out.”

He chuckled as he concluded “I try not to have a crust either!” From discussion, I gathered that participant #1 is somewhat stern with the children and is what can only be best described as a “sheep in wolves clothing.” When I asked him if the kids view him as such he related they all think he is tough and are afraid of him. This comment prompted actual belly laughs from the group members who chorused statements such as “you wish”, “oh they’ve got your number”, and “don’t let him fool you”. He blushed a bit, while laughing and nodding in agreement. Participant #5 returned to the serious topic of
the children’s behavior and restated, “A lot of these kids are the way they are because of their trauma. You’ve got to remember that when they are acting out.”

As I was aware that we had already been talking for over an hour, I asked the group to conclude the session with a discussion of what positive changes they have seen in themselves as a result of their work. I was quite aware that this topic had not been addressed when they were discussing the influence of the children’s trauma. I noted that this was a similar experience to what had occurred in my individual interview and was in line with one of my presuppositions. Participant #5 stated, “I think that I have become more open-minded and more able to handle change as a result of being here. I don’t get worked up about things like I used to. Small stuff is less important.” Participant #3 stated:

I think that it has helped me and my daughter. You know, to see that not everybody has things like we have. Not everybody has food on the table every night, not everybody has a winter coat, not everybody has a mommy and a daddy that keeps them safe. I think we appreciate what we have more and are more understanding of kids in that situation. I think it’s different than other kids.

This sentiment was echoed by participant #2 who said, “Yeah, I go home and appreciate what I’ve go. I have a whole different view. I sometimes go wow! I really have a good life kind of thing.” Participant # 4 summed up what appeared to be common to the group by saying:

One client in particular seemed to just be metaphorically smacked over and over again. But that client kept picking himself up and dusting himself off. He was so strong. It made me say, my life is a piece of cake. I really do examine my own status and the experience of some of these kids, their loss. I know I have, at times,
paid a lot more attention to my relationships in my real life because my clients had been given that message the hard way. They say hey, this is important in life-look at this horrible trauma thing. It could be you.

I asked the group members if they had anything else that they wanted to share or anything that they thought was important to talk about that we hadn’t covered. None of the members responded. I again reviewed the confidential nature of the proceedings and asked that they please hold each other’s information in confidence. I then thanked them for them time and let them know that I would be contacting them to have them verify the transcripts of the proceedings.

After the participant had exited the room, I again sat quietly and allowed myself to sit with the experience of the focus group. I was aware that many of the same topics had surfaced in this setting as had in my initial individual interview. I felt that the session had gone well and that my interview questions appeared to be targeting the topics of interest. My attempts to stay present during the session had been effective, and I felt my presence enable me to facilitate the group more effectively and purposefully.

The phrases of significance from focus group #1 are contained in Table 4.
### Table 4. Focus Group #1 Phrases of Significance

<table>
<thead>
<tr>
<th>Analytical Categories</th>
<th>Quotations of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. FOUR LIVED EXISTENTIALS</strong></td>
<td><strong>Lived body</strong></td>
</tr>
<tr>
<td>Lived body</td>
<td>This kid was under my skin</td>
</tr>
<tr>
<td></td>
<td>When they go they take little pieces of you with them</td>
</tr>
<tr>
<td></td>
<td>I heard the news and it hurt me, like a punch in the gut…</td>
</tr>
<tr>
<td></td>
<td>When it happens and I catch it, I get this jolt</td>
</tr>
<tr>
<td></td>
<td>It makes your chest swell up with pride</td>
</tr>
<tr>
<td></td>
<td>Roll with the punches</td>
</tr>
<tr>
<td></td>
<td>Like a warmth spreads across you</td>
</tr>
<tr>
<td>Lived relationship</td>
<td>Some who have a special place in my heart</td>
</tr>
<tr>
<td></td>
<td>I have strong relationships with the people I</td>
</tr>
<tr>
<td></td>
<td>That makes a difference, your relationships with your co-workers</td>
</tr>
<tr>
<td></td>
<td>So they can love and be loved</td>
</tr>
<tr>
<td>Lived space</td>
<td>…learn how to function, how to put things in the right places to allow us to make sense of it.</td>
</tr>
<tr>
<td></td>
<td>Protective gates we put up</td>
</tr>
<tr>
<td></td>
<td>Bad cases float back up to the top</td>
</tr>
<tr>
<td>Lived time</td>
<td>Keeping or maintaining everything in a constant routine</td>
</tr>
<tr>
<td></td>
<td>Those kids stick with you over time</td>
</tr>
</tbody>
</table>
## 2. PERCEIVED ROLE

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
</tr>
</thead>
</table>
| Helper        | I would like to think that I help the kids work through their traumatic experiences  
My day-to-day here is to help the kids cope and deal with their trauma  
Our job is to try and help  
I just say I help  
Help them be part of a community  
We help clients and families heal from traumatic events |
| Teacher       | teach them how to cope with things that they can’t change  
we are here to guide them and teach them |
| Baby sitter   | Sometimes we are just glorified babysitters  
Worst babysitting job in history |
| Role Model    | n/a |
| Safety officer| ..want to make sure they are safe.  
I want to try to keep the kids safe as much as can be  
...here at Glade Run. I am not going to hurt you.  
I’m just making sure everybody is safe. I worry about safety |

## 3. EXPERIENCE OF TRAUMA EXPOSURE

| “I never knew that really existed” | I am sometimes like, holy cow!, this shit does really happen  
I didn’t know that world before  
You do get surprised by what is out there. I mean this stuff is for real  
Her background was unreal. I’ve never heard of a person gone through what she went through |
| Nobody would believe it | *What he did to his son was horrible. You wouldn’t believe it. It was awful*
| | *It’s so scary. Stuff you can’t believe*
| | *Crap that happens to these kids, not just these kids, any kids; it’s just unreal, unreal*
| Something out of T.V or the movies | *not just on the Lifetime movie special*

### 4. NEGATIVE CONSEQUENCES OF TRAUMA EXPOSURE

| Paranoia/hyper-vigilance | *It makes me paranoid about my own children*
| | *I have such a heightened, a skewed view of what goes on*
| | *I have an increased awareness at church*
| | *I am very, very, I don’t want to say paranoid, but aware maybe, always aware of people around me, people around them.*
| | *I worry about my kids and who they are with.*

| Concern for outside relationships | *I watch my granddaughter, watch her behavior more that I normally would*
| | *I sometimes find myself talking to my daughter like a resident...life isn’t like that, be a mom, not a therapist*
| | *I think I watch her behavior because I constantly see the behavior around here*

| Negative view/taking it home | *I shouldn’t be taking it home, but I do*
| | *I don’t get the sleep like I should*
| | *As soon as my head hits the pillow, I start thinking about everything that has happened*

| Potential for leaving the job | *I’m going to end up quitting this job...*

| Feeling helpless | *n/a*
## 5. PROTECTIVE FACTORS AGAINST TRAUMATIC EXPOSURE

<table>
<thead>
<tr>
<th>Category</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Accepting the trauma | *Some of these kids have never had a normal childhood. How are they supposed to be able to function?*
|                    | *Sometimes the behavior is about the trauma they went through and even they don’t know it*                                                |
|                    | *A lot of these kids are the way they are because of their trauma. You’ve got to remember that*                                          |
| Personal characteristics | *I’m a “hoper”*                                                                                                                                  |
|                    | *I keep trying to figure out what I can do … to make things more successful. I keep working at it. I don’t scrap it.*                       |
|                    | *You have to be consistent*                                                                                                                   |
|                    | *No emotion, no anger*                                                                                                                         |
|                    | *You have to be able to adjust*                                                                                                                 |
|                    | *I take it to my mall prayer group at church. I leave it there*                                                                                 |
| “It is not about me” | *This is the first place I’ve been where I truly believe puts the kids first.*                                                                     |
|                    | *What that kid did. All about the kids making it.*                                                                                               |
|                    | *It’s about the kids who grow…but it’s also about the kids that don’t.*                                                                       |
|                    | *Just keep it about the kids*                                                                                                                   |
|                    | *The kids are the clients, the job is about them.*                                                                                              |
| Supportive environment | *I feel supported, held up by other staff.*                                                                                                    |
|                    | *You’re not an island, not all by yourself*                                                                                                    |
|                    | *There is lots of support*                                                                                                                      |
|                    | *We [everybody here] take care of each other*                                                                                                  |

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### Setting boundaries

*Sometimes you have to leave it at work...put it in the right places to allow us to make sense of it*

*I typically don’t take it home with me*  
*Protective gates we put up*  
*I needed to take myself out of that equation*

### 6. POSITIVE RESULTS OF THE WORK

| **Being the person who makes a difference** | **Because I make a difference to these kids**  
**I can try to make a difference and show these kids you don’t have to screw up and let your past determine your future** |
| **Seeing the smallest change** | **Just being able to see a difference**  
**I see the change!**  
**I like seeing a change**  
**I think the little changes in the kids reminds me...**  
**Things that we expect from our own kids are just huge for these kids!** |
| **Changes in outside behavior** | **I think I have become more open-mined**  
**More able to handle change**  
**I don’t get worked up about things. Small stuff is less important**  
**We are more understanding of kids in that situation**  
**I paid a lot more attention to my relationships in my real life** |
| **Benefits of comparison** | **Not everybody has things like we have. Not everybody has food....and a mommy and daddy that keeps them safe.**  
**We appreciate what we have more**  
**I go home and appreciate what I’ve got a whole different view.**  
**It made me say, my life is a piece of cake** |
<table>
<thead>
<tr>
<th>Sense of satisfaction</th>
<th>Helping kids is satisfaction enough, it certainly isn’t about the money</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>You stand back and scratch your head and say wow! That kid did it!</td>
</tr>
<tr>
<td></td>
<td>Those happy discharges….those stick with me</td>
</tr>
<tr>
<td>Finding a sense of hope</td>
<td>It makes you hope to see that</td>
</tr>
<tr>
<td></td>
<td>...even in the face of horrible adversity, there is still resiliency and it can still happen</td>
</tr>
<tr>
<td></td>
<td>I guess that is what keeps me going, that there always is hope</td>
</tr>
<tr>
<td></td>
<td>Those little glimmers, those kids reaffirm my hope</td>
</tr>
<tr>
<td></td>
<td>The ones you have to keep hoping to reach</td>
</tr>
</tbody>
</table>

**Focus Group #2.** The second focus group was conducted in the same conference room in which the first focus group was held. On the morning of this focus group, there were no unusual events occurring within the facility and the participants all arrived on time for the interview session. I had arrived prior to the scheduled start time in order to set up recording equipment and to make sure that the room was arranged in a manner conducive to recording and comfortable conversation. Upon their arrival, it was apparent from their jovial conversation, that the participants were familiar with one another. They appeared to be comfortable and congenial in their relationships. I noted that they were discussing the events of the morning and seemed to be enjoying their interactions with one another. I was aware that I was feeling anxious to begin and was very hopeful that the participants would validate the data I had previously gathered. I mentally reminded myself to keep my presuppositions in check and to be mindful to allow the information to emerge naturally without attempts to manipulate or manufacture its content.
As they entered the room, I directed the participants to choose any of the chairs that were arranged at the table. I introduced myself to them and provided them with copies of the consent document. Although each of the participants had previously received a copy of the document, I carefully reviewed the form to ensure that there was a clear understanding of the study and their rights as participants. I felt it especially important to review the voluntary nature of participation, the confidential nature of their participation with respect to the facility’s management, and confidentiality in group settings. All of the participants voiced understanding of the information and all agreed to document this understanding through the signing of the consent document. Once this process had been completed, I began taping the session. Focus group #2 was comprised of five participants whose demographic information is presented in Table 5.

**Table 5. Focus Group #2 Demographics**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Gender</th>
<th>Years employed</th>
<th>Years in Mental Health Field</th>
<th>Degree</th>
<th>Endorse personal trauma history</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 Focus #2</td>
<td>23</td>
<td>male</td>
<td>2</td>
<td>2</td>
<td>High School</td>
<td>no</td>
</tr>
<tr>
<td>8 Focus #2</td>
<td>25</td>
<td>male</td>
<td>3</td>
<td>3</td>
<td>BS- Sociology</td>
<td>no</td>
</tr>
<tr>
<td>9 Focus #2</td>
<td>32</td>
<td>male</td>
<td>3</td>
<td>3</td>
<td>BA - Journalism</td>
<td>no</td>
</tr>
<tr>
<td>10 Focus #2</td>
<td>43</td>
<td>male</td>
<td>8</td>
<td>8</td>
<td>Associates Accounting</td>
<td>yes</td>
</tr>
<tr>
<td>11 Focus #2</td>
<td>24</td>
<td>female</td>
<td>2</td>
<td>2</td>
<td>BA - Graphic Design</td>
<td>yes</td>
</tr>
<tr>
<td>average</td>
<td>29.4</td>
<td>M=4 F=1</td>
<td>3.6</td>
<td>3.6</td>
<td>Y=2 N=3</td>
<td></td>
</tr>
</tbody>
</table>

I began the interview by asking the participants to describe their roles within the facility. Without any hesitation, participant #9 stated, “managing chaos.” His comment
elicited chuckles from the rest of the group who quickly chimed in with elaboration. Participant #8 stated, “We try to teach, teach these kids all kinds of things they haven’t been taught by anyone else.” Participant #7 agreed and continued to elaborate with, “We teach them better ways to cope with their frustrations. We teach them different ways of dealing with anger.” Participant #11 agreed by stating, “We teach them lots of things, like hygiene, how to get along, social skills, boundaries, sometimes and stuff like basic manners.” As they continued to discuss the types of skills that they often find themselves teaching to the residents, participant # 8 stated:

Sometimes it’s parenting because these kids’ parents don’t or didn’t have the tools to parent. They don’t know how to do it. So it benefits the kids getting the role models from the adults around here. The kind of role modeling they have never had before.

Participant #10 continued by saying that, “we teach things they wouldn’t otherwise know, things they never learned. We also teach them to manage loss. This prompted participant #7 to blurt out, “babysitter, sometimes we are babysitters.” Participant #10 agreed with this assessment clarifying:

Babysitter, yeah sometimes. Just minding the babies. We are also a support system for the people we work with. They need people to talk to too. One other thing we do, especially with the people you have in this room, we provide a sense that the staff can do it. If we work together, we can do anything.

When I pushed for further description of their role, participant #8 said:
It’s all about hope for those kids you think are hopeless. If anybody asks me, I say have you seen those kids on TV that punch holes in the wall, those kids that head bang? I help those kids. That is what I do here.

This line of discussion seemed to energize the group. They became more animated, spoke more loudly and began to converse more with one another than with me. I consciously leaned back in my chair and allowed them to direct the discussion without my intervention. Their conversation revolved around why they do the work they do and how it is perceived by outsiders. Participant #9 said, “You know someone has to help these kids who, through absolutely no fault of their own, are a mess.” This comment was rapidly followed by participant #10 who related the following:

People don’t get that. They see that stuff on TV and in the movies and stuff like that, but it never seems real to people, it didn’t used to to me either. If you’re out talking to people about this happened today at work, blah blah blah and they’re like “what?” Like it’s way beyond the norm. They look at you like you’re crazy. Like kids do that? I’ve seen some of the craziest shit that I’ve ever seen in my life here. I didn’t even know a place like this with kids who have been through shit like this existed before I even started working here.

His comments flowed easily into a discussion of how the workers experienced the trauma of the children within the facility. Participant #7 related an early experience with an aggressive child. He stated, “I went home and I thought holy shit. That’s like the stuff that you see on TV in those weird Hallmark movies. Who knew this shit is real?” Participant #8 countered with, “No man, ABC Afterschool specials.” Participant #11 said, “When I read their backgrounds and stuff, I think in my head, I’d be the same way.
I’d act the same way.” The discussion continued with participant #11 saying, “you get how they [the kids] can be this way when you read all the unbelievable stuff that has happened to them. It makes me sick sometimes.” Participant #9 followed with discussing a former client whose history involved being locked in a basement for a year, being forced to have sex with her brothers in front of her mother’s drug addicted boyfriend, and who had been physically abused and neglected. He said, “When you first hear that stuff it makes you flinch, you’re just like, wow! That’s *fucked* up!” He seemed concerned that his use of an expletive would offend me and looked at me for approval. In order to reassure him that his language was not an issue, I stated that in whatever way they all wished to talk about their experience was fine with me. Further, I wanted to encourage them to talk about their work just as they would with one another and with no one else present. Participant #8 then validated #9’s reaction and said, “You sometimes get smacked in the face with it. You know, like it hits you on an emotional level, kind of makes you sick.” There was general agreement among the participants who discussed how, over time, the “shock and awe” to quote participant #8, diminishes. Participant #9 stated, “At the end of the day they are still kids. Kids that are looking to you for help, for comfort, for safety.”

The conversation then shifted to a discussion of the experience of the work and how it affects them. Participant #11 said:

I think it’s taken me along time to be able to separate myself from my job. I’d go home, when I first started, and I’d cry. I didn’t want to cry. I had a motherly instinct that wanted to take care of them, fix them. I thought about them at home. I dreamed about work. I carried it around. It was heavy.
Participant #9 followed with:

I don’t watch the news anymore. I used to watch the news every day. I live it every day, I don’t need to see it on the TV and I don’t need to talk about it with my wife. I need to have distance from it to keep it together. It took a long time to get that way.

This discussion lead to a conversation of the support that is present in the facility. The participants all related that the staff relationships are very important to their success and longevity on the job. Participant #10 stated, “There is camaraderie. There are people that you know you can count on, people that you look to to help with situations. Those people make a big difference.” Participant #7 followed with, “It’s loyalty to the people that help you get where you are right now. That keeps you going.” Participant #11 agreed by saying, “You want to work with people you trust, people you know, have a relationship with.”

I was then struck by how easily the participants moved to talking about the problems they perceive with the administration of the facility. They did not appear to be concerned that this discussion would find its way out of the confines of the room, or to be concerned that there could be negative repercussions related to their expressions of their complaints. Participant #7, in discussion about support, stated:

We process the stuff together. That helped me out when I first started out here.

That is one of the big reasons that has kept me here- the people that I work with.

Not administratively, but on the floor. Administration doesn’t do anything for us but give us stress.

Participant #8 echoed these sentiments:
I think the people that I came in working with are the only reason why I kept working here. I never knew a place like this existed. It makes a huge difference to have the support. It made it a lot easier for me to deal with crisis situations and the kid’s trauma stuff. I learned a lot from other staff. Administration didn’t teach me those things.

The group members continued to discuss the problems with administrative support. These problems ranged from “it seems like they want 1000 and 1 other things to be a focus besides the kids” as participant #10 stated, to participant #11’s view that the “pressure comes from [the facility] because of the pressure they receive outside of the organization and because of the pressure that organization receives and so on. It just keeps compiling and compiling.” Participant #7 continued by agreeing, “Yeah, pressure from the demands of DPW, [the facility], inspections, about being late, this, that and the other. The kids are the easy part.” The participants discussed a perceived lack of communication, lack of direct care experience among those who make decisions about client care, and a general sense that the facility is stratified into separate “sides.” Participant #9 interjected, “It isn’t the kids that are tough. My main purpose here is these kids, not all the outside pressure.” Participant #8 continued with:

What frustrates me most is people in management and all around know that we don’t get paid a lot. You still show up every day and work hard. There is a lot of pressure on us. The minute you screw up, it’s BAM, and it feels like you get kicked.

Participant #11 concluded the discussion with the follow quote:
You can have all the book knowledge in the world and it won’t touch what we do on a daily basis. Unless you have lived it, felt it, done it, you don’t know. It is hard to realize sometimes that there are people making decision outside of the jobs that we’re doing that I know, in my heart, have never really lived, the majority of them, not all, but the majority of them, never really lived a day in what this place looks like or feels like. They rely on trickle down information that is watered down. It’s sad because the kids are going to be negatively affected by those bad informed decisions.

The discussion segued to the topic of the children who reside in the facility. The participants seemed to agree that it became easier over time to deal with the issues the children present. Participant #7 stated, “I know how to deal with the kids now. I know it is about the trauma they have endured.” Participant #11 agreed with this statement and followed up with:

The staff that stay are good. They don’t get mad at the kids. They don’t take it personally. They understand that there is a lot of stuff going on with these kids, stuff that is related to where they come from and what they have been through.

Participant #8 stated:

I think it is like culture shock for these kids. Given all the crap they’ve been through, you can’t expect them to be any different, but here they are, with all these people laughing, smiling, and trying to have a good time with them. How could they be used to that?

During this part of the focus group, the participants were more subdued than they had been previously. Many of them shook their heads while others were discussing particular
cases that involved abuse and trauma. Participant #10 stated, “Given the stuff they’ve been through, you kind of have to expect it if the kid says “Fuck you! You’re an asshole when you’re trying to set boundaries and stuff. You just have to expect they are going to be that way” This sentiment of expectation was validated by Participant #11 who said, “That gets ingrained in you, that expectation. It’s like okay, you’re this way because. So now what can we do. Let’s go from here. How’re we going to change that pattern for you? Participant #9 summed it up by saying:

You always have to put them [the kids] in perspective. Are you going to keep coming back for the kids? Because it is about more than a pay check. You have to remember where they’ve been. Are you going to come back like this kid has seen their entire life? You know what- NO! I am coming back every single time smiling, like, hey! We are going to have a positive day today. Won’t that be new and different?

I then redirected the group by asking them, given the stressors and pressure of the job, what keeps them coming back to work. This question seemed to brighten the mood in the room. The participants became more animated and joked that they were all in it for the serious amount of monetary compensation that they receive. When the group members became serious, they reflected that there were other professions and jobs where they could make more money, but as participant #7 put it, “those would be less meaningful.” Participant #8 discussed the loyalty to his team members and “working with the kids, I enjoy the kids a lot.” Participant #10’s face lit up and he said, “I love working with the little kids. It’s the funnest experience I’ve ever has in my life. I love being a part of their process. Love seeing them change. Participant #11 related:
Even on the worst day, it’s still fun. I enjoy it. It’s loyalty to the kids. You’ll come in and maybe you had a bad day in the morning. You woke up, stubbed your toe, your wife or your husband was yelling at you, the dog pissed on the floor or whatever. You get in here and one of these little guys walks up to you and says – Man, you look like you are having a shitty day. Totally cracks me up. I mean, these kids have been through it and they can still crack me up. Keeps me showing up, showing up every day. What they’ve been through and they are worried about my dog pissing on the floor. Knocks you back a bit, makes you think.

The group members all laughed as participant #11 spoke and engaged in telling a number of humorous stories related to the children’s behaviors. Participant #8 stated, “You can’t help but laugh. It lightens things up too. You feel lighter. I like it when the kids make up their own swear words. That tickles me!” The group continued to discuss the occurrences and factors that keep them on the job. Participant #9 related the story of a client who continued to keep in touch after being discharged from the facility. He reported:

Sometimes you feel like, really, calling now? You’re in the middle of stuff and if feels like an inconvenience. But then, they start telling you how they are doing, giving you a heads up about what’s going on with them, asking for advice. Then you it smacks you like “wow, I could have had a v-8” This kid is calling for advice! That is meaningful, to say that you had that much of an impact.

Participant #7 continued, “Even those kids that say I hate this f’ing place, I don’t want to be here, they call back looking to talk. It is very reassuring. I, we made a difference.” The members seem to be in agreement that phone calls from discharged residents provided a source of satisfaction. Participant #11 stated, “It gives you hope to hear how they are, that
they are checking in, that you made a difference, you were one of the good guys.”

Participant # 10 said:

When they call back, you know we made a difference. They have us to ask for advice. Yeah, they should have parents and whatnot, but they have somebody. They can still continue to change. You can still be of help. Be that person who believes they can do it and helps them along.

The conversation then segued into the negative reports that the participants often receive regarding former clients. The group members discussed seeing clients who had committed crimes on the news, getting word that children had been put in another placement, and finding out that they had dropped out of school, or gotten pregnant. The members discussed how difficult it is to stay focused on the positive when they are constantly faced with negative situations. Participant #8 reported:

You don’t get to hear the positive stories as much as you want. That’s why the phone calls mean so much or the letters mean so much. You want to see that this place made a difference, even if the difference is small, just a little change.

Participant #7 continued with:

If even one out of the 14 kids you worked with is successful in doing something better, it’s worth it. If anything that we teach these kids makes them stop and think before that react like they used to, that’s worth it too, because that’s a change. One way or another it is a change and any change is good.

The group members continued their discussion regarding stories of successes that they have hear during their tenure with the facility. Participant # 10 concluded, “Even if they don’t stick to things 100%, even if they just manage something different some of the time
that is huge. Maybe they never did anything like that before.” Participant 9 continued this though with the following:

I look at it like when you see that change in somebody and know that you helped with it, you obviously feel good about yourself. When you feel better about yourself, you’re going to do better outside of here and you’re going to do better in here.

Participant #9’s comment steered the direction of the interview to the personal changes the group members have experienced as a result of their work in the facility.

Participant #7 stated, “This place puts things in perspective. I look at these kids here and think, wow, my life sure could be a hell of a lot worse.” Participant #11 continued by saying:

You get more willing to be acceptable to stuff out there. Like if I’m in a bad mood and somebody comes up to me messing around, I’m probably not going to react like I used to. I’m likely to just let it roll off my back. I am way more flexible, more adaptable, less easily worked up than I used to be.

Participant #10 stated, “This job makes you grow up fast. You can’t stay childish.” His comments lead to a discussion of how working with the children creates a desire to “be better for these kids” as participant #9 put it. The topic centered upon the idea that staff are often young professionals when they begin working at the facility, but there is no place for typical young behaviors. Participant #8 summed this notion as follows:

You can’t in all good conscience ask a kid to do something that you’re not willing to do yourself. You can’t do it. It is not fair. I can’t tell a kid not to hit somebody when they are angry if I’m going out on a Friday night, getting drunk, and beating
the hell out of somebody. You just can’t keep acting that way and work here.

These kids make you want to be a role model, one of the good guys.

The idea of wanting to be a positive role model was endorsed by participant #7 who said:

We tell our kids smoking is bad for you, don’t smoke. We’re smoking, the kids know we smoke. So we try to be the best role models we can. We need to teach them, we shouldn’t be doing it either. That’s kind of our job.

The idea of being a role model was discussed by the participants. Participant #11 stated, “As long as we are teaching them, we are learning too. There are a lot of things that I’ve learned from these kids.”

From the discussion of changes in personal behavior, the conversation moved to an exploration of further alterations in the participants’ larger world. Participant #10 addressed the issue of focusing on relationship by saying:

I used to really not think about my relationships, my family, but these kids are missing a lot of what I have. I think you kind of take that home with you.

Teaching these kids how to have relationships makes me pay more attention to mine. You know, how I am with the people I care about. How they are with me.

The participants continued to address their relationships with other people and the affect that working with traumatized children has had upon their approaches and interactions. Participant #8 pensively said, “My biggest fear is that when I have kids, I don’t want to analyze then or RTF them. Everything is so regimented, ‘cause it has to be, here. I don’t want to only know how to do kids this way.” He was supported by the other members who reassured him that he would “be fine”, which seemed to provide him with some comfort. Participant #11 said, “I find myself doing it with my nieces a lot. I do. I swear. I
tell them stuff just like I say to the kids here. I prompt {making quotations marks with his hands} them like the kids here.” What followed was a normalizing discussion which concluded with participant #9 saying, “But if that works, if it stays in the back of your mind, it will be present when you do have kids. It’s not so bad. You can move out of here into that.”

The group members continued with a further discussion of the affects the work has had upon their perceptions and interpretation of themselves, others and the world around them. Participant #7 stated:

I take care of my God kids and I’m just like thank God not every child has it like, is like these kids here. It’s another reality check on the flipside, it’s like how lucky are we to not have kids that have gone through the shit these kids have gone through and have had to deal like they have had to deal. I am so much more patient with people now. I think about this crap and it takes so much more to get me upset!

In a flurry, both participant #8 and #10 agreed that they “have a lot more patience outside of here now. A lot more patience.” Participant #11 said, somewhat defiantly, “I am the same.” This prompted the other group members to disagree. Participant #10 said, “I am going to call bullshit on that.” This was echoed by participant #9 who said, “I would definitely agree.” The participants engaged in a discussion regarding the changes they have seen in participant #11 while he continued to be resistant to accepting the idea that he has shown personal growth as a result of his employment. The members pointed to his becoming more open minded as participant #8 said, “he was kind of compartmentalized in one way of looking at things. But the time that he’s been here, he’s opened that up.”
Participant #7 stated, “You’re more understanding now. You’re so much better at dealing with people. You do see things from different perspectives.” Participant #11 finally acquiesced and said, “Ok, maybe I am able to recognize that there’s another point besides mine, but if I can it is very subtle, very subtle.” Participant #9 stated, “I have changed my outlook a lot. I see things differently; understand more how people can be how they are. I am more sympathetic, more oh, I get it.” He went on to talk about the success he felt when working with a child that was diagnosed with dissociative identity disorder. He related that although:

She was not the greatest success story in the world, she left here better. She dealt with some things here, made some movement. Kids like that make you say any change is good change. Moving forward is forward and that is good. Cases like that make you feel good about you too. They make you feel taller than when you walked in the door.

Participant #7, who had been quiet for some time looked directly at me and spoke the following:

I sometimes wonder if we do make a difference, if I matter here. It can get you down; make you feel lost, like you are just wondering around aimlessly. But then, you see that little change, that tiny spark of hope that ‘I think they can do it!’ That keeps me hanging in, just that little hope. This work is about these kids, what they can do. I have to remember that it isn’t about me alone. It is about the team, the people. I can do my thing, be constant, calm, positive and upbeat, but at the end of the day, they choose to change. They choose to accept help. They do it. And you know, most of them, even if it is in a small way, eventually make that choice.
The room was quiet for a moment while the participant seemed to take that in and think about it. I was conscious that the group members were looking at participant # 7 who was blushing slightly. Participant #8 said, “You’re right, it’s not about us, but the successes do make me feel better about myself too.” They continued their discussion about being validated by their positive influence in the children’s lives until participant #10 received a text message asking him to come provide assistance on one of the units. The other group members quickly packed up their belongings and indicated they would go with him. This interested me because the group members were not currently on shift yet were quite willing to go and lend a hand. I thanked them all for their participation, made sure that they had copies of the consent document and tried to remind them about confidentiality as the hurried from the room. As I was packing up the recording equipment, participant #8 stuck his head in the door to retrieve his coat, he stated, “Thanks for giving us the opportunity to talk about this stuff. I think it might make me try to think more positively about what I do here. There really is a lot of good stuff, isn’t there?”

I sat for some time thinking about my experience with this focus group. I was struck by how honest the participants were and how willing to share their thoughts and feelings they were. Again, they had to be prompted to look at the positive changes in themselves as a result of the work. One member had to be convinced that change in him had even occurred. This group made me even more curious to see if this same phenomenon would be evident in my next individual interview, which was scheduled for later the same day. Focus group #2 had provided a number of phases of significance which were in line with those previously gleaned in my data collection. These phrases or organized below in Table 6.
<table>
<thead>
<tr>
<th>Analytical Categories</th>
<th>Quotations of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. FOUR LIVED EXISTENTIALS</strong></td>
<td></td>
</tr>
<tr>
<td>Lived body</td>
<td>When you first hear that stuff it makes you flinch</td>
</tr>
<tr>
<td></td>
<td>It makes me sick sometimes</td>
</tr>
<tr>
<td></td>
<td>You sometimes get smacked in the face with it</td>
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<td></td>
<td>On an emotional level, kind of makes you sick</td>
</tr>
<tr>
<td></td>
<td>It feels like you get kicked</td>
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<tr>
<td></td>
<td>Knocks you back, makes you think</td>
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<td></td>
<td>It lightens things up, you feel lighter too</td>
</tr>
<tr>
<td></td>
<td>Then it smack you like, wow!</td>
</tr>
<tr>
<td></td>
<td>That tickles me!</td>
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<tr>
<td></td>
<td>I’m likely to just let it roll off my back</td>
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<tr>
<td></td>
<td>They make you feel taller than when you walked in the door.</td>
</tr>
<tr>
<td>Lived relationship</td>
<td>There are people that you know you can count on</td>
</tr>
<tr>
<td></td>
<td>People, you know, you have a relationship with</td>
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<tr>
<td></td>
<td>I think the people are the reason</td>
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<tr>
<td></td>
<td>...how I am with the people I care about</td>
</tr>
<tr>
<td>Lived space</td>
<td>I have to have distance from it to keep it together</td>
</tr>
<tr>
<td></td>
<td>Moving forward is forward and that is good</td>
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<tr>
<td>Lived time</td>
<td>It took a long time to get this way</td>
</tr>
<tr>
<td></td>
<td>At the end of the day, they are still kids</td>
</tr>
</tbody>
</table>
## 2. PERCEIVED ROLE

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helper</td>
<td>You know, someone has to help these kids</td>
</tr>
<tr>
<td></td>
<td>Kids that are looking for help</td>
</tr>
<tr>
<td></td>
<td>You can still be of help</td>
</tr>
<tr>
<td></td>
<td>I help those kids; that’s what I do here.</td>
</tr>
<tr>
<td>Teacher</td>
<td>We try to teach these kids all kinds of things they haven’t been taught by anyone else</td>
</tr>
<tr>
<td></td>
<td>We teach them lots of things ...</td>
</tr>
<tr>
<td></td>
<td>We teach things they wouldn’t otherwise know</td>
</tr>
<tr>
<td></td>
<td>We need to teach them</td>
</tr>
<tr>
<td></td>
<td>As long as we teach them, we are learning too</td>
</tr>
<tr>
<td>Baby sitter</td>
<td>Babysitter, sometimes we are babysitters</td>
</tr>
<tr>
<td></td>
<td>Babysitter, yeah, sometimes just minding the babies</td>
</tr>
<tr>
<td>Role Model</td>
<td>Benefits the kids getting the role models from the adults around here. The kind of role modeling they have never had before</td>
</tr>
<tr>
<td></td>
<td>These kids make you want to be a role model</td>
</tr>
<tr>
<td></td>
<td>We try to be the best role model that we can</td>
</tr>
<tr>
<td>Safety officer</td>
<td>Kids that are looking for safety</td>
</tr>
</tbody>
</table>

## 3. EXPERIENCE OF TRAUMA EXPOSURE

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I never knew that really existed”</td>
</tr>
<tr>
<td>I dint’ even know a place like this with kid who have been through shit like this existed before I even started working here</td>
</tr>
<tr>
<td>I went home and I thought holy shit</td>
</tr>
<tr>
<td>Who knew this shit was real?</td>
</tr>
<tr>
<td>I never knew a place like this existed.</td>
</tr>
</tbody>
</table>
Nobody would believe it

> It never seems real to people, it didn’t used to to me either

> Unless you’ve lived it, felt it, done it, you don’t know.

> They’re like what? That’s way beyond the norm.

Something out of T.V or the movies

> That’s like the stuff that you see on TV and those weird Hallmark movies

> No man, ABC Afterschool specials.

> They see that stuff on TV and in the movies and stuff like that

> I say have you seen those kids on TV that punch holes in the wall, those kids that head bang?

### 4. NEGATIVE CONSEQUENCES OF TRAUMA EXPOSURE

<table>
<thead>
<tr>
<th>Paranoia/hyper-vigilance</th>
<th>n/a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concern for outside relationships</td>
<td>My biggest fear is that when I have kids, I don’t want to analyze them or RTF them.</td>
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<tr>
<td></td>
<td>I don’t only want to do kids this way.</td>
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<tr>
<td></td>
<td>I swear. I tell them stuff just like I say to the kids here. I prompt.</td>
</tr>
<tr>
<td>Negative view/taking it home</td>
<td>I went home and thought</td>
</tr>
<tr>
<td></td>
<td>I think it’s taken me a long time to separate myself from my job. I’d go home, when I first started, and I’d cry.</td>
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<tr>
<td></td>
<td>I thought about them at home. I dreamed about work.</td>
</tr>
<tr>
<td></td>
<td>I don’t watch the news anymore. I live it every day.</td>
</tr>
<tr>
<td></td>
<td>I think you kind of take that home with you.</td>
</tr>
<tr>
<td>Potential for leaving the job</td>
<td>n/a</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----</td>
</tr>
</tbody>
</table>
| Feeling helpless              | *It can get you down, make you feel lost.*  
*You don’t get to hear the positive stories as much as you want.* |

### 5. PROTECTIVE FACTORS AGAINST TRAUMATIC EXPOSURE

| Accepting the trauma | *You get how they can be this way when you real all the unbelievable stuff that has happened to them.*  
*When I read their backgrounds and stuff, I think in my head, I’d be the same way. I’d act the same way.*  
*There is a lot of stuff going on with these kids, stuff that is related to where they come from and what they have been through.*  
*Given all the crap they’ve been through, you can’t expect them to be any different.*  
*You kind of have to expect it....you have to expect that they are going to be this way.*  
*That gets ingrained in you, that expectation. It’s like oaky, you are this way because. Now, what can we do?*  
*You always have to put them in perspective.*  
*I know it is about the trauma they have endured.* |
| Personal characteristics     | *I had a motherly instinct.*  
*They don’t get mad at the kids.*  
*They don’t take it personally.*  
*I’m going to come back every single time smiling*  
*I enjoy the kids a lot.*  
*I love working with the little kids.*  
*Be constant, calm, positive, upbeat.* |
| “It is not about me” | My main purpose here is these kids  
     It’s loyalty to the kids  
     This work is about these kids, what they can do. I have to remember it is not about me alone  
     You’re right, it’s not about us |
|----------------------|---------------------------------------------------------------|
| Supportive environment | We are also a support system for the people we work with.  
     We provide a sense that the staff can do it  
     It’s loyalty to the people that help you get where you are right now.  
     That is one of the big reasons that has kept me here- the people that I work with.  
     It makes a huge difference to have that support. |
| Setting boundaries | I don’t need to see it on TV, don’t need to talk about it with my wife. I need to have distance from it to keep it together.  
     You can’t help but laugh. It lightens things up too. |
| **6. POSITIVE RESULTS OF THE WORK** |  |
| Being the person who makes a difference | That is meaningful to say that you had that much of an impact.  
     It is very reassuring. I, we, made a difference  
     ...that you made a difference, you were one of the good guys.  
     When they call back, you know that we made a difference.  
     ...they have somebody...be that person who believes  
     ...and know you helped with it, you obviously feel good about yourself. |
| Seeing the smallest change | They can still continue to change.  
|                          | Even if the difference is small, just a little change  
|                          | One way or another it is change, and any change is good.  
|                          | Even if they just manage something different some of the time, that is huge  
|                          | ...then you see that little change  
|                          | ...even if it is in a small way  
|                          | Love seeing them change  

| Changes in outside behavior | I am way more flexible, more adaptable, less easily worked up than I used to be.  
|                           | This job makes you grow up fast. You cont’ stay childish.  
|                           | Teaching these kids about relationships makes me pay more attention to mine.  
|                           | I am so much more patient with people now. I think about this crap and it takes so much more to get me upset.  
|                           | A lot more patience outside of here now. A lot more patience.  
|                           | ...compartmentalized in one way of looking at things. But the time that he’s been here, he’s opened that up.  
|                           | You’re more understanding  
|                           | You’re much better at dealing with people.  
|                           | I am able to recognize that there’s another point besides mine  
|                           | I see things differently; understand more how people can be how they are.  
|                           | I am more sympathetic, more oh, I get it.  

| Benefits of comparison | ...what they have been through and they are worried about my dog pissing on the floor?!  
I look at these kids here and I think, wow! My life sure could be a hell of a lot worse.  
These kids are missing a lot of what I have.  
How lucky are we not to have kids that have gone through the shit these kids have gone through |
| Sense of satisfaction | Won’t that be new and different?  
I love being a part of their process.  
Even on the worst day it is still fun.  
...one out of the 14 kids you worked with is successful in doing something better, it’s worth it.  
When you see that change in somebody and know you helped with it, you obviously feel good about yourself.  
The successes do make me feel better about myself. |
| Finding a sense of hope | That keeps me hanging in, just that little hope.  
...that tiny spark of hope  
It gives you hope to hear how they are |

**Individual Interview #2.** The second individual interview conducted for the study was with a 28 year old female who had been employed by the facility for 5 years. She had one year of prior experience in the mental health field working in a community service position. On her demographic information, she self-identified as having a personal trauma history.

In order to provide consistency in data collection, the interview was conducted in the same manner as the other interviews for the study. I met with participant #I-2 in a
secluded therapy room away from the general population, but still within the therapeutic milieu. I had arrived prior to the scheduled start time to set up recording equipment and to ensure that the room would be comfortable for the interview. Participant #I-2 arrived on time for the interview. She entered the room in an ebullient manner saying, “I’ve been looking forward to talking to you. Everyone says this is really interesting!” I expressed my pleasure that she was so willing to participate and directed her to make herself comfortable. Out of concern that other study participants had discussed the interview questions ahead of time, I asked her what she had been told about the study. Participant #I-2 related that her peers had told her that the questions were thought provoking and that the process was “painless.” I asked if she had been told about the questions I would be asking, she indicated that the other participants said they wouldn’t tell her because of confidentiality. She laughed when she stated this saying, “You know how big we are on HIPAA and confidentiality around here!”

As with the other interviews and focus groups, I provided her with and reviewed another copy of the informed consent document. She expressed and understanding of the purpose of the study and its parameters and that her participation was voluntary and bore no influence upon her employment at the facility. Participant #I-2 willingly signed the consent document and we began the interview process. I was aware that I was pleased that she expressed interest in participating in the study and had a sense of excitement that this interview could be the culmination of my data collection.

I began the interview by asking participant #I-2 to describe her role as a mental health worker. Without taking much time to think she said:
Well, basically you are the parent, a babysitter and a therapist all rolled into one and I would say, you come in, you walk these kids through basic everyday skills that you assume children of their age have and you find that a lot of them don’t have it. So starting at the very basics is teaching them everyday living skills. Without the need for further prompting she continued her description by saying:

We move on to how to be nice to each other, how to ask for what you want in a positive way. We teach how to get along with adults and other children and a lot of just teaching how to live socially. And then from that, it is their behaviors.

She continued to chat quite easily about her role, duties and perceptions about the work, such that there no need for me to interject, prompt, probe or do anything beyond attending and listening carefully. She discussed the children’s trauma history and her belief that there is a connection between their trauma and their behaviors by saying:

There’s a lot of really awful things that they have lived through and then that leads to their coping mechanisms that they have developed that are not healthy. So you have to accept that and accept who they are and let them know that it’s okay to be that way. And that they’ve learned those things.

She further clarified by relating a stories of how she has physically experienced the children by being, “punched in the face” and “having ridiculous things happen like being peed on, barfed on –on purpose!” Participant#I-2 followed this story with:

You have to look at why they are doing that and why they are that way. To a lot of them, that is their comfort, that’s what they come from, that’s what they know, whether that is completely dysfunctional, that is where they want to be.
She continued this line of thinking by discussing some of the behaviors of the children that she has found to be disturbing, such as a child who purposefully chose to lay in her own urine for hours at a time, and resisted any efforts to be assisted in cleaning herself up. Participant #1-2 related that such circumstances sometimes make her think, “My God, this in nothing I should be doing!” She was then able to reframe the experience and said, “You have to not react emotionally to it and that is the hardest part. Because some of them that’s all they know.”

She spoke a number of times about the relationship with the children being an essential part of the work. Participant #1-2 said, “Ultimately, from that relationship you build acceptance with them, and then you start to teach them. But primarily I would say that the biggest thing is building that relationship.” She further defined her role by saying, “you are staying in a role where you are therapeutic, but you have to be consistent and you have to have clear expectations, and boundaries. That sets the relationship.”

She addressed the issue of safety by saying, “You have to present things in a way that doesn’t instill fear in them, being that person that they are not afraid of.” Participant #1-2 touched on the fact that the work is about the children within the facility and not the workers through statements such as, “Staff have to remember what they are doing here in not about them, it’s about the kids.” and “the responses they are getting from these kids is not about them, it’s about the kids.”

Participant#1-2, through the discussion of specific cases, very vividly described how she views her role in the day-to-day. Beyond teaching coping and social skills, she addressed hygiene, academics, and working with families to help them see the potential for growth and change in the children. She talked about helping the families distinguish
between age appropriate behaviors and pathology and, “teaching the families to not be emotionally reactive because that is what will spiral the kids every time.”

After participant #I-2 seemed to have exhausted the topic of role, I asked her to talk about her experience with the trauma of the children. Without hesitation she stated:

The first time reading the history, it opened up a whole different planet. I would not even consider it a whole other part of society, but it was like a whole other experience that I didn’t even know existed.

She described her own upbringing as somewhat sheltered as she came from a rural, low crime, low violence environment where she attended a private school. She continued by saying, “when I first saw the stories of abuse, just the history of not even just the kids, but what their parents had been through, it was like a sick nauseous sensation.” She went on to talk about a few specific cases that she found to be particularly difficult. Participant #I-2 said, “I was just absolutely blown away by what they had been through. It opened up a whole other understanding not only of the world, but of the why the world is the way it is.” She then talked about experiences student teaching in the inner-city where she saw thing that she found to be shocking but continued to emphasize her experience at the facility, “But these kids, their histories still shock me. You read stuff and you can’t even believe it. It comes down to, you want to go eew, icky.” As she said this she shuddered and shook her head as if to ward off the negative images within her mind. She continued this line of discussion by talking about children that she has worked with who were the products of incest. She said, “…your first response is like “eew” {shuddering again}, but it has absolutely nothing to do with that child.” She talked about a specific child who she found troublesome to deal with when she first became a resident. This child had a sever
abuse history and a number of behaviors that “triggered” participant #I-2. She said, “Honest to God that kid, I’d just hear their voice and my skin started to crawl, and I was like “oh no, I can’t do that right now.” She went on to talk about her experience of the families where members knew about the incest and abuse and how difficult it is to work with them:

You have the kids that have been sexually abused by their own family members repeatedly. And then the cases where the other family members knew about it and just looked the other way because the needed the support of that particular family member. It kind of makes it hard to work with some of the families because you know what they allowed to happen…Yes, it’s definitely hard hearing all that.

She said, “Some of the stories you wouldn’t believe.” She related a story about a client who had been repeatedly raped by her father from the time she was 2 years old. As she talked she became excited, almost agitated. Finally, participant #I-2 said, “She was exposed to unbelievable things. She saw her dad fuck a goat! She sexually abused a foster family’s dog and the dog actually died. She was raping it with a hot dog!” She continued this story to its conclusion. Eventually this child, after a long course of treatment, was successfully discharged to a foster family. Participant #I-2 said, “Crazy when you think about it. But yeah, she made it and she had the worst life ever. That stuff sticks to your brain. If she could do it there is so totally hope.”

After this topic, participant #I-2 seemed to be pensive and subdued. She sat quietly and gazed out the window. I allowed her to sit like this for as long as she seemed to wish to do so. I was aware that it felt as if she has been exerting a great deal of effort while telling her story to this point. Now, it felt as if she needed to recharge her batteries
and collect herself. Finally, she looked at me expectantly and loudly exhaled. I asked if she was alright and she replied, “Yeah, wow, I guess, just thinking. The shit we see, crazy.”

In order to move the interview forward, I asked her to talk more about how she deals with the traumatic histories of the children. She replied, “You definitely take it home with you and sometimes I still do. “ We’ve had a couple kids that have been here forever and it’s really hard to not take their stuff home.” She continued to talk about the children who are left behind through no fault of their own and their influence upon her. She discussed how hard it was to witness, “[kids where] it is one thing after another that doesn’t work out for them and you have no ability to control that. It is harder when we can’t control it.” Participant #I-2 further described this circumstance by, “It’s a time when you feel helpless with helping this kids and it’s pretty tough.” She talked about that type of event as perhaps a “boundary issue” or “a flag maybe.” and said, “There’re definitely some kids that yeah, I take it home, but I don’t take it home to my family. It might be something I am still dealing with, but I keep it that way. For the most part, (she chuckled here and shook her head), I’ve learned to kind of drop everything at the door.”
In further discussion she confirmed this has not been an easy skill to learn. Participant #I-2 further explained, “I’m not taking my work bag in the house, it’s really hard because I know I have 8,000 things that I could do, but like this is where I draw the line.” She again laughed and smiled when she said this.

I asked her what she believes, given the works stressful nature, keeps her on the job. She replied quickly, “It’s the people we work with; it’s the staff, because they become your second family.” When I asked her to elaborate on that she stated:
There is like a united group of people that deal with the same bullshit you deal with, day in and day out, and they carry that same burden I guess of these kids.

But they deal with it and we deal with it together.

She validated the notion that “it’s not like it’s a high paying job” or something of prestige that keeps her returning. “It’s definitely that group dynamic that I think keeps everybody coming back,” she said. Participant #I-2 talked about the value of a cohesive team and how both staff and the children benefit when the team is functioning well. She related stories of units providing assistance to one another in crisis situations and how that seems to solidify relationships among the staff.

During her discussion about the supportive nature and importance of staff relationships, participant #I-2 expressed a number of characteristics that she felt make workers productive in the job. She mentioned staff that are “down to earth”, “level headed”, “positive”, “people who don’t take it personally” as those that seem to be successful at the work. She also talked about the danger of not having those characteristics. Participant #I-2 said, “our staff gets burnt out, especially when you have the exact same situation day in, day out, day in, day out, and you can’t see that the kids are moving forward.” She used the phase moving forward to describe the progress of the children a number of times throughout the interview. She furthered, “when the staff get burnt out, they get easily frustrated with the kids and that isn’t O.K. If you can’t control that, you need to move on.” She discussed how when staff leaves it upsets the balance of the team and that is often hard, but stated:
If you’re a good staff you need to stay here with my team! And I want to be selfish. I know, I mean it isn’t about me and I need to get the best care for my kids, they have to be happy. It’s hard.”

Participant #I-2 also talked about her negative changes as a result of exposure to the children’s trauma. She discussed changes in how she views the world, such as, “Sometimes being in a family setting or public setting where there are other kids, I’m like hyper-vigilant, and like oh my god, why are they letting the kid do that?”

Next I asked her if there was anything positive that she would like to talk about. Her affect immediately brightened and she said, “Oh there’s so much good stuff!” She quickly followed with, “Well, me, I’ve always been an optimist so every time I see them make a simple good choice, I mean that’s huge.” She continued by telling a story that illustrated a child who made “baby steps” and how that affected her. She said:

Seeing little, little tiny changes. Seeing two kids play a game together when they got here, they couldn’t sit in a room with another kid. It was pretty rewarding. But also the relationships I would say is the biggest part. Sometimes for relationships, we offer them the best relationships they have ever had.

Participant #I-2 then talked about it being “really cool” to able to be the person who, “gives them a sense of acceptance and sees them get through.” She related a story about a girl who had severe school phobia when she entered the facility. Over time, this child grew to not only attend school without issue, but “it became like her favorite thing ever. She became such an outgoing extraverted little kid.” Participant #I-2 stated it was “amazing” that, “she became a whole different person.” While she was discussing this
particular child, participant #I-2 was quite animated. She smiled broadly and laughed as she was talking. It was quite clear that the success of this child was a positive.

I asked participant #I-2 to talk about her personal positive experiences with the work. She first commented, “I guess it’s mostly just really rewarding that you were able to be there for somebody and show them that they are worth caring about. And you get that back. If you care for them, they care for you.” She continued by saying:

To love some of these kids is a little bit strange a lot of the time, but it is still very rewarding and just knowing that they feel safe with you makes you feel really good about who you are and how you are able to reach out to people that nobody has been able to reach out to, so that’s very rewarding.

Participant #I-2 talked about the changes that happen with the children saying, “You get to see that anybody can change. Nobody can do it by themselves, but they can do it if they want to.” She referenced the story of the child who had been raped from the age of two and said:

I think it was just showing her love, honestly. It was just keeping her safe. And telling her enough times that not everybody was trying to hurt her and that she could trust some people. That some people do care. I cared. A lot of it was knowing what she had been through and then looking at that and gosh, can you blame her?”

I just nodded when participant #I-2 was speaking and she said:

Yeah it makes you feel warm and fuzzy and it makes you feel like a better person. But I think even, I mean I can’t take credit for that it wasn’t just me. It was part of a community, it was everybody.
She continued this line by saying, “It definitely lets you know it can happen. You can do it.” She went on to describe her favorite part of her daily routine, such as waking the kids up in the morning or tucking them in at night. She was almost wistful as she talked about being the one who, “goes in with a smile and lets them know, Hey! Wake up; we’re going to have a great day.” She continued, “The best part is probably making them feel safe, giving them somebody that generally cares about them, giving back to them. Being that person they probably don’t have.” At this point, participant #I-2 brought the conversation back to role and said:

When anybody asks, what do you do? My answer is, well, I take care of the kids that nobody else wants to take care of. When it comes right down to it that is what we do. These kids are either here because people don’t want their behaviors or just didn’t want them and didn’t do enough to care for them. That is what I do.

I asked her to talk more about the benefits of the job. She brought up being able to provide holiday rituals for the children like Halloween and Christmas traditions and connected that it was, “rewarding to show them this is what some people’s lives look like and yours could look like someday!” She also pointed that her job makes it easier to tolerate some of the negative stressors outside of the work. With respect to outside stressors, participant #I-2 said:

It’s like this economy and you can whine and whine and complain about it. Yes I want my 3% back Yes I want raises back {the facility had frozen raises and enacted pay cuts the previous year}. But in the big picture, do I have a job, do I eat food, can I pay my bills, am I safe, is my life secure? Yes!”
She also stated, “I am a more open minded person, more supportive, more tolerant as a result of working with these kids.”

I asked her if she had anything further she wished to share and she concluded the interview with the following:

It amazes me to watch them bounce back. Resilience is one of those mysterious things that they say you get from having support when you go through things when you’re young. Resilience is a tough thing to instill in people. It sure is cool when you see it.

I thanked her for participating in the interview and let her know that I would be in contact in order for her to verify the transcriptions once that process was completed. After she exited the interview room I completed my initial reflective entries noting specifically how talkative she had been in the process. I had said very little during the interview process and really had only interjected to steer her thinking toward one topic or the other. I reviewed my brief notes and found that her conversation brought forth many of the same issues and phrases that had been brought forth in my other interviews. I felt that the data points were saturated and there was no need for further data collection.

Participant #I-2 provided many phrases of significance. Below, Table 7 organizes these phrases. As participant #I-2 was so open to discussion, there are phases included in the table that were not addressed in the narrative.
Table 7. Interview Participant #I-2 Phrases of Significance

<table>
<thead>
<tr>
<th>Analytical Categories</th>
<th>Quotations of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. FOUR LIVED EXISTENTIALS</strong></td>
<td></td>
</tr>
<tr>
<td>Lived body</td>
<td>It was like a sick nauseous sensation</td>
</tr>
<tr>
<td></td>
<td>Yeah it makes you feel warm and fuzzy</td>
</tr>
<tr>
<td></td>
<td>My skin started to crawl</td>
</tr>
<tr>
<td></td>
<td>This stuff sticks in your brain</td>
</tr>
<tr>
<td>Lived relationship</td>
<td>Ultimately from that relationship you build acceptance.</td>
</tr>
<tr>
<td></td>
<td>I would say the biggest thing it the relationship.</td>
</tr>
<tr>
<td></td>
<td>That sets the relationship</td>
</tr>
<tr>
<td></td>
<td>We deal with it together</td>
</tr>
<tr>
<td></td>
<td>To love some of these kids is a little bit strange a lot of the time.</td>
</tr>
<tr>
<td></td>
<td>I think it was showing her love.</td>
</tr>
<tr>
<td></td>
<td>But also the relationships I would say is the biggest part.</td>
</tr>
<tr>
<td>Lived space</td>
<td>This is where I draw the line</td>
</tr>
<tr>
<td></td>
<td>You need to move on</td>
</tr>
<tr>
<td></td>
<td>I learned to drop everything at the door.</td>
</tr>
<tr>
<td>Lived time</td>
<td>Oh no, I can’t do that right now.</td>
</tr>
<tr>
<td></td>
<td>Bull shit you deal with day in , day out.</td>
</tr>
<tr>
<td><strong>2. PERCEIVED ROLE</strong></td>
<td></td>
</tr>
<tr>
<td>Helper</td>
<td>...helping this kids is pretty tough</td>
</tr>
<tr>
<td>Teacher</td>
<td>Starting at the very basics is teaching them everyday living skills</td>
</tr>
<tr>
<td></td>
<td>We teach how to get along with adults and other children</td>
</tr>
<tr>
<td></td>
<td>A lot of just teaching how to live socially</td>
</tr>
<tr>
<td></td>
<td>Teaching families to not be emotionally reactive</td>
</tr>
<tr>
<td>Role</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>Baby sitter</td>
<td>Basically you are parent, a babysitter and a therapist</td>
</tr>
<tr>
<td>Role Model</td>
<td>n/a</td>
</tr>
<tr>
<td>Safety officer</td>
<td>You have to present things in a way that doesn’t instill fear in them.</td>
</tr>
<tr>
<td></td>
<td>It was just keeping her safe</td>
</tr>
<tr>
<td></td>
<td>The best part is probably making them feel safe</td>
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<tr>
<td></td>
<td>...wasn’t scary anymore, it became her favorite thing.</td>
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<tr>
<td></td>
<td>...always tell her, I’m just keeping you safe</td>
</tr>
<tr>
<td></td>
<td>So we’re going to hold you until you feel safe.</td>
</tr>
</tbody>
</table>

### 3. EXPERIENCE OF TRAUMA EXPOSURE

| “I never knew that really existed” | The first time reading the history, it opened up a whole different planet. |
| | ...it was like a whole other experience that I didn’t even know existed. |
| | I was just absolutely blown away by what they had been through, opened up a whole other understanding |
| | It opened up a whole other world of Oh my God! People like this are real |
| | Shows you a whole other plane I guess |

| Nobody would believe it | You read this stuff and you can’t believe it |
| | Some of these stories you wouldn’t believe |
| | She was exposed to unbelievable things |
| | Crazy when you think about it! |

<p>| Something out of T.V or the movies | n/a |</p>
<table>
<thead>
<tr>
<th>4. NEGATIVE CONSEQUENCES OF TRAUMA EXPOSURE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoia/hyper-vigilance</td>
<td><em>I’m like hyper-vigilant</em></td>
</tr>
<tr>
<td></td>
<td>Like, <em>Oh my god why are they letting the kid do that?</em></td>
</tr>
<tr>
<td></td>
<td>See a 4 year old go into the bathroom by themselves</td>
</tr>
<tr>
<td></td>
<td>You’re a little more overprotective definitely</td>
</tr>
<tr>
<td>Concern for outside relationships</td>
<td><em>I’ll look at struggling people and I want to step in and say “you have to do this” But I cont’ do that because it’s not my kid.</em></td>
</tr>
<tr>
<td>Negative view/taking it home</td>
<td><em>You definitely take it home with you and sometimes I still do</em></td>
</tr>
<tr>
<td></td>
<td><em>It is really hard not to take their stuff home</em></td>
</tr>
<tr>
<td></td>
<td><em>I take it home</em></td>
</tr>
<tr>
<td>Potential for leaving the job</td>
<td><em>Our staff gets burned out, especially when you have the exact same situation day in day out.</em></td>
</tr>
<tr>
<td></td>
<td><em>If you can’t control that [frustration] you need to move on</em></td>
</tr>
<tr>
<td>Feeling helpless</td>
<td><em>It’s a time when you feel helpless with helping these kids</em></td>
</tr>
<tr>
<td></td>
<td>How do you explain that to a 14 year old kid that has had the shittiest life ever already and then how do you keep her motivated because she wants nothing more than to be with that mom who never took care of her in an appropriate way ever.*</td>
</tr>
<tr>
<td></td>
<td><em>It’s harder when we can’t’ control it.</em></td>
</tr>
<tr>
<td></td>
<td>That’s the most discouraging part, seeing a kid come so far... going back to the same environment*</td>
</tr>
<tr>
<td>5. PROTECTIVE FACTORS AGAINST TRAUMATIC EXPOSURE</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Accepting the trauma</strong></td>
<td></td>
</tr>
<tr>
<td>There's a lot of really awful things that they have lived through and then that leads to their coping mechanisms</td>
<td></td>
</tr>
<tr>
<td>That's what they come from, that's what they know</td>
<td></td>
</tr>
<tr>
<td>Because some of them that is all they know</td>
<td></td>
</tr>
<tr>
<td>A lot of it was knowing what she had been through and then looking at that and “gosh, can you blame her?”</td>
<td></td>
</tr>
<tr>
<td><strong>Personal characteristics</strong></td>
<td></td>
</tr>
<tr>
<td>You have to be consistent</td>
<td></td>
</tr>
<tr>
<td>Down to earth, and positive</td>
<td></td>
</tr>
<tr>
<td>People who don’t take it personally</td>
<td></td>
</tr>
<tr>
<td>I've always been an optimist</td>
<td></td>
</tr>
<tr>
<td>You are able to be there for somebody</td>
<td></td>
</tr>
<tr>
<td>You have to not react emotionally</td>
<td></td>
</tr>
<tr>
<td>Come in everyday with a smiling face</td>
<td></td>
</tr>
<tr>
<td><strong>“It is not about me”</strong></td>
<td></td>
</tr>
<tr>
<td>Staff has to remember what they are doing here is not about them, it’s about the kids.</td>
<td></td>
</tr>
<tr>
<td>The responses they are getting from these kids is not about them, it’s about the kids.</td>
<td></td>
</tr>
<tr>
<td>I mean it isn’t about me and I need to get the best care for my kids, they have to be happy.</td>
<td></td>
</tr>
</tbody>
</table>
| Supportive environment | *It's the people we work with. It’s the staff, because they become your second family.*  
  *There is like a united group of people that deal with the same bullshit you deal with.*  
  *...they carry the same burden...and we deal with it together.*  
  *It’s definitely that group dynamic that I think keeps every body coming back.*  
  *It was part of a community, it was everybody.* |
| Setting boundaries | *You have to have clear expectations and boundaries.* |

6. **POSITIVE RESULTS OF THE WORK**

| Being the person who makes a difference | *Sometimes we offer them the best relationships they’ve ever had.*  
  *You were able to be there for somebody and show them that they are worth caring about.*  
  *Reach out to people that nobody has been abl to reach out to.*  
  *Giving somebody that genuinely cares about them.*  
  *Being that person they probably don’t have.* |
| Seeing the smallest change | *Every time I see them make a simple good choice.*  
  *Baby steps.*  
  *Seeing little, little, tiny changes.*  
  *They do change.*  
  *She is as good as she is ever going to get.* |
### Cross Case Analysis

The participants in the individual interviews and focus groups expressed many similar thoughts regarding their experiences as mental health workers who work with traumatized children. The phrases of significance were echoed between the sessions. Table 7 provides a cross case analysis which illustrates the saturation of the phrases of significant between the interview session.

<table>
<thead>
<tr>
<th>Changes in outside behavior</th>
<th>You come to the overwhelming realization that nobody can do it by themselves</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>You get to see that anybody can change.</td>
</tr>
<tr>
<td></td>
<td>I’m more open-minded,</td>
</tr>
<tr>
<td></td>
<td>I’m more supportive</td>
</tr>
<tr>
<td></td>
<td>I’m more tolerant</td>
</tr>
<tr>
<td>Benefits of comparison</td>
<td>But in the big picture, do I have a job, do I eat food, can I pay my bills, am I safe, is my life secure? Yes</td>
</tr>
<tr>
<td>Sense of satisfaction</td>
<td>It is still very rewarding and just knowing that they feel safe with you makes you feel really good about who you are</td>
</tr>
<tr>
<td></td>
<td>Rewarding to show them this is what some people’s lives look like and yours could look like someday</td>
</tr>
<tr>
<td>Finding a sense of hope</td>
<td>If she could do it, there is so totally hope</td>
</tr>
<tr>
<td></td>
<td>We are just hoping that we can get the foster family to understand</td>
</tr>
<tr>
<td></td>
<td>She became a whole different person</td>
</tr>
<tr>
<td></td>
<td>You just have to keep hoping that it will all work out.</td>
</tr>
</tbody>
</table>
Table 8. Cross Case Analysis

<table>
<thead>
<tr>
<th>Analytic Category</th>
<th>Int. 1</th>
<th>Focus Group 1</th>
<th>Focus Group 2</th>
<th>Int. 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VAN MANEN EXISTENTIALS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Body</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Relationship</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Space</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Time</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td><strong>PERCEIVED ROLE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helper</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Teacher</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Baby sitter</td>
<td>n/a</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Role model</td>
<td>x</td>
<td>n/a</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Safety officer</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td><strong>EXPERIENCE OF TRAUMA EXPOSURE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“I never knew that really existed”</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Nobody would believe it</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Out of TV or the movies</td>
<td>n/a</td>
<td>x</td>
<td>x</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>NEGATIVE CONSEQUENCES OF TRAUMA EXPOSURE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paranoia/hyper vigilance</td>
<td>n/a</td>
<td>x</td>
<td>n/a</td>
<td>x</td>
</tr>
<tr>
<td>Concern for outside relationships</td>
<td>n/a</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Negative view/taking it home”</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Potential for leaving the job</td>
<td>x</td>
<td>x</td>
<td>n/a</td>
<td>x</td>
</tr>
<tr>
<td>Feeling helpless</td>
<td>n/a</td>
<td>a/a</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>
Table 8 illustrates the parallel phrases of significance found between the interview sessions. All of the interviews contained discussion of what can only be characterized as symptoms of vicarious trauma. Behaviors such as thinking and dreaming about the children outside of work, being hyper-vigilant with your own children, and having your world view altered are all negative affects related to working with traumatized individuals. While conducting the interviews, I was reminded of my own experiences as a young clinician. The stories of the workers brought back memories of children with whom I had worked long ago and their stories of trauma and pain. I was not surprised that these memories emerged, but I was surprised by how little I had considered my own history of vicarious traumatization prior to conducting this research. When I reflected
upon my own experiences, they aligned with the experiences of the workers as if I were one of them.

Further, all of the interviews revealed descriptions of the personal characteristics, supports, and view of the children that provide protective layers that ward off burn out, and vicarious traumatization. The participants accepted the trauma experience of the children as central to their functioning. The descriptions of personal characteristics included temperament, sense of humor, attitude, ability to be positive, and adaptability. Most notably, the participants spoke very strongly about the supportive nature of their relationships with their colleagues as a significant factor in job satisfaction and the mitigation of traumatic stress.

Finally, the participants were able to identify personal satisfaction and positive changes in themselves that are found as a result of their work with traumatized children. What was of interest was that I had to ask the participants to describe these benefits. It was a topic that did not come up naturally through conversation, but had to be promoted. I had expected that this might be a tendency, but I was surprised that it occurred in every interview.

There were no substantial differences or bits of information that could be considered extreme data points throughout the interview process. Although several topics, such as administrative support, were not discussed in every interview, the topics and experiences salient to the research questions were consistent between the sessions. As such, the phrases of significance in the cross case analysis above have been used to develop the central themes of the research that will be discussed in detail in chapter 5.
Summary

This chapter explicates the data collected during the two individual interviews and two focus groups of the study. The chapter contains narrative descriptions of the interview process that provide illustrations of phrases of significance related to the research questions. These narratives also incorporate my observations from the interview session and my reflective journal. Also provided in this chapter are tables that organize the phrases of significance into a clear picture of the data obtained. The chapter concludes with a cross-case analysis of the phrases of significance within the main analytic categories obtained through explication of the data. These data points are used to construct the main themes that are discussed in chapter 5.
CHAPTER V: DISCUSSION

Introduction

In the field of mental health treatment, there has long been an awareness that exposure to traumatic events can create psychological disturbance in those who endure it. This awareness of and focus upon the negative symptoms that result from exposure to horrific events has led to treatment methodologies that concentrate upon the prevention or alleviation of posttraumatic symptoms (Bober & Regehr, 2005). Individuals working within the helping profession have, in tandem, increasingly begun to provide treatment from a trauma informed perspective.

Research in the field of trauma care has shown that the work of providing care to people who have experienced trauma can also have negative psychological consequences for the caregiver (McCann & Pearlman, 1990). Significant research has been conducted that supports the constructs of burnout (Maslach, 1996), compassion fatigue (Figley, 1995), and vicarious trauma (Pearlman & Saakvitne, 1995) as potential negative conditions that result from secondary exposure to trauma through the work of service provision. These conditions can result in the provision of less effective treatment, inappropriate detachment, the dehumanization of clients, and may result in exodus from the profession, or worse yet, impaired individuals continuing to practice (Joyce, 2004; Figley, 1994; Pearlman & Saakvitne, 1995). There is little disagreement within the profession that mental health workers can, and do, experience negative symptoms that mirror those of their clients who directly experience trauma (Canfield, 2005; Baird & Kracen, 2006).
What has recently begun to emerge in the literature is a trend toward looking at traumatic exposure from a positive perspective (Lindley, 2004; Tedeschi & Calhoun, 2004). The idea that humans are resilient (Bonanno, 2005) and that suffering through life crises can lead to positive personal change is a construct that is steadily gaining in interest (Tedeschi & Calhoun, 2004; Park, 2004; Zoellner & Maercker, 2006). This salutogenic approach to traumatic exposure views resilience and benefit finding, as opposed to pathology and disturbance, to be normative to traumatic experiences. A positive approach to trauma work examines the strengths, hardiness and adaptability of those who experience trauma instead of approaching the work from a deficit-based methodology (Bonanno, 2004; Luthar et al., 200).

Following the trend of positive psychology and salutogenic approaches to treating individuals with trauma histories, there is a burgeoning interest in the positive symptoms that can arise in those who provide trauma care. Compassion satisfaction, or finding a sense of personal achievement from the work has been a well recognized by-product of helping others (Stamm, 2002; Pearlman & Saakvitne, 1995). Literature regarding vicarious trauma and secondary traumatic stress is copious, but few studies have been undertaken that specifically explore vicarious posttraumatic growth in providers of psychotraumatology.

The focus of this study was to explore the lived experience of mental health workers who work with multiply traumatized children in a residential treatment facility and who self-identify as experiencing vicarious trauma and compassion satisfaction. The workers in this study endorsed experiencing a level of emotional disturbance related to their work (vicarious trauma) but also reported being able to find positive psychological
meaning (compassion satisfaction). This combination of experience led to a finding that vicarious posttraumatic growth was on-going among the workers.

The findings of this study revealed that the workers have experienced vicarious trauma as a result of their work. Their discussions unearthed internal shifts in their fundamental cognitive schemas. They expressed finding the trauma histories of the children to be well beyond the bounds of anything the workers had know existed and detailed how the experience changed their world view, sense of trust, control, and how they experience relationships with others. The workers also described benefit finding and personal growth as a result of their work with the children in the facility. According to Calhoun & Tedeschi (1999) posttraumatic growth can be characterized as creating positive changes in five broad domains: strength, new possibilities, relationships, appreciation of life, and spirituality. Themes explicated from the data collected in this study exposed perceived growth in these domains.

In phenomenological research, perceptions are regarded as a primary source for information (Mostakas, 1994, p.54). Twelve participants engaged in this study to provide their unique perspectives and voices to describe the experience of the residential treatment of traumatized children with mental health diagnoses. Husserl (1977) discusses the notion that every perception adds to the totality of the experience, and when reflected upon, this totality will bring forth the essence of the phenomenon at hand. The two individual interviews and two focus groups conducted for this study produced individual perspectives that, when examined for totality clearly delineated 8 dominant themes that emerged from the data.
This Chapter first provides a discussion of the dominant themes that emerged from the data, which are organized around the research questions and underlying theoretical assumptions. Within the exploration of each research question, a discussion of the implications of the research for the mental health field is provided. Finally, the chapter provides an examination of the limitations of the study, questions that the study has generated, and suggestions for further research on the topic.

Discussion of the Findings

Various themes arose that can be subsumed within the answer to each of the research questions posed for this study. The inquiry was directed by the semi-structured interview questions which encouraged a centralized focus. The following section provides a discussion of each of the research questions considered for this study, and the resultant themes that were revealed through explication of the interview data. The implications for the field of mental health treatment and work with individuals who have trauma concerns are addressed.

Research Question #1

This study was grounded using Van Manen’s (2007) four life world existentials. This theoretical foundation informed the question, “How do mental health workers describe the experience of working with multiply traumatized children?” Thematically, the interview data described an experience ripe with “felt” experience that aligns with the theoretical foundation for the study.

Theme #1. Existential, corporeal experience. This study was framed using the existentials of lived space, body, time and relation. Through the interviews conducted with the study participants, a very clear picture of the experience as a “felt”, existential
actuality emerged. The study participants spoke of lived body with negative descriptors such as feeling physically sick, and experiencing the work as being smacked, kicked or punched. Phrases such as “sometimes it smacks you in the face” and “it was like a sick, nauseous sensation” clearly speak to the visceral, negative impact of the work. However there were positive body experiences as well. The participants talked about feeling warm and fuzzy, swelling up with pride, feeling lighter and taller, and being filled-up by the work. They used descriptors such as “when they are doing well it fills you up” and “like a warmth spreads across you” to express the internally perceived benefits of their difficult work.

With respect to lived relationship, it was clear that relationship was an integral part of their experience. The workers discussed their relationships with the children and with one another as essential to their success or failure within their positions. They discussed how the relationships among the staff provide them with a sense of support that empowers them to continue to perform their job duties in a stressful environment. Phrases such as “that makes a difference, the relationships you have with your co-workers” and “if I didn’t have the relationship with these people that I have I wouldn’t be happy here” show the importance of lived relationship in the provision of treatment to the children. Additionally, their use of phrases like “some who have a special place in my heart” and “the relationship is the biggest part” indicate that need for relationship transcends staff to staff benefit and is an ultimate factor in direct success with the children.

Lived space was expressed with relation to movement, change and boundaries. The participants discussed the protective benefit of “drawing lines” and setting limits for themselves and for the children. They talked about moving forward as a noticeable part
of the change process that is a fundamental source of satisfaction in the work. According to the workers, movement forward or change, no matter how tiny is integral to benefit finding in the work.

Lived time revealed the essence of a day-to-day, here in the moment focus in the work. The participants identified this concept as essential to managing the stressors of the job. They used phrases such as “roll with the changes day-to-day and minute-to-minute” and “at the end of the day” to describe how they compartmentalize or divide their work into tolerable units. This compartmentalization of lived time appears to be a protective factor employed by those successful in enduring long term exposure to vicarious trauma.

Through the use of the Van Manen’s (2007) existentials as a lens for viewing the perceived experience of the mental health workers in this study, it is evident that the experience is one that is both tangible and metaphysical. The richness of the description of the experience provided by the study participants leaves us with an incontrovertible understanding of their lived experience of the work. The nature of the experience of working with traumatized children is felt from a base, physical level to a purely esoteric plane.

**Implications.** The participants in this study experienced their work in a manner that can be structured using Van Manen’s life world existentials. By exploring the descriptions of their “lived experience”, their work can be understood as more than simply daily activity for which they are paid. When we examine the literature around the vicarious effects of helping traumatized people, we see that the research supports these life world experiences. Burnout, which is defined as a state of emotional and physical exhaustion (Pines & Aronson, 1988), can alter the quality of caregiver relationships
through detachment and depersonalization. Compassion fatigue involves the experiences of somatic complaints, increased arousal and reliving events (McCann & Pearlman, 1990; Herman, 1992). Vicarious trauma involves shifts in a person’s fundamental meaning making of the world around them (Pearlman & Saakvitne, 1995). From a salutogenic perspective, the literature is beginning to suggest positive life world experiences are common in vicarious exposure to trauma. Vicarious post traumatic growth is characterized by positive changes in self-perception, interpersonal relationships and general philosophy of life (Tedeschi & Calhoun, 1999). The workers expression of their experience of working with traumatized children exemplified the totality of Van Manen’s existential, which strongly correlate with the suggestions found in the literature. Through careful consideration of their experience and a review of the remaining themes that emerged from this study, recommendations for enhancement of the field and suggestions for further research are made later in this chapter.

Research question #2

The interviews with the participants also sought to answer the question, “How do mental health workers ascribe meaning to their work?” The essence of this question was to discern how the workers find meaning and value in their everyday tasks with the children. Through a discussion of role and purpose, a clear theme, which is discussed below, emerged.

Theme #2. “We are here to help.” Linley et al. (2005) examined the phenomenon of vicarious adversarial growth with respect to the construct of sense of coherence. The construct of sense of coherence includes an individual’s ability to make sense of his or her world and the meaningfulness a person can ascribe to the challenges
with which they are faced (Linley, Joseph & Loumidis, 2005). In all of the interviews conducted for the study, the participants were asked to describe what they perceived to be their role in working with the children within the facility. On the surface, the discussion of role appeared to be somewhat separate from the notion of meaning, but from the interview data, it is clear that the workers found the meaning of their work to be intractably intertwined with their definition of role. In each and every interview, the study participants overwhelmingly characterized their role as “helper.” Although their perceptions could be placed into the sub-categories of teaching, role modeling, safety officer and babysitting, the over-riding essence of their description of their purpose was that they are in the work to help. As the participants talked about their various perceptions of their role, their sense of the deeper meaning of their work bubbled to the surface. Participant #9 said, “I look at it like when you see that change in somebody and know that you helped with it, obviously you feel better about yourself.”

The participants identified a number of relational experiences as part of the essence of helping. The participants in focus group #2 talked about the meaning of helping through descriptions of teaching the children basic skills they wouldn’t otherwise have been taught. These skills ranged from basic hygiene to more intangible efforts, such as how to participate in a meaningful relationship with adults. The idea of teacher as helper was pervasive throughout the course of the interviews. The participants in all of the sessions identified meaningful ways that they positively influence the children with whom they work through exposing them to new skill sets and behaviors. All of the interviews contained value and meaning finding in helping to teach the children skill sets,
but more importantly, the contained a discussion of the value of helping the children experience positive relationships.

When the interview data was mined for meaning around the question of role, it was apparent that the workers found meaning in helping the children to experience safe, appropriate, caring relationships such as they may have never experienced before.

Participant #1 stated:

Because some people can have such a, because of what’s happened to them in the past, can create such a crust around them, that they can make it through life, but they aren’t enjoying life. They don’t enjoy other people. They exist. And I’d like to think that we do something to break that crust off, help them break that crust off, help them to be a part of the community so they can love and be loved. Help them break it down. And when they do, it’s like warmth spreads across you. This sentiment encapsulates the expressions of many of the other participants who spoke to meaning finding in being a person the children could experience in a positive way.

Participant I-2 spoke of being able to offer children from abusive homes the “best relationship they’ve ever had.” Participant I-1 talked about providing the first safe opposite sex relationship a child who experienced a rape had had. He stated, “Because she felt safe with me, the only male she felt safe with. How wild is that? I was the first safe guy.” Throughout the interviews, the participants spoke of the meaning of being the person who helped the children experience positive relationships that led to helping the children effect positive change.

As he talked about his relationship with the child who had been raped, participant I-1 stated, “Maybe my relationship with her will be the one that changes it for her.” This
notion of the workers being the helping person instrumental to positive change for the children was echoed by many of the study participants. Phrases such as “that is meaningful to say that you had that much of an impact” and “you made a difference, you were one of the good guys” were brought out through discussion in focus group #2. In focus group one, participant #4 stated, “I can try to make a difference and show these kids you don’t have to screw up and let your past determine your future.” Pervasive in their sense of meaning was the conviction that through the workers’ help in skill development, role modeling of behavior, providing safety, babysitting, and most importantly helping with the fresh experience of positive relationships, the children in this facility were able to effect change for the better. This reported sense of being part of the solution and the enjoyment of enhanced relationships are both discussed in the budding study of the benefits of vicarious exposure to trauma through helping (Arnold, Calhoun, Tedeschi, & Cann, 2005).

**Implications.** The workers in this study derived a sense of meaning and purpose through their identification of themselves as helpers. Humans are creatures that continually seek to find meaning in their world. Sartre said that man feels alien in a world without meaning. The participants in this study used their perceived meaning as “helpers” to assist them in finding value in their work. The individuals interviewed for this study were primarily line staff at the facility. They are people who are charged with the management of the children’s daily routine. The tasks they perform include waking, providing direction and instruction on hygiene, monitoring peer interactions, setting structure, assisting with homework, and providing recreation. In short, these workers are often seen, as they mentioned, as glorified babysitters. The expectation of the facility is
that the workers will maintain structure, routine and discipline. Although the workers are provided training regarding how to act therapeutically with the children, and the expectation is that these workers are part of a treatment team, the message of the facility appears to be that these workers are essentially disciplinarians or monitors.

A large part of successful work with traumatized individuals involves being able to derive personal satisfaction from the work. Compassion satisfaction is defined as enjoying a sense of achievement, increases in confidence and a sense of humanistic benevolence as a result of empathic engagement with others (Stamm, 2002). Clearly, the participants in this study found this sense of achievement and personal satisfaction, but it was through their identification as being people who are teaching, role modeling, and keeping the children safe or as they defined it, helping.

There is an assumption that there will be high turnover among direct care staff in residential facilities, yet no real examination of retention could be found in the literature. There are copious studies that explore the use of restraints (LeBel, 2010) and the success of treatment or satisfaction of the residents (Southwell, 2010; Rozaski, 2009), but no information was available that spoke to worker satisfaction, role definition or the benefits of maintaining well trained, experienced staff. The workers in this study had a mean length of employment of 5.2 years. Through discussion with the workers, it was evident that their tenure was well above the average for the facility. In fact, I inquired as to what the turnover rate of staff was and was informed by the director of residential services that new hire retention does not exceed 50%. The findings of this study suggest that the workers interviewed remained employed at the facility, at least in part, because of the satisfaction and meaning they found through their role as helpers.
This study suggests that meaning and purpose are an integral part of a positive work experience for those employed in residential treatment. Although the workers endorsed perceiving themselves in other less desirable roles than helper, they overwhelmingly found self-efficacy through their work. The study further suggests that adopting methods to enhance the workers role satisfaction and meaning finding in their work could increase retention within the facility.

**Research Question #3**

Central to the discussion of work with traumatized children is the question, “How do the workers make sense of their experience of vicarious trauma?” As the participants interviewed for this study all endorsed that they experienced vicarious trauma through their work, it was key to explore how these workers organized their thinking about their experience. The interview data revealed two distinct themes that address the thought processes and internal coping mechanisms that allow the workers to assimilate the experience of VT into a functional approach to the work. What follows is a discussion of these themes and their implications for the work.

**Theme #3. It is not about me.** According to Figley (1995), compassion fatigue is “the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other and the stress resulting from helping or wanting to help a traumatized or suffering person” (Figley, 1995 p.7). The symptoms of compassion fatigue are consistent with PTSD and may include the helper experiencing intrusive and disturbing imagery (Way et al., 2004) and a heightened sense of awareness or hyper-vigilance (Steed and Bicknell, 2010). Vicarious trauma emphasizes the psychological effects of working with individuals who have experienced
trauma (McCann & Pearlman, 1990). VT does not focus on observable symptoms, but rather concentrates on the inner experience of the helper (Pearlman & Saakvitne, 1995; McCann & Pearlman, 1999). Based on Constructivist Self-development Theory, VT is a fundamental shift in the cognitive schemas or mental framework that is experienced by helpers as a result of their witnessing or secondarily experiencing traumatic events (Iliffe & Steed, 2000; Pearlman & Saakvitne, 1995). It is these cognitive schemas that provide a mechanism by which the workers can make sense of their experiences, their expectations regarding the world, and their beliefs and assumptions (Iliffe & Steed, 2000; Pearlman & Saakvitne, 1995). Certainly the workers in this study described the experience of both compassion fatigue and vicarious trauma, which is addressed specifically with respect to research question number five, but they displayed mechanisms for coping with and making sense of this vicarious trauma that allowed them to continue their work.

Through examination of the interview data the theme of the participants being able to view their work with traumatized as children as “not about them” seemed to be the essence of their experience of the trauma. Although they described deleterious effects from the work, as is discussed later, they function from a viewpoint that the trauma is an inherent part of the work and the work is about helping the children. Phrases such as “it’s all about the kids stuff, not mine” used by participant I-1 and “The work is about these kids and what they can do” used by participant I-2 indicated that the workers consciously separate themselves and their experience from that of the children.

Both of the focus groups contained discussions around the perception that the work, the daily experience, and the behavior of the children is separate and removed from the workers themselves. In focus group # 1 there was a strongly expressed notion that the
facility “puts the children first” and that the staff have awareness that this focus is healthy for them. Statements such as “‘just keep it about the kids’, ‘the job is about the kids’, and “it’s all about the kids” indicate that the workers continually foster this notion. In focus group #2 this idea was expressed in much the same manner. Phrases such as “staff has to remember what they are doing here is not about them, it’s about the kids.” and the responses they are getting from these kids are not about them, it’s about the kids” indicated the effort exerted around keeping the children’s trauma history and behaviors compartmentalized. This intentional effort to keep the trauma externally focused allowed the workers to experience the negative effects of exposure while continuing to be able to function effectively on the job.

**Theme #4. How could they not be a mess?** While the workers discussed their meaning making around their experience of vicarious exposure to trauma, they demonstrated an acceptance of the children’s disturbance as a result of their trauma history. This acceptance of the causal link between the children’s trauma and their disturbed behaviors within the facility further aided the workers in maintaining a beneficial view of the work, the children, and the world. The workers all engaged in story-telling as a means to describe their work experience. They told me of clients who had been raped beginning at age two, who had been physically abused and neglected, and who had suffered emotionally horrific events beyond their abilities to comprehend. The workers also talked about the experiences that they had had with the children within the facility. These behaviors were also beyond the cognizance of the workers prior to their employment with the facility. They spoke of children making themselves vomit and intentionally urinating and defecating on themselves in order to achieve a goal. They
spoke of witnessing what can only be characterized as animalistic behaviors such as scratching, growling, biting, and physically aggressing. What made sense to the participants who were faced with such disturbing behaviors was to view them from a standpoint of trauma informed care.

The study participants all endorsed accepting the children’s behaviors as being a result of their traumatic experiences and even further, viewing the children’s trauma histories as an accepted part of their “whole”. The participants in this study had all been through training specifically designed to address the provision of care from a trauma informed stance. They expressed that this training was beneficial in helping them to put the trauma in perspective.

Participant I-1 spoke of not “being surprised how these kids act given what they have been through.” Of significance was the continuation of that thought regarding, “not making assumptions about how they [the children] were going to be based on their f’d up pasts.” He talked about accepting the children for who they are in the present and not defining their potential before they even arrive at the facility. The concept that the horrific trauma that some of the children experience is integral, but not definitive was echoed in the focus group discussions.

During focus group #1, the participants discussed the children’s disturbed behavior as a function of their trauma histories. Participants spoke of the children not having normal childhoods and being ill prepared to function appropriately without support. They related that many of the children were unaware of the influence their trauma history has had upon their development and that workers could help increase functioning through increasing awareness. The participants also addressed that it was
essential for the workers to remember that the children have been traumatized in order to ensure appropriate care was provided.

The participant in focus group #2 also brought forth the idea of accepting the children’s trauma as a means of understanding who they are and where they have come from. Statements such as “a lot of it was knowing what she had been through and then looking at that and saying gosh, can you blame her?” indicated that the workers were using the trauma histories as an enhancement of their treatment perspective. Focus group #2’s participants also looked at the function of trauma with respect to the development of coping mechanisms, which provided a more positive view of the children’s behaviors.

The individual interview with participant I-2 provided a clear saturation point for the theme of accepting the trauma as part of the experience of the “whole”. She said, “Given the crap they’ve been through, you can’t expect them to be any different.” Her statement of, “when I read their backgrounds and stuff, I think in my head, I’d be the same way. I’d act the same way” was an illustration of the conceptualization of trauma as a normative influence that was working in the cognitive schemas of the workers. When this notion of the normative effects of trauma was successfully combined with the ability to compartmentalize the vicarious exposure to trauma as “not of themselves”, these workers were able to make sense of their experience and continue to be productive helpers with these traumatized children. The workers all pointed to this ability to accept the trauma and keep it separate from themselves as a characteristic of individuals who find success and longevity in the work. They expressed that workers that do not last long at the facility are those that cannot seem to find a place to “put” the trauma of the
children with respect to their exemplification of disturbance and leave within a short time of their hire dates

**Implications.** A substantial body of literature speaks to the potential negative effects of vicarious exposure to trauma through helping. Burnout is measured by the amount to which helpers exhibit impersonal responses or numbing towards clients and their circumstances (Maslach, Jackson & Leiter, 1996). Compassion fatigue has been shown to manifest as a result of the unique psychological strain that comes with the provision of empathic care (Figley, 1995). Vicarious trauma relates to the disruptions of the helper’s ability to make sense of the world to which they are exposed or to find congruence between their perceptions and fundamental cognitive schemas and the horror to which they are exposed (Pearlman & Saakvitne, 1995). The review of the literature speaks to the need for helpers to be able to withstand the strain of empathic engagement and be able to make sense of the trauma experience in order to continue to provide treatment intervention.

The participants in this study demonstrated an ability to establish a perspective of the trauma history of the children that permitted them to continue to function effectively. Their sense that the trauma was “not about them” served as a protective factor that allowed them to establish a healthy boundary between themselves and the work. Employed as a coping mechanism, this notion that the work, and thereby the trauma, was about the children, served them well both in their work and outside environments.

The workers in this study were also able to normalize the children’s behaviors within the facility through their ability to look at the behaviors from a trauma informed perspective. They did report stories of highly disturbing events that they witnessed within
the facility and did not discount that these events had a lasting negative impact upon them. However, the participants were able to reframe these extreme behaviors as normative given the horrific experiences through which they had suffered. This ability to accept the trauma history of the children as part of their “whole” offered a protective factor related to the potential for the workers to be traumatized by their work at the facility.

There has been a significant amount of research conducted around the provision of supervision to mental health counselors (Stamm, 2003), but little information was available regarding supervision of direct care staff. It was of note that the staff interviewed for this study did not mention receiving and formal supervision around their work. Supervision would provide these workers with an outlet in which to process and explore their experience of vicarious trauma.

When working with a traumatized population, it is assumed that workers will be exposed to information that could be disturbing, but this is not often addressed. Initial training related to the topic is generally minimal. Pearlman and Saakvitne (1995) discuss the psychotraumatology as “subversive work” that encompasses dealing with the shameful secrets of our society. In the state of Pennsylvania, residential treatment workers are provided with 40 hours of training per year (Pa. Code § 3800.58). This training must included education on restraints, CPR, HIPAA privacy and security, child protective service law, fire safety, and infection control (Pa. Code § 3800.58). Through my experience in residential work, I am aware that the primary focus of administration is often on ensuring that the facility merely meets the regulatory requirements for training, and training is expensive. There are significant costs associated with the provision of
education and staff lost time to attend those trainings. With a declining budget for mental health services, the margin for facilities to remain fiscally viable grows smaller each year. Training budgets are some of the first to be reduced with only the basic, mandated trainings being provided.

This study suggests that training on the issue of vicarious trauma and the experience of providing care to children who have significant trauma histories could be of benefit toward helping the workers find ways to cope with their vicarious exposure. It is essential that individuals who perform trauma work can find a way to make sense of the horror that assails the very core of their understanding. Enhanced training and supervision directly targeted to such topics could increase the workers ability to maintain a healthy perspective as they continue their work.

**Research Question #4**

An area of significance for the study was to explore the question, “What sustains the workers in the field of working with traumatized children?” The participants in this study worked long hours, in a stressful environment, for arguably minimal pay. They endorsed experiencing deleterious effects from the work, yet they continued to remain on the job. The interview data revealed two distinct themes that help to explain the cognitive and emotional processes that enable the workers to remain in the field. These themes and their implications are discussed below.

**Theme #5. The tiniest change.** The literature contains a growing body of research that addresses a positive or salutogenic approach to the treatment of the effects of traumatic exposure. Salutogenics is the notion that growth and meaning making can, and do, occur as a result of adversity (Volanti, Patton & Dunning, 2000). The literature
now contains explorations of human resiliency (Bonanno, 2008), adversarial growth (Joseph & Line, 2005), and posttraumatic growth (Tedeschi & Calhoun, 1996). There is no question that people can experience positive changes in themselves as a result of exposure to negative conditions. The workers in this study found meaning and satisfaction in their work by finding “the tiniest positive change” in the children within the facility. The satisfaction of being a person who was, either directly or as part of a team, responsible for effecting a positive change was identified as a salient factor in the retention of the workers on the job.

Compassion satisfaction (CS), as defined by Stamm (2002), includes the component of respect for human resiliency. The study participants validated the experience of CS as a function of perceived resiliency. Participant #1-1 exposed the concept by stating:

I have seen the worst kids get it together to be better. I know they can do it. As long as I can keep having hope, can keep finding even the little positive change, I can keep doing this job.

In this discussion, he spoke at length about expecting that the children would grow and change for the better. He expressed a firm conviction that the children with whom he works could all demonstrate positive development, even if it was “something small.”

The focus groups both contained discussions around job satisfaction and what sustains the workers in the field. As in the individual interviews, the group participants spoke of effecting change and witnessing “baby steps” toward a better outlook. Of note, all of the interviews contained reference to the lack of pay received by the workers. A topic of some consternation, the comments were, “it certainly isn’t about the money”, “I
don’t get paid that much”, “the paycheck isn’t why I’m here”, and “none of us here will say that we get paid enough to do what we do.” There was a general sense that the workers harbor resentment regarding the amount of remuneration received for their services, yet they spoke of consciously choosing to focus on personal satisfaction instead of pay rate. The participants spoke a great deal about being witness to or part of change. They spoke of personal satisfaction, “When you see that change in somebody and know you helped with it, you obviously feel good about yourself.” and pride “you stand back and scratch your head and say, wow!” The focus group discussions centered on the workers’ ability to harvest success, even if that success was minor, in the larger scheme of things.

Time after time in the interviews, the workers referred to small achievements as providing a sense of satisfaction and a reason to continue the work. They used phrases like “even if the difference is small”, “any change is good”, “then you see that little change”, “I think the little changes in the kids remind me”, and “just being able to see a difference.” This notion of forward progress, even if minimal resonated throughout the data collection process. The participants did not describe the expectation that the children would be “healed” or “normal” upon their discharge from the facility. They held no illusions that a stay in a facility could remediate other forces, such as family dynamics and environment. What they did hold as true was that each child had the potential to make a change, any change, and that would be an achievement. Of course the workers strive for great success. They discussed those discharges where the children were able to maintain their gains at home, be mainstreamed in school, and have gratifying social relationships as being the ultimate hook to staying in the field. But, underlying the hope
for the great success was a conviction that the small changes can be as gratifying as the grand discharge. This ability to accept the reality of the work and find satisfaction in the small victories was presented as strength of the workers and a factor that contributes to longevity among the employees at the facility.

**Theme #6. Personal characteristics and approach to the work.** The participants in this study pointed to a number of personal characteristics and specific attitudinal approaches that keep them on the job and functioning effectively. Their discussion of providing care to the children in the facility was peppered with adjectives that described the attributes that are exemplified by successful workers. In common, the interviews contained reference to the worker who can control their emotions and not react personally to the children’s behavior. Each interview contained at least a mention of not allowing one’s self to become angry in the course of interaction with the residents. The workers brought forth being consistent, both in emotion and application of rules presentation as a positive trait.

The issue of the workers’ ability to control their emotions and reactions was closely tied to how the workers viewed the behaviors with which they were confronted. The interviews all contained discussion around the participants’ perception that healthy interaction with the children involved not “taking their behavior personally.” They described being able to place the children’s behaviors in context. As mentioned earlier, these workers viewed the children’s issues as a function of their trauma histories. They also viewed negative behaviors, such as verbal and physical aggression directed toward them as a function of the trauma, and not a personal attack. This attitude or approach to
their daily experience was pointed to as a major protective factor against compassion fatigue and burnout.

Another characteristic that was mentioned across the data collection process was the workers’ ability to adapt to changes in the work environment, be they related to cottage assignment, schedule, administrative functions, or the children themselves. The participants spoke of being “able to adjust” and having the ability to “roll with the punches” as desirable traits for those wishing to remain in the work. The participants talked about changes in the facility in response to the shifting landscape of social services. They identified these shifts as potential stressors and highlighted the need to put those changes in the perspective of the work being about the children. Adaptability is also discussed later in this chapter as the participants identified this attribute as a resultant benefit of their work.

The study participants also mentioned a number of general personality characteristics as beneficial, if not essential, to employment longevity. They highlighted maintaining a positive outlook and demeanor as a protective factor that enabled them to continue their work, as well as a benefit in relationship building with the children. The participants expressed feeling that the negative behaviors of the children could be mitigated if the staff approached the children from a positive standpoint. They spoke about “coming back every single time smiling” and “spreading positiveness” as attributes that made the work easier to cope with. The participants identified themselves as being optimistic, positive people who have hope that they can make a difference for the better in the children’s lives.
The attitude of hope was pervasive in the discussions with the study participants. They identified the ability to hope as an essential component of their ability to stay in their jobs. Tied to their ability to see the smallest change as success, the participants pointed to their sense of potential for the positive as a significant affirmation in their work. Participant #3 stated the concept of hope quite succinctly when she said:

I think it [the work] reminds me that even in the face of horrible adversity, that there is still resiliency and it can still happen, regardless of the horrible, horrible stories you hear. There is always hope. I guess that that’s what keeps me going, that there is always hope. And those little glimmers, those kids reaffirm my hope, I guess, in change, in resilience and growth.

The other participants’ comments mirrored her thinking. They referenced the hope for change as the factor that keeps them “hanging in” and remaining positive about the work. The study participants all demonstrated an optimistic outlook regarding the ability of the children to overcome their traumatic pasts. They clearly did not define the children by their past experience, nor did they appear to be jaded in making assumptions that the children were destined for a negative outcome based on their experiences. Their optimism was striking given the fact that they identified that the “successful discharges” are few and far between.

There were a number of other characteristics that were provided as traits that are common among those workers who choose to remain in the profession. The participants enumerated being able to relinquish control, spirituality, calmness, openness, and being down to earth as traits that contribute to longevity in the work. Of note, the participants talked a great deal about the support of a team being an essential reason they stay in the
work. Separate from their individual characteristics, the value of their relationships with their colleagues was evident in their conversations. In his description, Stamm (2005) includes feeling positively about one’s colleagues as an integral part of compassion satisfaction. Although not directly mentioned by the participants, I observed them to be quite humble in accepting credit for the success they have with the children. They demurred to the team and their supportive colleagues as the source of accomplishment with the children. Statements such as, “I don’t deserve that much credit” and “it was part of a community, everybody” indicate not only their perception of the importance of a supportive, collaborative working environment, but that success is outside of themselves.

Implications. The participants in this study supported the findings in the literature review related to people’s ability to find benefit from their work with traumatized individuals. The workers identified themselves as individuals who find satisfaction and success from the smallest positive change. This benefit finding is discussed in detail in the section related to VPTG under research question #5, but it bears significance related to the personal characteristics of the participants.

The participants in this study identified a host of personal characteristics and attitudes that they believe keep them in the field of mental health work with traumatized children. As stated before, their 5.2 years average length of service is uncommon to the facility and likely the field of residential work with children. These individuals were selected because of their scores on the ProQOL (Stamm, 2005), which directly measured their job satisfaction. This scoring is discussed in the limitations of the study; however it is of interest that the individuals that met criteria for the study and responded to agree to participate had lengthy employment histories. There were only a handful of individuals
that met the criteria who had less than 1 year of service and only one of these individuals responded to inquiries.

The literature reveals efforts to elucidate those characteristics that make some individuals able to continue in the work while others become debilitated or leave. It is very much of interest that some helpers manage the stress of trauma work with few negative symptoms, while others develop full-blown, debilitating CF. For the past decade, a significant body of research has focused on the specific factors that lead to the development of VT. As much of the empirical data seems to conflict, there is agreement within the field that the current literature is insufficient in scope to provide definitive conclusions regarding what factors lead to the development of VT and what practices may reduce its potentially harmful effects (Harrison & Westwood, 2009; Arvay, 2001; Figley, 2004; Pearlman, 2004). Research into the influence of different types or specifics of trauma on the development of VT has proven to be inconclusive (Kadambi & Truscott, 2004; Schauben & Frazier, 1995). Also inconclusive have been the studies of the influence of the personal trauma history of the helper (Sabin-Farrell & Turpin, 2003; Jenkins & Baird, 2002). It does appear that the helper’s level of experience and education (Adams et al, 2001; Pearlman & Mac Ian, 1995), the number or percentage of trauma cases on a helper’s caseload (Bober and Regehr, 2006; Kassam & Adams, 1995), and the availability of social support (Ortlepp & Friedman, 2002) all play a role in the development of VT.

Another area of research interest is the elucidation of what protective strategies can be employed to help ameliorate the potential for VT. There has been a focus on including curricula on VT in counselor training programs, the development of
specific self-care strategies for helpers, and the importance of quality clinical supervision (McCann and Pearlman, 1995). The workers in this study clearly identified being adaptable, open-minded, non-emotionally reactive and positive as characteristics of successful workers. They also pointed to having the ability to not take the work personally and remaining hopeful for change as attitudes that keep them productively in the work. From this study, it was clear that these individuals have found ways to mitigate the negative influences in the work and can identify the traits in one another that are helpful in doing so. It may be productive to explore adding questions regarding these specific characteristics into the interview and screening process for employment. If we identify that individuals with the above characteristics are more able to withstand the emotional rigors of the job and will therefore remain on the job longer, hiring people with these characteristics may increase the ability to build strong, cohesive, and supportive teams, which was also mentioned as a factor in staying with the work. The personal characteristics of these workers also seem to suggest a potential relationship to the construct of hardiness. Kobosa (1979) first defined hardiness as the ability of individuals to remain healthy during stressful circumstances. According to Rowe (1999), hardy individuals are those who approach traumatic circumstances with the belief that stressors are changeable and who view challenges and change as a growth opportunity rather than a struggle. The workers in this study described approaching their days with a sense of anticipation of change, a will to find the smallest indication of growth, and a positive assessment of stressful circumstances. This approach to the work seems to demonstrate a high level of cognitive hardiness, which helps to sustain them in their positions. Further exploration of how these workers came to be “hardy” also could
lead to enhanced training opportunities, mentoring opportunities among the staff, and the development of agency policies and procedures designed to foster such characteristics.

The study findings also are in line with research that correlates the availability of quality support in reducing the potential for VT (Ortlepp & Friedmans, 2002). The participants spoke of the support of other staff as being paramount in their decision to remain on the job. They described these relationships as being a second family, which speaks to interactions that transcend mere work acquaintance. Of note was the perception that the administration of the facility did little to support the workers or encourage the development of their supportive network. They brought forth issues like the hiring and use of part-time staff and “floaters”, individuals that move from unit to unit, as negative influences to team building. The workers felt that the support of and development of a cohesive team was very important. They expressed that having an experienced team that was accustomed to working together made their jobs less stressful and their interactions with the children more productive. As mentioned earlier, staff retention is an issue in residential work. Finding ways to focus on retaining staff and establishing long-term, standing teams could be a way to increase job satisfaction and performance.

Research Question #5

At the heart of this study was the question, “How do mental health workers describe the ways in which they have been affected by their work with trauma?” This question directly addressed both the negative and positive effects of the worker’s vicarious contact with the trauma of the children residing in the facility. What follows is a discussion of the themes that surrounded the workers description of these effects. First discussed is the negative sequelae exposed by the participants. They described vicarious
traumatization that parallels that discussed in the available literature. In contrast, and of paramount importance is the participants’ elucidation of the final theme that highlights their experience of vicarious posttraumatic growth. Implications for the field are also addressed.

**Theme #7. My eyes were opened to a whole new world (vicarious trauma).**

The participants in this study endorsed that they have experienced their work in ways that meet the definition of compassion fatigue and vicarious trauma. As previously discussed, CF and VT are related constructs that differ slightly in conceptualization. Compassion fatigue (CF) is defined as “the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other and the stress resulting from helping or wanting to help a traumatized or suffering person” (Figley, 1995 p.7). These consequences involve symptoms that mirror those of individuals suffering from posttraumatic stress disorder. In this study, the participants spoke of a number of symptoms that they had experienced as a result of their work with traumatized children. A common pattern was the development of hyper-vigilance. Hyper-vigilance is the characteristic of being overly sensitive the potential dangers in one’s surroundings (Steed & Bicknell, 2001). This heightened sense of the awareness of danger can be especially intense with respect to children. Participant #3 elucidated that her exposure to the horrible stories of the trauma that can be perpetrated upon children has made her “paranoid” and overly cautious about her own children. She spoke of her care in ensuring that her children are safe at their friends’ houses, wanting to know who will be present during sleep overs, and a general sense that the world is a dangerous place from which she needs to protect her children. This hyper-vigilance was discussed by the
participants who did not have children as well. Participant #1-2 talked about being in public places and observing how other people cared for their children. She recalled being shocked and upset when, at a public pool, she saw a family permit their small child to go to the bathroom by himself. The participants were aware that their increased sense of the potential for danger for children was a function of their vicarious exposure to the residents’ trauma. They were able to point to specific cases that they found particularly disturbing as sources for their increased concern. Cases that involved sexual abuse and severe physical abuse were those that were spoken about the most.

The participants also spoke about experiencing intrusive imagery and rumination or persistent thinking about the trauma histories to which they were exposed. This symptom pattern of having visions or unwanted thoughts about the trauma are consistent with PTSD (Way et al., 2004; Pearlman & Maclan, 1995). Many of the workers described “taking it home” with them as a negative consequence of the job. They expressed having difficulty falling asleep, dreaming about the children, crying when they went home from work, and rumination of thought as results of their vicarious exposure to trauma. They also reported avoidance of negative stimuli or things that would remind them of the children’s trauma. Behaviors, such as not watching the evening news or reading newspapers were identified as the result of feeling overwhelmed by the trauma. These symptoms parallel the experience of those who directly experience a trauma and develop PTSD. The workers also revealed changes in themselves that are in line with vicarious trauma (VT).

Vicarious Trauma (VT) “is a process through which the therapist’s inner experience is negatively transformed through empathic engagement with client’s trauma
material.”(Pearlman & Saakvitne, 1995 p. 280). The concept of VT emphasizes the role of meaning and adaptation as a function of vicarious exposure (Canfield, 2005). Further Pearlman & Saakvitne (1995 p. 280) describe disruptions in the helpers’ frame of reference as a result of vicarious traumatic exposure as follows:

Multiple aspects of the therapists and their life are affected, including their affect tolerance, fundamental psychological needs, deeply held beliefs about self and others, interpersonal relationships, internal imagery, and experience of their body and psychical presence in the world.

As discussed earlier in this chapter, the participants clearly expressed a physical experience of the children’s trauma histories. They also discussed fundamental changes in their view of the world.

In each of the interviews, the participants referenced their exposure to the trauma histories of the children as “opening eyes” to a “whole world” they “never knew existed.” They discussed reading the histories as experiencing “another planet” or “a whole other plane.” From their conversation, it was clear that they experienced the trauma histories of the children with whom they work as something out of their norm. The participants expressed not knowing such horror existed before they came to work at the facility.

The participants in the study also expressed that they found the trauma histories to be something that other people “wouldn’t believe.” They talked about the information being unreal or beyond the scope of most people’s understanding. The workers likened the trauma stories to something that was fictitious, and not to be believed, like something “you see on TV and those weird Hallmark movies” or “a Lifetime Movie or ABC Afterschool Special.” The workers’ expressions of their experience were quite telling.
They used far more expletives to describe this experience than any other discussed. The workers referred to the trauma as “shit” and described it as “f’d” up and crazy.

The traumatic histories encountered by the workers led them to have pervasive and last shifts in their world view. They reported a new, not desirable, awareness of the way the world “really” is and a broadened understanding of how cruel people can be to one another. McCann & Pearlman (1990) argue that these changes to the world view of those affected by vicarious traumatization are cumulative, pervasive, and permanent. The participants in the study all endorsed that there is no unlearning this information.

Implications. The findings of this study clearly demonstrate that the workers at this facility have experienced vicarious trauma as a result of their exposure to the trauma histories of the children with whom they work. VT can spawn from the workers over identification with, or sympathetic response to the traumatic experiences of their clients (McCann & Pearlman 1990, Figley, 1995; Stamm 2005). Indeed, it is often workers who have the strongest desire to help and facilitate change who experience VT and CF at the most significant levels (Gentry, 2002).

The workers in this study described many of the components of vicarious trauma and compassion fatigue as being present in their experience. They also seemed to be unaware of the kind of stories to which they would be exposed or the potential impact of those stories upon their psyches prior to beginning employment within the facility. It is also of note that the facility employs individuals that have a variety of educational backgrounds. Some participants in this study did have psychology or therapy degrees, but most had backgrounds in non-therapeutic disciplines like education, criminal justice, journalism, and business. Although there is a great deal of discussion as to how well even
the therapeutic disciplines prepare counselors to deal with trauma (Skolvholt & Ronnestad, 2003), it can be expected that non-therapeutic disciplines, such as business will not have any mention of trauma in their curriculums. As part of the training and educational process within the facility, there should be material that focuses on the experience of the worker with respect to vicarious trauma. Again, it is highly likely that retention rates are substantially affected due to the negative experiences of novice staff who are unable to come to terms with the changes in their world view and as a result, leave the facility.

Additionally, the literature describes the decreases in effective and appropriate treatment that can occur as a result of burn out, compassion fatigue and vicarious trauma. Workers can become emotionally detached and desensitized to the issues of their clients (Maslach, 1982), may be irritable and bored with their work (Swearingen, 1990) or may begin to feel unsafe, out of control and devalued (Dunkley & Whelan, 2006). These symptoms can have a significant negative effect on the efficacy of treatment provided and, indeed, if severe enough, could be damaging to those that we are trying to help. Ethically, we have responsibility to not allow impaired individuals to engage in the treatment of others. The issue of vicarious traumatization of these workers goes beyond the need to protect them, but spills over into protecting the children with whom they work.

Theme #8. I find benefit and positive changes in me! (Vicarious PTG). As mentioned earlier in this study, there is a burgeoning area of research that is focusing upon benefit finding within traumatic exposure. Sprouting from this budding area of interest is an interest in examining the experience of vicarious exposure to post traumatic
growth. It is this notion that is at the heart of this study. If as a field we are willing to accept that those in the helping professions can be negatively affected just by hearing about or having second hand exposure to trauma, should we not explore the possibility that personal growth can occur in the same vicarious manner? To date, there has been little research conducted on the phenomenon of vicarious post traumatic growth. The construct is currently viewed as a conceptual extension of PTG. VPTG can be considered a parallel or isomorphic process to growth in individuals who directly experience trauma. Empirical evidence suggests that those who endorse PTG experience that growth within five domains; strength, new possibilities, relationships, spirituality, and appreciation for life (Tedeschi & Calhoun, 1995). The small body of available research suggests that vicarious posttraumatic growth reflects gains in three broad categories postulated by Calhoun & Tedeschi (1999). These categories, which are a more general delineation that encompasses the above listed five domains, represent positive changes in self-perception, interpersonal relationships, and philosophy of life (Calhoun & Tedeschi, 1999).

The participants in this study all endorsed experiencing some level of personal growth as a result of participating in and being exposed to the post traumatic growth of the children. It is of note, and is discussed later in the implications of the study, that this topic was the last to be raised by the participants, and required prompting from this investigator. When I asked the participants to discuss personal benefits and changes as a result of the work, they easily could evoke them, but this theme did not readily come to the fore of the discussion. The participants all identified changes in their personal characteristics that they attributed to their work. Many of the changes would fell into the category of self-perception. They identified becoming more open- minded, more tolerant,
and more flexible as changes in their general demeanor. Several of the workers stated that they were more patient. The participants were quite clear that these changes happened in their “outside” lives as well as within their world of work. They described themselves as being more adaptable and less likely to be perturbed by the “small stuff” or having a reduced tendency to get “worked up”, which reflected changes in the domain of philosophy of life.

The participants illuminated the experience of their changed philosophy of life by reflecting upon the experience of comparison. A number of the study participants talked about looking at their lives through a lens colored by a new awareness of what the world is like. Although this change in perception of the world can create negative symptoms as addressed above in the discussion regarding VT, such a change in awareness has also been shown to enhance benefit finding. In this study, the workers talked about comparing their own lives to that of the children or the children’s families. Participant I-1 stated, “My life is easy. I have a good life. I have everything I need, most everything I want. Look at these kids” They are working so hard just to get over the crap!” Other voices echoed this perception. Participants in the focus groups talked about how they view their own lives as being easier as a result of the exposure to the children’s histories. They used phrases such as “piece of cake” and “could be a hell of a lot worse” to illustrate this change in the way they look at their world.

The study participants also discussed growth in the domain of appreciation for life. Participant #7 illustrated this point by saying, “How lucky we are not to have kids that have gone through the shit these kids have gone through.” The workers all expressed finding value in their lives as a result of the work. They were able to identify desirable
elements of their existence that the children are missing, as well as negatives that the children have experienced that the workers have been fortunate to avoid. Participant #3 directly expressed, “We appreciate what we have more.” The workers reported looking at the simple facets of their life with a deeper appreciation. They identified having warm homes, plenty to eat, safety, and security as things that are no longer taken for granted as a result of their work. This notion of “having” did not relate solely to material possessions, although that was a part of the concept, but also referred to their appreciation for their own stable homes and positive relationships.

A perceived positive shift in relationships is the most consistently reported change that results from traumatic exposure (Tedeschi & Calhoun, 1996). A review of the literature reveals that these changes include a deeper appreciation for family and friends, closer, more meaningful relationships and an enhanced sense of value (Tedeschi & Calhoun, 1990, 2006; Park, 2008; Janoff, 2006; Affleck et al., 1985). This was reflected in the vicarious experience of the study participants. Experiencing an increased sense in the value of relationships was strongly endorsed by the participants in this study. They identified that the awareness that the children often had not experienced appropriate, loving relationships made them consider their own experiences. Further, they related that watching and participating in the children’s discovering how to have meaningful relationships spurred them onto pay more attention to their inter-personal relationships.

The participants also identified a change in their sense of possibilities. Although this domain is generally characterized by the notion of a “second chance”, the workers in this study spoke of developing a sense of increased possibilities for human resilience and
change. They talked about those children who had suffered horrendous trauma and exhibited significant impairment that had positive dispositions. The workers classified these experiences as those that made them realize that what they used to believe was impossible, was not. They expressed a general sense that their observation of the extent of the resilience and growth of the children with whom they worked enhanced their own ability to explore new possibilities and expect positive outcomes.

**Implications.** The findings of this study demonstrate that the participants can identify personal positive psychological and emotional growth that has occurred as a result of their work with traumatized children. They presented changes that are in concert with those described in the literature related to post traumatic growth in the domains of self-perception, interpersonal relationships and their philosophy of life (Tedeschi & Calhoun 1990).

Of note, is that the theme of personal growth as a result of their vicarious exposure to trauma was the last to emerge in the research. When asked to describe their experience of the trauma of the children with whom they work, the participants all initially focused on the negative effect this exposure has had upon their lives. The participants did not need time to think about or consider their responses, but were all able to readily discuss a number of deleterious effects that they have suffered from their work. They easily related specific stories to their negative experience and could have filled the entire interview with the negatives of their experience. I had to specifically ask the workers to talk about the positives they found in their work. In several cases, their initial response was to sit quietly and think about the question. Two of the participants actually expressed that they had never really thought about that question before. It is curious that
the workers are negatively focused, and such a focus seems indicative of work in the helping professions.

The mental health professions are, for the most part, pathologically focused. We use the DSM to diagnose individuals based on their pattern of pathological or negative symptoms. Mental health is generally viewed as the absence of negative symptoms (Seligman, Rashid, Acacia & Parks, 2006). Positive emotions are rarely the focus of therapeutic interventions and when they are mentioned, they are generally cited as evidence of progress or improvement (Stalikas & Fitzpatrick, 2008). Much of the literature regarding positive psychology points to an understanding that psychotherapy was born out of a need to assist individuals who are in distress and psychological pain (Stalikas, 2003). It was not until the last decade that the tentative beginnings of the study of positive psychology began to take root (Seligman & Csikszentimihalyi, 2000). This focus on the negatives of the clients with whom we work has influenced our perception of the mental health field and, indeed, how we perceive the work itself.

The findings of this study show that the workers experience a great deal of satisfaction and personal growth from their experience of watching the children in the facility triumph over their trauma histories, yet they needed to be coached to discuss these positives. In a related finding, they participants were also more likely to talk about the negative behaviors they observed in the children than the positive behaviors. This focus on the negatives of the work and the negatives of the clients translates into a deficit based approach to the work. When we expect the clients to have negative behaviors, we are generally rewarded with finding those behaviors. How often do the workers expect the children to exhibit positive behaviors? The findings of the study suggest that although
the workers attempt to be open minded regarding the children’s potential, they expect that their behavior will be aggressive, and out of the norm.

The workers are also conditioned to expect deleterious effects from the work. As mentioned, the study of the work of helping has focused on the multiple deleterious conditions that can arise. Burnout, compassion fatigue, and vicarious trauma are all well researched, and even if only on a surface level, are talked about in training and degree programs. These conditions are the expected outcome of on-going work with traumatized individuals. There has been a great deal of research conducted that points to the need for educating helpers about these potentially deleterious conditions (Black, 2008; Harrison & Westwood, 2009; Pearlman & Saakvitne, 1995), but no research can be found that discusses the need to encourage a positive perspective on the work of psychotraumatology.

The movements of positive psychology and salutogenic approaches to the work of trauma care have been growing over the last decade. The notions of adversarial growth (Linley, 2004), resilience (Bonanno, 2005) and posttraumatic growth (Tedeschi & Calhoun, 1990) seem to be gaining a foothold in the professional literature regarding methodology. Lagging behind is the concept of vicarious exposure to posttraumatic growth. It is evident that individuals who can find meaning and growth in the experience of psychotraumatology are more able to tolerate the work. Certainly, in a residential setting, administration should desire to retain staff that find meaning and purpose in their work and can approach their clients and daily tasks with vigor and a sense of esteem. Consciously educating workers on the potential for growth and finding ways to recognize
and foster that growth can only serve to enhance the emotional well-being of the staff and thereby the facility as a whole.

This study’s findings have significant implications for the field of residential mental health treatment. The themes elucidated address perceived characteristics that make residential workers successful in their jobs and lead to long term employment. The themes also speak to the positive and negative effects of the work which can be a significant factor in the efficacy of the facility and its treatment. The participants in this study reveal themes salient to the enhancement of residential treatment of traumatized children, residential treatment in general, and the workers employed within such facilities. Additionally, these themes suggest areas for further research that can be more broadly applied to psychotraumatology in general. Table 9 provides an overview of the eight themes delineated from the study.

**Table 9. Themes Delineated from the Research.**

<table>
<thead>
<tr>
<th>Theme #1</th>
<th>Existential, corporeal experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme #2</td>
<td>We are here to help</td>
</tr>
<tr>
<td>Theme #3</td>
<td>It is not about me</td>
</tr>
<tr>
<td>Theme #4</td>
<td>How could they not be a mess</td>
</tr>
<tr>
<td>Theme #5</td>
<td>The tiniest change</td>
</tr>
<tr>
<td>Theme #6</td>
<td>Personal characteristics and approach to the work</td>
</tr>
<tr>
<td>Theme #7</td>
<td>My eyes were opened to a whole new world. (vicarious trauma)</td>
</tr>
<tr>
<td>Theme #8</td>
<td>I find benefit and positive changes in me! (vicarious posttraumatic growth)</td>
</tr>
</tbody>
</table>
Limitations of the Study

This qualitative study used 12 participants who were employed in a residential treatment facility for multiply traumatized individuals. The participants in this study were selected based on their place of employment and their scores on the ProQOL (Stamm, 2005). This instrument was used as a screening tool to establish thresholds that would narrow the potential pool of participants and provide the best possible chance for the presence of the phenomenon to be examined. Limiting participation to staff that met the criteria thresholds in the screening instrument inadvertently created a pool of candidates that had a longer tenure with the agency than the average. Very few of the potential participants had over 1 year of experience. This homogeneity in length of service could have had an impact on the type of individuals who agreed to participate in the study. It could be that those individuals who experience VPTG are those individuals who decide to stay in the work. Additionally, length of tenure may also correlate with the individual characteristics identified by the workers as those that contribute to job satisfaction and meaning finding.

Another limitation of the study is that it is not generalizable to all workers who are employed in residential facilities for children. The study facility operates from a perspective of trauma informed care so the participants may have an enhanced sense of trauma work than facilities that are not similarly focused. Additionally, the workers in this study were primarily Caucasian. Only one of the study participants identified as African American and she was the youngest participant with the shortest tenure. Although the sample does essentially reflect the lack of diversity present in the
geographic area where the study was conducted, as well as the ethnicity of the children within the facility, it is not reflective of all residential treatment workers.

I may have also been a limitation of this study through my presuppositions and biases in both interviewing and interpreting the data (Krueger, 1988; Patton 2002). I have prior experience in residential treatment and have been a therapist for 30 years. I bring to the research my own notions of the work and its effects that may have influenced the research. Although I attempted to mitigate these issues through the use of the reflective journal and consultation, nonetheless, they remain. I may also have had an influence upon the participants in this study. The participants may have felt anxiety to perform or answer in a way they believed I expected (Patton, 2002). The participants may also have felt uncomfortable being completely honest as the information being collected was directly related to their livelihoods. Although I assured the participants that they would be afforded confidentiality and that their participation was in no way tied to their employment, underlying insecurities may have influenced their answers.

**Implications for Future Research**

A number of areas for further research were derived from this study. The participants identified characteristics that they found in themselves that led to increased satisfaction with the work and thereby to longevity within the facility. It would be beneficial to ascertain if, indeed, these characteristics are those that contribute to length of employment and job satisfaction. In general, we can assume that a well trained, seasoned staff enhances treatment provided. An awareness of what characteristics increase the likelihood that staff will remain in the field could prove to be extremely helpful to the retention of quality staff.
The participants in this study also spoke of their ability to accept the trauma histories of the children within the facility and not allow those histories and the negative effects of “knowing” to impede their performance. They addressed specific attitudes, such as normalizing behaviors, and not personalizing the work as protective against debilitating VT. It was not apparent as to how this viewpoint developed or what fostered it. It would be beneficial to study how this perception develops and how it could be maintained.

Finally, and most importantly, further study of the benefits of a salutogenic approach to working with individuals with trauma needs to be conducted. Looking at the benefits of a positive approach to trauma with the clients and a positive approach to looking at the experience of working with trauma can only serve to enhance the field of psychotraumatology. What would happen if we operated from a positive perspective instead of a pathologic, deficit based orientation? Would we get more positive outcomes because that would be what we expected? Would we have emotionally healthy workers employed in the field? There are a great many unanswered questions.

Questions Generated by the Research

Often in qualitative research, more questions are generated than answers (Glesne, 2006). This study has brought forth a number of further questions regarding the research.

- Does the ability of the participants in this study to think positively about the effects of the work make a difference in the efficacy of their job performance?
- Does length of employment lead to an increased ability to see positives, or do employees stay longer because they are more able to see the positive?
• What is the relationship between the workers’ self-described traits and the construct of hardiness?
• How are VPTG and hardiness related?
• Do workers who are seasoned perform better than new employees?
• Can VPTG be increased through a culture shift within a facility?
• Do all the workers, not just those who scored within the thresholds of the screening instrument, experience VPT?
• What role does supervision play in the benefit finding and VPTG of the workers?
• How do administrative/management staff in this facility view the notion of VPT?
• Has the introduction of the Sanctuary Model® influenced the perceptions of the workers within this facility regarding traumatology and vicarious trauma?

Conclusions

The purpose of this study was to examine and explore the lived experience of mental health workers in a residential facility for multiply traumatized children. These workers had all identified themselves as experiencing both vicarious trauma and compassion satisfaction as a result of their work. The findings of this study highlight their perceived benefits and costs of doing this work. The study provided an in-depth description of how these workers find meaning and value in the work that they do despite their negative exposure to vicarious trauma. Of special focus is the workers’ experience of vicarious posttraumatic growth as a result of paying witness to the growth of the traumatized children.
Twelve individuals participated in this study through 2 focus groups and 2 individual interviews. They provided a description of their work that is rich with examples of their daily experience and the true essence of their experience. From their discussions around the five research questions, eight distinct themes emerged. These themes revealed that the workers are traumatized by their vicarious exposure to the traumatic histories of the children. They endorsed experiencing symptoms related to both compassion fatigue and VT. The workers were also able to identify characteristics within themselves that mitigate this negative experience and help them to find benefit and satisfaction in their work. This benefit finding and satisfaction sustains the workers employed within the field of psychotraumatology. Finally, the workers were also able to identify and examine their experience of VPTG. They described personal growth that has occurred as a direct result of their paying witness and playing a part in the posttraumatic growth of the children with whom they work. The workers identified growth in the areas of improved relationships, an increased appreciation for life, and the development of an improved self.

The study findings highlight the need for a more intentional focus on the characteristics that are present in workers who withstand the rigors of trauma work. If we can discern what makes people “cut-out” for this type of work, we may be able to improve the quality of the work force employed in treating individuals with trauma histories. An improvement in this work force could lead to increased efficacy in trauma care.

Additionally, the study reveals the on-going pathological approach to mental illness. This includes a negative or pathological approach to both individuals with mental
illness and to the experience of helping them. The movement toward strength-based
treatment and a salutogenic approach toward being helped and helping can serve to shift
our focus to what may be a more productive and healthier approach to the work of
psychotraumatology.

This study provides insight into the heretofore unexamined experience of
providing daily care to traumatized children, which must be some of the hardest work
within the mental health field. The workers in this field are generally underpaid and are
often undervalued. It is hoped that the information contained herein and the questions
generated will lead to further examination of this experience and a continued pursuit of a
salutogenic approach to the work of trauma care.
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Appendix A: Participant Solicitation
Hi ____________,

My name is Debra Hyatt-Burkhart and I am a doctoral candidate at Duquesne University. I am contacting you regarding your potential participation in a research study that I am conducting as part of the requirements for my doctoral degree in counselor education and supervision.

I am seeking to explore the experiences of mental health workers who work residentially with multiply traumatized youth. I am interested in talking with workers who score high on measures of vicarious trauma and compassion fatigue. You were previously administered the ProQOL assessment. I am looking for participants who scored above 17 on the vicarious trauma scale and above 42 on the compassion satisfaction scale of that instrument. I believe that people who score above these thresholds may experience vicarious posttraumatic growth, which is the phenomenon I am interested in examining. Participation in this study is absolutely voluntary and has no bearing on your employment with Glade Run Lutheran Services. All information from the study will be kept confidential.

I am asking you to participate in either a group or individual interview that will last for approximately 90 minutes and be scheduled at a time convenient to you. You won’t receive any compensation for participation, but there won’t be any cost to you either.

If you believe you meet the scoring criteria and are willing to participate in the study, please respond directly to this e-mail or contact me via my cell phone at 724 421-7774. Please be aware that I will ask that you consent to allow me to review your ProQOL scores to verify that you meet the study eligibility criteria.

Thanks for your consideration

Deb Hyatt-Burkhart
Appendix B: Informed Consent
CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE: The Lived Experience of Mental Health Workers in a Residential Treatment Facility Who Work with Multiply Traumatized Children and Self-Identify as Experiencing Vicarious Trauma and Vicarious Posttraumatic Growth.

INVESTIGATOR AND ADVISOR: Lisa Lopez Levers, PhD.
Duquesne University
School of Education
Dept. of Counseling, Psychology, and Special Education
412 396-1871

CO-INVESTIGATOR: Debra Hyatt-Burkhart
320 N. Main St. P.O. Box 27
Harrisville, PA 16038
724 735-2132

SOURCE OF SUPPORT: This study is being performed as partial fulfillment of the requirements for the doctoral degree in Counselor Education and Supervision at Duquesne University.

PURPOSE: You are being asked to participate in a research project that seeks to investigate the lived experience of mental health workers who work with multiply traumatized children. You have stated that your scores on the ProQOL, which you were administered at your place of employment, meet the
study criteria and you consent to allow the researcher to examine your questionnaire to verify those scores. Your scores on that instrument indicate you have the potential to experience vicarious posttraumatic growth, which is the phenomenon of interest to this study. In addition, you will be asked to allow me to interview you or to participate in a focus group. The interviews will be taped and transcribed. Each interview or group will last approximately 90 minutes.

These are the only requests that will be made of you.

**RISKS AND BENEFITS:** There is no risk to participating in this study. As you are only being asked to discuss your job experiences and your reactions to your work related activities, there are no more risks to participating in this study than you would encounter in everyday life. The potential benefit to participating in this study is the contribution that this investigation may make to professional understandings about the experiences of clinicians working with young trauma survivors. You may or may not experience emotional benefit from participating in this study.

**COMPENSATION:** You will not, in any way, receive compensation for your participation in this study. However, participation in the project will require no monetary cost to you.

**CONFIDENTIALITY:** Your name will never appear on any survey or research instruments. No identification will be made in the data analysis. All written materials, consent forms, and audio tapes, which are inherently identifiable by voice, will be stored in a
locked file in the researcher's home. All identifying material, including information regarding anyone discussed in the interview will be deleted from the tapes at the time of transcription. The transcription will be shared with the researcher’s dissertation committee. Portions of the transcription may be anonymously quoted as illustrations in the dissertation itself. All audiotapes will be destroyed immediately after the completion of the study. Written materials, such as transcripts and field notes, will be retained for no longer than 5 years. All written material will be destroyed in compliance with HIPAA guidelines for document disposal. The information will be held confidential by the researcher; however, no guarantee can be made that participants in the focus groups will not disclose information outside of the group. Every effort will be made to stress confidentiality to the participants throughout the process. Your response(s) will only appear in aggregated data summaries.

RIGHT TO WITHDRAW: You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time. Should you choose to withdraw after engaging in a portion of the study, the researcher will not draw from or make any references to data that has been collected as a result of your individual participation.

SUMMARY OF RESULTS: A summary of the results of this research will be supplied to you, at no cost, upon request.

VOLUNTARY CONSENT: I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason.
On these terms, I certify that I am willing to participate in this research project.

I understand that should I have any further questions about my participation in this study, I may call Debra Hyatt-Burkhart at 724 735-2132; Dr. Lisa Lopez Levers, my dissertation advisor, at 421 396-1871; or, Dr. Paul Richer, Chair of the Duquesne University Institutional Review Board, at 412-396-6326.

__________________________________________________________________________
Participant's Signature
Date

__________________________________________________________________________
Researcher's Signature
Date