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Implications of Working with Trauma: Therapists' Perspectives

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Abstract

Vicarious trauma is a serious problem because it can be severe enough that a therapist may experience post-traumatic stress disorder (Bride, 2007). If therapists do not get help to prevent or treat compassion fatigue and burnout, there is a high likelihood that they will leave the field, which is a tremendous loss of resources (Harrison & Westwood, 2009). If they continue their work while impaired it is unethical and harmful to clients (Stalker & Harvey, 2002). If researchers gain insight on how therapists maintain compassion satisfaction while working with trauma, this could potentially reverse the effects of burnout and compassion fatigue. The purpose of the present study was to gain awareness of the lived experiences of therapists who work with clients who have faced trauma to discover negative or positive consequences that influence therapists work and personal lives. I had the following objectives: 1) To learn what factors contribute to an increase or decrease of both positive and negative consequences that counselors experience from working with trauma; 2) To determine what consequences affect counselor's well-being both at work and in their personal lives. 3) To determine what counselors do to cope with any adverse effects reported. Eleven therapists working in a large outpatient mental health clinic completed qualitative interviews and open-ended questionnaires. Findings supported evidence of burnout and compassion satisfaction while results of secondary trauma were varied. Future research should focus on the implications for therapists by analyzing methods used to train and support therapists.

Keywords: burnout, secondary trauma, compassion satisfaction, self-care

Implications of working with Trauma: Therapists' Perspectives

Listening to vivid reports of terrible experiences and observing the results of extreme trauma is inherent in therapists' work. Some counselors specialize in trauma related fields with the majority of their clientele being victims of trauma (Ben-Porat & Itzhaky, 2009; Bride, 2007; Carmel & Friedlander, 2009; Craig & Sprang, 2010; Deighton, Gurriss, & Traue, 2007; Hunter, 2012; Jankoski, 2010; Warren, Schafer, Crowley, & Olivardia, 2012). There are consequences for counselors who work with victims of trauma such as: compassion fatigue, burnout, and compassion satisfaction (Adams & Riggs, 2008; Ben-Porat & Itzhaky, 2009; Bride, 2007; Carmel & Friedlander, 2009; Craig & Sprang, 2010; Deighton et al., 2007; Harrison & Westwood, 2009; Hunter, 2012; Jankoski, 2010; Linley & Joseph, 2007; Sprang, Clark, & Whitt-woosley, 2007; Warren et al., 2012).

The terms vicarious trauma, secondary trauma, and compassion fatigue are used interchangeably in the literature. Trauma is one's emotional reaction to a terrible, distressing, and disturbing event like an accident, sexual assault, violence, or natural disaster (American Psychological Association, 2015). Vicarious trauma is the harmful effect on therapists when exposed to traumatic events of clients (Deighton et al., 2007). Vicarious trauma is a serious problem because it can be severe enough that a therapist may experience post-traumatic stress disorder (PTSD) symptoms. These typically include invasive symptoms, avoidant symptoms, hyperarousal, loss of control, and isolation (Bride, 2007; Carmel & Friedlander, 2009; Deighton et al., 2007; Jankoski, 2010; Ruyschaert, 2009). Along with PTSD symptoms, vicarious trauma can have an effect on a therapist's emotions, thoughts, self-worth, identity, and perceived safety (Hernandez, Engstrom, & Gangsei, 2010; Hunter, 2012; Jankoski, 2010; Ruyschaert, 2009).

While vicarious trauma involves fear and anxiety, another experience of working with trauma can be burnout, which means exhaustion and an absence of self-efficacy (Ruysschaert, 2009).

A major consequence of working with trauma is burnout. Burnout occurs when there is not an adequate balance between work and other important parts of life due to being under extreme stress (Ruysschaert, 2009). If therapists do not get the help they need to prevent or treat compassion fatigue and burnout, there is a high likelihood that they will leave the field, which is an enormous loss of resources (Harrison & Westwood, 2009). Furthermore, staying in the field while experiencing compassion fatigue or burnout is problematic because both the clients and the therapists do not get the help they need (Harrison & Westwood, 2009). If therapists remain in the field with untreated burnout symptoms, a consequence can involve emotional exhaustion that affects the work done with clients (Stalker & Harvey, 2002). If the therapist is exhausted being present is challenged with feelings of depletion. When burnout causes negative attitudes, therapists can become cynical toward the mental health consumers and the work environment. With burnout, therapists might also begin to doubt their competence and job effectiveness resulting in a reduced sense of self-efficacy and personal accomplishment (Stalker & Harvey, 2002). Code C.2.g. in the American Counseling Association (2014) Code of Ethics require therapists to monitor for individual impairments including physical, mental, and emotional problems and avoid providing services when personally impaired. It is important when following this code to seek help when having personal problems and requires that therapists limit, suspend, or terminate responsibilities until they can safely do their work (American Counseling Association, 2014). Therefore, burnout is harmful to both clinician and client and practicing therapy while suffering burnout is unethical.

In contrast, there can be positive effects on therapists who work with victims of trauma. Compassion satisfaction, also known as post-traumatic growth, is joy and happiness that results from witnessing the lessening of a victims pain (Ruyschaert, 2009). If researchers gain insight on how therapists maintain compassion satisfaction while working with clients who have suffered trauma they could potentially reverse the effects of burnout and compassion fatigue.

Purpose of the Research

The purpose of the present study is to examine the perspectives of counselors on their personal experiences and consequences of working with trauma. I had the following objectives:

1) To learn what factors contribute to an increase or decrease of both positive and negative implications that counselors experience from working with trauma; 2) To determine what consequences affect counselor's well-being both at work and in their personal lives. 3) To determine what counselors do to cope with any negative effects reported. I produced qualitative research to hear counselors' perspectives on the consequences they have experienced involving work with clients who disclose trauma. I was able to learn what therapists experienced by allowing the stories to come from them.

The purpose of the research is to gain increased awareness of how employed therapists view the implications of working in highly stressful positions. If a therapist experiences many negative consequences, it is important to know so the agency can support employees. Therapists suffering from vicarious trauma with PTSD symptoms may need time to seek professional help themselves and in those instances it can be harmful and unethical to provide services to clients. Negative consequences of working with trauma could lead to absenteeism and turnover (Harrison & Westwood, 2009). The client/counselor relationship may also be affected by therapist burnout and vicarious trauma, which could lead to increased no-shows for

appointments, resulting in fewer billable visits (Taris, 2006). Therefore, both the agency and the clients may benefit from the knowledge gained from this research. The stories of therapists can help counseling professionals understand what helps others, what makes the work more difficult, and how other counselors prevent negative consequences.

Literature Review

An examination of the literature concluded that therapists who work with victims of trauma experience compassion fatigue, burnout, and compassion satisfaction (Adams & Riggs, 2008; Ben-Porat & Itzhaky, 2009; Bride, 2007; Carmel & Friedlander, 2009; Craig & Sprang, 2010; Deighton et al., 2007; Harrison & Westwood, 2009; Hunter, 2012; Jankoski, 2010; Linley & Joseph, 2007; Sprang, Clark et al., 2007; Warren et al., 2012). Multiple research studies have found that PTSD symptoms are common in the experience of compassion fatigue. Specifically, these include intrusive thoughts, avoidant behaviors, and a feeling of numbness (Bride, 2007; Carmel & Friedlander, 2009; Deighton et al., 2007; Jankoski, 2010; Ruyschaert, 2009). Along with these PTSD symptoms, counselors may experience interpersonal problems, negative worldview, and feelings of low self-worth (Ben-Porat, 2009; Hunter, 2012; Jankoski, 2010). The literature also includes positive aspects of working with trauma.

Most of the literature suggests negative consequences on therapists and fails to recognize that they can experience growth from the work. Compassion satisfaction is the joy therapists experience when they witness a person transforming from a victim to a survivor (Radey & Figley, 2007). Compassion satisfaction can lead to improved relationships, communication skills, and anger management techniques (Ben-Porat & Itzhaky, 2009). The present literature review will report trends in past research on working with clients who have faced trauma in the areas of compassion fatigue, counselor burnout, compassion satisfaction, and self-care. I will discuss

prevalence, symptoms, and influencing variables in the field of compassion fatigue. I will also consider benefits and influencing variables in the area of compassion satisfaction. Following this discussion, types of self-care utilized by therapists will be highlighted. I will conclude with a brief discussion regarding limitations in the research and a brief description of the present study.

Compassion Fatigue and Burnout

Compassion Fatigue is a common issue for therapists who witness the reports of traumatizing situations. A study investigated the prevalence of secondary trauma stress by assessing the number of individual symptoms; the number of symptoms that meet diagnostic criteria for PTSD; and the severity of secondary trauma levels of 282 clinical social workers. Bride (2007) found that 97.8% of the social workers worked with clients who experienced trauma, and 88.9% reported that their work with clients directly addressed those traumas. Also, 70.2% of the sample reported at least one secondary trauma symptom in the prior week, 55% met the criteria for one of the core symptom clusters (intrusion, avoidance, and arousal symptoms), and 15.2% met the criteria for a PTSD diagnosis (Bride, 2007). There are many symptoms of compassion fatigue but overall, it appears to deprive therapists of their self-worth, well-being, and sense of security (Ruyschaert, 2009).

Symptoms of Compassion Fatigue

In the previously mentioned study of 282 clinical social workers, the most commonly experienced symptoms of vicarious trauma were invasive thoughts, avoidance of client reminders, and numbing responses (Bride, 2007). Intrusion symptoms were found for almost 50% of the sample while avoidance and arousal symptoms were present for 25% of the sample (Bride, 2007). The qualitative results of another study of eight counselors from five different counseling agencies included counselor reports of safety concerns, trust issues, and lack of

control (Hunter, 2012). Some of the counselors indicated a change in their worldview or beliefs; they reported that they no longer thought the world was a safe place. A mixed methods study conducted in Israel with both qualitative and quantitative data compared 143 family violence therapists that work consistently with trauma and 71 social workers who do not work in the family violence field (Ben-Porat & Itzhaky, 2009). Family violence therapists reported more adverse changes in their worldviews; they described this change as a damaged trust in humanity due to their work. Similar to the previous study, family violence therapists saw the world as dangerous and unfair; they reported a view that society is violent, immoral, and hateful (Ben-Porat & Itzhaky, 2009). In past research, different variables were found to play a role in the probability that a therapist will experience these symptoms (Adams & Riggs, 2008; Craig & Sprang, 2010; Harrison & Westwood, 2009; Ruyschaert, 2009; Sprang et al., 2007). I will discuss these variables below.

Variables that influence Vicarious Traumatization

Research has found that different variables can affect vicarious traumatization. The first is the amount of trauma-related training received by therapists. Another is the number of clients on a caseload. Third, the years of experience working with trauma and last the type of intervention used by therapists (Adams & Riggs, 2008; Craig & Sprang, 2010; Harrison & Westwood, 2009; Ruyschaert, 2009; Sprang et al., 2007).

Training. Completing trauma specific training is a variable found to influence the presence of vicarious trauma as a preventative factor. The research found that twenty-five percent of 129 graduate students in clinical and counseling psychology programs reported that they had worked with trauma victims with no previous trauma-related training (Adams & Riggs, 2008). There was a high correlation between the amount of trauma specific training and

symptoms of secondary trauma (Adams & Riggs, 2008). Lack of trauma-related training for therapists working with trauma victims is unethical. The American Counseling Association (2014) codes under C.2 that deal with professional competence highlight that counselors are only to practice within the lines of their competence and when working with a new specialty area should only do so after completion of relevant education and training.

Sprang and her colleagues (2007) found that trauma specific training increased compassion satisfaction and decreased compassion fatigue and burnout in a sample of 5,752 psychologists, psychiatrists, social workers, marriage and family therapists, professional counselors, and drug/alcohol counselors. The results demonstrated a negative correlation between specialized training and burnout, where less training led to higher rates of burnout. Similarly, Harrison and Westwood (2009) did a qualitative study with therapists who had at least ten years of experience in trauma work. The sample only included counselors who showed few signs of burnout and compassion fatigue and self-identified as coping well with their work (Harrison & Westwood, 2009). The counselors emphasized contributions to their success to be adequate training, professional development, and consultation (Harrison & Westwood, 2009).

There could be many reasons why more training correlates with decreased levels of compassion fatigue and burnout. Training may increase self-efficacy because of increased skills, successful treatment outcomes, and feelings of personal achievement (Craig & Sprang, 2010; Sprang et al., 2007). Also, training allows a break from daily work to learn and to develop peer support networks (Craig & Sprang, 2010; Sprang et al., 2007). Training may prepare therapists for high stress with a large case load.

Caseload. Another variable that may influence counselors' likelihood of experiencing compassion fatigue is the number of trauma-related clients on their caseloads. Craig and Sprang

(2010) found a statistically significant relationship between the percentage of clients with PTSD in a counselor's caseload and the counselor's level of compassion fatigue and burnout. Not only does the number of clients on a caseload influence the likelihood of compassion fatigue but the length of counseling experience a therapist has can make a difference (Adams & Riggs, 2008; Craig & Sprang, 2010).

Experience. How long a counselor has been working with trauma may influence the prevalence of compassion fatigue, but the findings throughout the literature are conflicting. On one hand, Adams and Riggs (2008) found that student therapists with 0-2 semesters of trauma work experienced higher levels of secondary trauma symptoms than the students who had more semesters of experience. Similarly, Craig and Sprang (2010) found that more experience led to higher levels of compassion satisfaction while younger age predicted burnout. On the other hand, in a study of 156 therapists, Linley and Joseph (2007) found that those who had been in the field longer reported more undesirable psychological transformations and burnout. There is a need for more research to determine whether years of experience negatively or positively impact compassion fatigue as the findings are varied and contradictory. The research on previously discussed variables such as training and caseload appears to be more congruent (Adams & Riggs, 2008; Craig & Sprang, 2010; Harrison & Westwood, 2009; Sprang et al., 2007). The type of work done with clients in sessions can also impact therapist symptoms of compassion fatigue and burnout (Craig & Sprang, 2010; Linley & Joseph, 2011).

Intervention choice. Counselors use a variety of therapeutic interventions when working with clients who have experienced trauma. Interestingly, Craig and Sprang (2010) found that counselors who used evidenced-based practices for treating trauma had lower levels of compassion fatigue and better client outcomes than those that did not. Examples of evidence-

based practices included exposure therapy, cognitive-behavioral therapy (CBT), and eye movement desensitization (Craig & Sprang, 2010). A reason for this difference may be that after training in a specialized intervention method, counselors felt prepared to deal with severe trauma (Craig & Sprang, 2010). However, Linley and Joseph (2007) found that therapists who utilized CBT were more likely to report burnout. A reason could be that CBT is known to work with victims of trauma so those therapists may have taken on heavier caseloads of clients with PTSD (Linley & Joseph, 2007). Therefore, the type of intervention that counselors choose may impact compassion fatigue but there are many factors involved in this conclusion. It is important to note that not all therapists working with trauma suffer from burnout and compassion fatigue; on the other hand, some therapists experience positive consequences from their work with clients who have faced trauma.

Compassion Satisfaction

The majority of research on the outcomes of counseling work focuses on the negative sacrifices that therapists make for their jobs (Linley & Joseph, 2007). However, if counselors are resilient and remain positively connected to their work there is potential for growth, also known as compassion satisfaction (Ruysschaert, 2009). Hunter (2012) found that several therapists in a qualitative study obtained great enjoyment from working with trauma. Seven out of eight counselors reported loving their jobs (Hunter 2012). For those counselors, the gratification from their work overshadowed the negative risks.

Benefits of Compassion Satisfaction

In their research of family violence therapists, Ben-Porat and Itzhaky (2009) found that trauma work improved the counselors' lives, intensified their gratitude for life, and helped them strengthen their personal relationships. In the previous section, the adverse changes in the

worldviews of family violence therapists were discussed. However, there were also unique areas of growth experienced by family violence therapists when compared to those who did not consistently work with trauma (Ben-Porat & Itzhaky, 2009). For the family violence therapists, there were more positive changes in the confidence of anger management and communication skills. The therapists also reported having more awareness and communication in intimate relationships and more awareness of their children's needs (Ben-Porat & Itzhaky, 2009). Therefore, trauma work can have harmful effects such as burnout and vicarious trauma but working with clients and experiencing their healing from trauma can produce positive consequences such as compassion satisfaction.

Another qualitative study found major themes among six therapists by asking how they maintained happiness and well-being while working with traumatized clients (Harrison & Westwood, 2009). The nine major themes included avoiding isolation, developing awareness of self, continuously expanding perceptions, focusing on optimism, self-care, boundaries, empathy, satisfaction at work, and generating meaning. Several variables may influence the probability that a therapist will experience compassion satisfaction, which I will discuss below.

Variables that Influence Compassion Satisfaction

Similar to compassion fatigue individual variables might affect the presence of compassion satisfaction. These variables include personal therapy, supervision, and professional identity (Carmel & Friedlander, 2009; Harrison & Westwood, 2009; Linley & Joseph, 2007).

Individual therapy and supervision. Linley and Joseph (2007) determined that therapists who attend personal therapy remain resilient in their work. The counselors who received therapy reported more positive psychological changes and less burnout than counselors who did not. Also, increased compassion satisfaction has been reported by counselors who

utilize clinical supervision (Linley & Joseph, 2007). Some counselors said supervision helped them with feelings of embarrassment about compassion fatigue symptoms (Harrison & Westwood, 2009). Also, peer supervision groups allowed for an increased sense of community (Harrison & Westwood, 2009). As a result, it appears that consulting with other professionals and seeking help were beneficial for therapists by reducing isolation and decreasing feelings of shame related to vicarious trauma (Harrison & Westwood, 2009). Supervision was also reported to improve self-awareness and enforce the importance of self-care (Harrison & Westwood, 2009). On an individual level therapists' professional identity also impacts the development of compassion satisfaction.

Professional identity. Counselors make many choices when developing their professional identities. In doing so, they are typically aligning with a counseling theory, developing a counseling relationship with clients, and establishing professional roles (Harrison & Westwood, 2009; Linley & Joseph 2007). Linley and Joseph (2007) found that counselors oriented with humanistic and transpersonal theories were more likely to report compassion satisfaction from their work. Also, the researchers found that a therapeutic bond is related to compassion satisfaction (Linley & Joseph, 2007). Therefore, how a counselor decides to work with a client can make a difference in counselor well-being. On the other hand, what a therapist does outside of sessions, in other roles, can influence compassion satisfaction as well.

Harrison and Westwood (2009) discovered that the more diverse a counselor's work functions were, the better he or she was able to manage the negative consequences of working with trauma. For example, all of the therapists in the sample reported involvement in numerous roles such as teaching, supervising, and administration along with their counselor roles. Diversifying professional roles may be beneficial because it allows the counselors to come in

contact with a larger group of people, which may increase feelings of connection (Harrison & Westwood, 2009). Also, being successful at work, being skilled, and being confident in one's work are important contributors to compassion satisfaction (Harrison & Westwood, 2009; Carmel, & Friedlander, 2009). To maintain these positive effects and prevent harmful effects of working with clients who have suffered trauma, therapists must take care of themselves.

Self-Care

Self-care is a strategy that has been found to reduce vicarious trauma and burnout while promoting compassion satisfaction (Radey & Figley, 2007; Ruyschaert, 2009; Warren et al., 2012). Self-care can include behaviors such as exercise, spending time with others, hobbies, vacations, sleeping, nutritional diet, etc. (Harrison & Westwood, 2009; Warren et al., 2012). Self-care involves attending to physical, mental, emotional, spiritual, and aesthetic domains that are needed to maintain well-being, provide comfort, and increase satisfaction in one's life (Harrison & Westwood, 2009). In a study of 298 eating disorder treatment providers, almost all of the participants found that they worried about their client's health, which turned into anxiety and fear (Warren et al., 2010). Ninety percent of the professionals reported that self-care is the most effective way to reduce burnout. Self-care in this study included exercise, social support, hobbies, time off from work, relaxing, vacation, sleeping, supervision, creating work/life balance, personal therapy, continuing education, spiritual/religious activities, healthy eating habits, humor, and limiting caseloads (Warren et al., 2010). The professionals identified supervision as being the most important part of self-care. Over 25% of the participants found work/life balance (social support, non-work activities, and taking time off) to be the most important aspect of taking care of oneself (Warren et al., 2010). Harrison & Westwood (2009) found holistic self-care to be a major theme in their qualitative research. Examples of self-care

were similar to the previous study but also added cuddling, work training, mindfulness, expressing emotions, releasing anger, meditation, nature, and creating meaning. Self-care helps therapists who work with trauma reduce the effects of compassion fatigue and burnout and maintain satisfaction in their jobs. After researching these experiences, I concluded that there are limitations in the literature that are worth discussing.

Limitations in the Literature

A considerable amount of research exists on the consequences of working with trauma, but even so there are still gaps in the literature. Many of the findings on compassion fatigue are conflicting. Years of experience and type of intervention used by counselors are variables that were found to increase compassion fatigue in at least one study. In other studies, it was concluded that the same variables either led to a decrease or had no effect on compassion fatigue (Adams & Riggs, 2008; Craig & Sprang, 2010; Linley & Joseph, 2007). Also, most of the literature suggests negative consequences on therapists but fails to recognize that growth from the work is possible.

Much of the research on counselor experiences with trauma has been conducted by using surveys and a quantitative approach (Adam & Riggs, 2008; Bride, 2007; Carmel & Friedlander, 2009; Deighton et al., 2007; Linley & Joseph, 2007; Sprang et al., 2007). A quantitative approach can be useful in determining variables that potentially influence secondary trauma, burnout, and compassion satisfaction. However, there is a lack of qualitative research on therapists' lived experience regarding consequences of working with trauma. The current study aims to investigate the perspectives of therapists who work with clients who have experienced trauma, and the implications of this work on their professional development.

Method

The present qualitative study investigated therapists' perspectives on the consequences of working with clients who have suffered trauma, both for therapists' work and personal lives. I explored factors that may increase or decrease positive and negative consequences such as self-care techniques and trauma-based training. I also looked at experiences of burnout and secondary trauma. In qualitative research such as this study, data comes from the participant's personal narratives providing an opportunity to learn about participants' actual experiences. A qualitative research design was used for this study to focus on the lived experiences of counselors in face-to-face interviews and with open-ended self-reflection questionnaires. The goal to obtain full awareness of how therapists are professionally and personally affected by the work that they do aligns with the decision to use a qualitative approach.

Participants

A purposeful sampling procedure was used to recruit therapists who are currently working in an adult outpatient mental health clinic. Purposeful sampling procedures use categories of people who most fit the purpose of the research and who are most available to researchers (Coyne, 1997). The participants in this study work at my internship location and are therapists who work mostly with trauma populations. I initially expected to have 15 participants, five interviews and ten questionnaires. I chose this number after consulting with a clinical supervisor on a sufficient sample size for qualitative research and after considering the number of therapists employed at the clinic. There were eleven participants in the present study, nine females and two males. Participants reported the average number of hours they work each week as 40, 40, 40, 40, 43, 43, 45, 45, 52, 53, and 55. The average number of hours worked by the therapists in the study per week was 46. The years participants have worked in the field were 1, 1, 1, 2, 2, 4, 5, 15, 16, and 34 with an average of 7.5 years. Participants reported the number of

clients on their caseloads as 65, 90, 95, 102, 110, 110, 110, 120, 120, 120, and 120. The average caseload consisted of 104 clients. Some of the reported numbers were rounded to the nearest whole. All participants have at least a master's degree. Three of the participants received their degree in social work, six in mental health counseling, one in marriage and family therapy, and one in human health and development. The clientele at the clinic includes a diverse population with a large range of mental health diagnoses from moderate to high levels of severity.

Research Setting

The research took place in a large adult outpatient mental health clinic in Rochester, NY. The agency is a clinic setting in which participants are required to maintain productivity requirements, meaning they typically have a caseload of around 100-120 clients at one time. The agency provides diagnosis and 90-day treatment planning of all clients seen. The counselors provide individual, group, and family therapy. The research site also has psychiatrists who are available to prescribe medications. The agency works with a diverse population of clients with varying cultural backgrounds, genders, ages, socioeconomic statuses, and mental health diagnoses. The site has a large number of clients who have faced trauma and offers trauma specific group therapy. All participants in the study described their work to include a large portion of clients who have suffered trauma. I collected all data at the research site.

Materials

I interviewed three participants in person, and eight answered the same interview questions with a questionnaire. The interview and questionnaire consisted of eleven questions with ten sub-questions; a total of 21 questions (Appendix). I created the questions after I reviewed the literature and consulted with a clinical supervisor to determine the purpose of the research. During the interviews, additional follow-up questions were asked as they came up.

With the informed consent document, I informed participants of data management details before collecting any information. I discussed the information in the consent form with participants and answered any questions they had. Interviews were audio recorded using a Samsung Galaxy tablet. The recordings were listened to directly from the device and not transferred to digital software. The interviews were transcribed using a Dell laptop. Both devices are used only by me and are password protected. I stored the questionnaires and informed consent forms in a locked safe that only I have access to the key. I stored the safe in my home. I permanently deleted interviews and shredded paper documents after the close of the study.

Research Design

The literature review revealed that several past studies have used quantitative approaches measuring the consequences therapists face in their work (Adam & Riggs, 2008; Bride, 2007; Carmel & Friedlander, 2009; Deighton et al., 2007; Linley & Joseph, 2007; Sprang et al., 2007). Qualitative research was used in this study to achieve the goal of hearing the lived experiences from participants. This study explored participants narrative of any negative and positive consequences they have faced in their work, what it is like for them to work with a client who has faced trauma, their thoughts on self-care, and any experiences of burnout or secondary trauma they may have suffered. The questionnaires were constructed to be open-ended to allow space for the participants to explain themselves. The interviews provided a different, more in-depth opportunity to use active listening skills and ask follow-up questions.

Procedure

I submitted a proposal to IRB in April 2015 and received approval to begin research at the end of July 2015. Immediately after receiving IRB approval, I started to recruit participants and obtain informed consent. Between August 2015 and October 2015 participants handed back

their questionnaires or scheduled and completed interviews. The cut-off for data collection was 10/8/15 based on the time needed to code, categorize, and identify themes to present at a scholarly research conference.

I asked therapists to participate in the research via word of mouth. I went individually into their offices and explained the purpose of the study, asked if they wanted to be involved, and obtained informed consent. The therapists at this location see a lot of clients back to back. As a result, it was difficult to schedule a time to discuss the research initially. Therefore, I approached them individually when their doors were open. I offered them as much time as needed to think about it, but some participants signed consent during that same meeting. For the participants who had not yet signed consent or returned their questionnaires, I followed up a month before the cut-off date to determine if they were still interested.

The options of returning the questionnaires included placing them in my work mailbox, returning it by hand, or if preferred to type their answers and submit via email. The participants gave the questionnaires back at various times that fit in with their schedules. I was unable to document clearly the timeframe for data collection due to the various way in which participants responded over the 2.5-month time span.

Three counselors scheduled a time to complete a semi-structured interview. A semi-structured interview approach allowed me to ask follow-up questions and make reflections based on the interviewees' responses. On the day of the interview, I offered to answer any questions before we began and then I started the audio recorder. I recorded the entire interview. The interviews lasted an average of 42 minutes. Participants were asked to discuss negative and positive experiences and consequences related to working with clients who have endured trauma.

Data Analysis

I transcribed the audiotape recordings and the questionnaires into a Microsoft Word document, which was saved to my laptop and password protected. I consulted with Professor Outland at The College at Brockport in the coding process I used for condensing narratives into categories and themes. I evaluated participants' responses to find central themes, which means identifying patterns to make meaning of the data. To identify themes, I began by coding the data initially and then recoding. Codes are words or phrases that I assigned to responses while using a line by line approach. Using coding, I distinguished the core messages portrayed in the statements. I used color highlighting to create the codes and highlight the patterns. I then placed the codes into labeled categories that consisted of similarities found in the codes. The categories enlightened themes that were apparent in the responses. Ten major themes are listed in the following section.

Results

The research findings describe how participants are affected by their work as therapists primarily working with clients who have suffered trauma. I separated the results into ten major themes: agency work, exhaustion, incompetence, challenges of trauma work, feeling what the client feels, lack of preparation and support, burnout, secondary trauma, compassion satisfaction, and self-care. Below I describe the ten prominent themes that emerged from participants' narratives of how their work with traumatized clients both depletes and sustains them.

How the Work Depletes Therapists

Agency work. Interestingly, although the research aimed to understand the consequences therapists face when working with trauma, a theme emerged related to general therapy work in an agency/clinic setting. When I asked participants about the negative effects they have faced working as a counselor ten out of eleven participants reported being overworked. Three reported

the stress comes from being required to work extra hours. Five reported exhaustion from seeing back to back clients. Nine reported having excessive amounts of paperwork to complete. When asked, tell me about any negative experiences or consequences related to working as a therapist, participants made the following statements: “Excessive paperwork.” “Too many late hours.” “The environment we are in.” “All the notes I have to do.” “The amount of people we have to see here.” “Going home and feeling burnt out from a long day, with no time to do anything else.” “With back-to-back clients I catch myself thinking of something outside of here.” These statements do not reflect the consequences of working with trauma but instead reflect the challenges participants face with administrative tasks.

Exhaustion. Exhaustion is another theme that came up several times throughout the study. Unfortunately, due to feeling overworked two participants reported thoughts of quitting and three said the demands of the job such as listening to trauma filled stories led to feeling stressed and drained. “My stress level has gone up just in life; I feel my body being stressed.” “When I get home, I’m tired.” “May lead to resigning if burnt-out.”

I have less patience at home because of the day. Sometimes I’m tired with the amount of people I have to see and work, I have less patience for interpersonal things, like if someone really needs a lot of my energy, I don’t feel like I have the energy to give because I give so much all day.

Incompetence. Another theme brought forth responses that were connected to feelings that deplete therapists’ sense of self-efficacy. Four out of eleven participants reported an adverse consequence that was feeling less competent and unprepared for the work. “I wanted to quit at times because I felt I wasn’t making a difference and clients did not want help.” “Clients get

under my skin; make me feel incompetent, ineffective, angry, or sad.” “I feel like a less competent therapist, I feel like I’m not fully present at times.”

Challenges of trauma work. The results thus far were mostly connected to general consequences participants have experienced in their work related to administrative duties and not specifically to trauma work. On the other hand, ten out of eleven of the participants described working specifically with clients who have faced trauma as challenging. Five out of eleven participants responded by saying it is difficult to sit with a client who was traumatized and in emotional pain. Some of the participants described the experience as demanding and difficult: “it is uncomfortable to listen to trauma stories, “draining and exhausting.” “It is tiring hearing and seeing and sometimes feeling their pain. There is not much you can do other than sit with them in it. It is draining.” “I am getting better at the urge to want to change the subject (I was conditioned to do this at internship but at my job I am learning to provide empathy while not avoiding those topics).” Another therapist described his/her experience as feeling helpless when working with victims of trauma. “I feel helpless talking to traumatized clients because I cannot imagine what it would be like to endure their experience.”

Feeling what the client feels. Four out of eleven participants described experiences of taking on client symptoms or feeling the pain with the client when they are disclosing significant traumatic experiences in a session. “I can take on patient’s symptoms when they are highly emotional and in distress.” “I feel what they are feeling: fear, loss, sadness, trauma, but also feel surprised or unexpected.”

My reaction is often affected by their reactions to the experience. I don’t think that I react as much to what people tell me about their situations, but I do to their emotional experiences. I think I am very comfortable with most emotions. I think it is most difficult

to be with people who feel like they are out of control or cannot handle their emotions.

It's difficult not to experience that feeling myself when I am with them.

Lack of preparation and support. The responses thus far illuminate symptoms of burnout such as a depleted sense of self-efficacy, feeling drained, thoughts of quitting, and feeling overworked. The major problem is that the majority of participants admitted that their educational program did not adequately prepare them to work with trauma, but all of the participants reported actively working with trauma clients regularly. Nine out of eleven of the participants said there was a lack of trauma-related training in their educational programs. While only two participants reported that their educational program prepared them well to work with trauma. "Not as much as when working because you get a caseload. It is overwhelming to go into a full case load and realize how much trauma there is." "I think my experience with that does not have anything to do with the program. I did not learn that there." "In class I had to read about trauma cases but did not directly discuss how to help someone after they disclose it, other than providing basic counseling skills of empathy, validation, and support." "The program did not directly discuss how to help someone after they disclose trauma."

Other participants spoke of their work with clients who have faced trauma as challenging because of a lack of support. "Personal time spent feeling angry/frustrated that I was not getting the help I needed/wanted." "If I have a hard day or heavy things in session, I have to not feel resentful that don't have anyone to process with, recognize that I am affected but not let it come into session."

In fact, six out of eleven participants reported a lack of support and two of those six specified that this was due to inadequate supervision. "I felt unsure of my skills and questioned my abilities as a counselor due to feeling unsupported."

Burnout. Participants reported several symptoms of burnout some of which have already been discussed above. Only one out of eleven participants stated they have not experienced burnout symptoms at some point. Three others reported experiencing the symptoms coming and going during more challenging times. “It comes and goes; there are periods where for a month things feel really hopeless.”

I will think why am I doing this, let me look for other jobs but then something will happen with a client or work, and I get reenergized and in a couple of months I feel overwhelmed, I think that is normal in this setting.

Two out of the eleven participants reported they felt burnout more when they interned and were still in school. “It was worst when I was at school because I was taking three classes, interning, and working.”

The symptoms of burnout that were most commonly described by the participants was depression, anxiety, anger, isolation, irritation, self-doubt in their abilities, procrastination, sleep problems, tiredness, not being present in sessions, lack of motivation, frustration, and not wanting to go to work. “I haven’t had it really extreme, but I have felt what am I doing as a therapist, am I really helping.” “I questioned if I still wanted to be a counselor.”

Five out of eleven participants related burnout experiences to job responsibilities and administrative duties. “The many roles and responsibilities become too much.” “I feel like I don’t or can’t make a difference, so it is all about numbers.”

The burnout is the paperwork, the documentation, the requirements coming from uncoordinated mandates at the way top that have never said what do the providers actually do, what are their needs, the people doing the work. They aren’t a part of the process, so the work actually gets done in a way that is most helpful to the

consumer, to the customer. My fear of burnout is only that that would lead to all of the symptoms. What we are required to do with no reason that is the big huge machine, the medical model. Trauma fatigue is less scary to me as a possibility of having to go through a machine.

Secondary trauma. Four out of eleven participants reported when asked about working with clients who disclose trauma that they can take on a client's symptoms at times. In another question about experiences with secondary trauma, seven out of eleven of the participants said they have never experienced it, including those who reported taking on the client's symptoms after listening to disclosures of trauma. "It has not happened to me; I don't see it happening because of the way I am experiencing that kind of work."

I found that the interview question about secondary trauma elicited confusion in that many of the participants were not familiar with the phenomenon and needed clarification. When unprompted four participants described secondary trauma without giving it a name but when asked specifically about any experiences of secondary trauma, the results of the same four people were different; they reported it is not something they have encountered.

Four other participants reported some instances of secondary trauma, including countertransference experiences. "There were a couple times I have taken it home, or someone reminded me of my dad that was really tough; I took it home for a while."

When a death of a client's mother was similar to a death in my own family; she was removed from the hospital room and not allowed to visit for a week up to the death, so she was not there for it. For a while when I thought to the person she had lost I started to feel hypervigilant or on edge when I thought of the client's death.

Two out of the four who spoke of secondary trauma reported anxiety related to the work.

My secondary trauma is manifested as anxiety. I feel anxiety in reaction to hearing our clients' difficulties with systems more than in reaction to trauma. For example, a lot of our clients are in the legal system. I often feel like they are helpless. It seems like a person can get caught up in the system easily. That leads me to feel uneasy at times.

Only one therapist reported a negative world view because of working with trauma.

It changes how I view the world about what can happen and safety and things. So many stories, you could never experience them in life. Makes you think about what can happen, what people are capable of, what the world can do, second guess things you wouldn't expect from people. You think people are good and start to question that sometimes.

How the Work Sustains Therapists

Compassion satisfaction. Nine out of eleven participants reported the challenges of sitting with traumatized clients. Two out of eleven participants, on the other hand, reported feeling comfortable working with trauma and described the experience as rewarding.

Compassion satisfaction sustains a therapists' work when he or she can witness a client healing from trauma (Hunter, 2012). A participant who is new to the field puts this into words:

There is an exquisiteness of being with someone showing you this hurting part, sitting with someone who is in pain like that and able to be in the room and feel safe while you are holding that experience is extraordinary to me. It's one of those things, I can't explain what it is, literally it feels like a container, like its Tupperware. I feel like that, at this moment that is how I feel, again I am at the beginning, but that is the gift to this work. Someone has a place to come and be all the things that no one in their life ever let them

be. If a client worries about you, then it is over. I don't feel poisoned by someone who is revealing their trauma in front of me, with me. It is a matter of feeling comfortable being with and in someone else's pain without drowning in it.

Another participant described his/her experience of compassion satisfaction as follows:

Sometimes I feel grateful to be able to sit with them and hear their story and that they are there with me, that is the rewarding part. Even though they are in pain being able to witness and see it not everyone gets that chance.

Successful therapy work. All of the participants reported that providing successful therapy work, such as seeing growth and change within a client, has contributed to their feelings of compassion satisfaction. Participants in this study reported that when a client completes therapy or makes significant progress their work feels validated, meaningful, and important. From seeing clients change participants feel uplifted, appreciative, satisfied, and experience increased motivation, energy, and confidence. "When people successfully complete therapy or do better, I feel proud of them, and I feel good as a therapist. It is rewarding." "Seeing clients improve is motivating to make myself a better therapist." "Being able to discharge to successful completion of treatment goals, this is rewarding." "I appreciate when something clicks for someone that we have been working on and seeing that build up, a success story or pride in something." "A successful episode of care with a client and successful discharge (client completed all therapy goals and had marked improvement in functioning). It made me feel confident and motivated to work with other clients." "Seeing clients have breakthrough moments (reclaim a sense of themselves from trauma or recovery from substances)." "When I am overwhelmed and want to quit when I don't want to be a therapist anymore, I think of all the people that are successful and thanked me. It makes me think that is why I am doing this."

Factors that influence compassion satisfaction. Participants gave mixed responses when asked about the factors that affect compassion satisfaction. Four participants reported that clients largely influence the positive consequences in their work; whether the person is goal-oriented, wants to change, and is motivated to do better. “Getting a patient who is goal-oriented, which is just luck.” “The type of patient whether they are motivated to get better/do well in therapy.” “People have to want to change.”

On the other hand, four participants suggested it is the personal outlook of the therapist that leads to positive consequences in working with trauma. “Your outlook, recognize positive things and take pride in them.” “Knowing what to do without having to plan it, trusting myself, self-confidence that I know what I am doing.” “Being open to positives, not letting myself get bogged down, you can disqualify positive things because difficult or hard things are so much in this work.”

Self-care. When gathering data, several questions related to self-care were posed, as historically through past research it has been found that self-care reduces burnout and secondary trauma, and increases feelings of compassion satisfaction (Radey & Figley, 2007; Ruyschaert, 2009; Warren et al., 2012). In this study, seven out of eleven participants reported that the work is too exhausting, which prevents them from doing self-care activities that they would like to be doing outside of work. “It is mentally exhausting to spend the day listening and providing therapy to emotionally challenged patients. Going home to walk or exercise is usually too difficult to consider.”

I wish I was more active, I want to go home and sit all day after sitting at work all day. I wish I was walking the dog more, or going to the gym that I pay for a membership and do not use. Being active feels like work, another thing I have to do, like a chore.

Four out of eleven participants think they are doing well with self-care. These four participants highlighted the importance of self-care in their lives. “Self-care is very important in counseling.” “Self-care is essential, I cannot survive without it.” The four participants who find self-care to be vital spoke of the importance of having a balance between work and home life. They also reported a need for clear boundaries.

I do a good job at self-care. I set pretty good boundaries between myself and work. While I do work at home, I work pretty hard to protect most of my away from work time. I work hard to prevent having to stay late at work or go in early. I try not to go home and write notes after work, although this is unavoidable at times. Over the years, I have come to recognize my responsibilities versus the client’s responsibilities. I worry about clients at times but realize that I cannot control what they do so I worry much less.

The participants listed a large range of activities they found important for self-care. Those on the list that were most often repeated by several participants were spending time with friends and family, cooking, walking, exercise, reading, and enjoying nature. The participants also reported self-care activities they did at work. The most common response was taking breaks to leave the office to get fresh air or go in the break room to talk to co-workers.

Discussion

The participants in this study concentrated on the emotional aspects of trauma work but additionally reported the job stress related to working in a fast-paced agency setting. Some of the questions asked may have signaled reports of general work stress because they were not specifically geared toward work with trauma while others were trauma specific. On the other hand, the reports of job-related stress may suggest the overwhelming roles and responsibilities participants experience both therapeutically and among additional complex roles. Additionally,

this research delivered extensive data on participants' experiences of working with trauma and enhances the existing data of the three implications of working with trauma: secondary trauma, burnout, and compassion satisfaction (Hunter, 2012).

Secondary Trauma and Burnout

All participants in this study were trained to be empathetic and to sit with clients as they reveal deeply profound emotional journeys and trauma. Moreover, all of the participants self-identified as working with trauma. Only four out of eleven participants reported experiencing secondary trauma. However, participants described in detail how they are affected emotionally, personally, and professionally by spending large portions of their day listening to reports of trauma, abuse, crisis, and emotional pain.

The participants in this study shared experiences of countertransference in sessions, such as hearing stories of clients that are similar to something themselves or their family members have experienced. Countertransference experiences affected therapists' ability to be present in sessions and contribute to taking the worries of clients home with them. Participants also reported anxiety that comes from worrying about clients who are suicidal, violent, struggling with the legal system, and suffer the impacts of trauma. This finding is congruent with a previous study by Warren and her colleagues (2010) in which almost all of 298 participants reported worrying about their client's health outside of work, which turned into anxiety experienced by the therapists. The finding by Warren and her colleagues (2010) is supportive of the present study in that participants in both studies are affected by the work that they do even after they have left work and went home. Both studies participants worried about their clients when they were not at work.

Along with anxiety, participants reported taking the work home with them has an effect on their personal relationships. Several participants spoke of being irritable with their families, feeling unheard because they lack support, and not being present or having the energy in personal relationships. The effect on the participants' interpersonal relationships is conflicting with previous research in which therapists described positive changes in their interpersonal relationships after working with clients who have faced trauma such as having more awareness and communication in intimate relationships and more awareness of their children's needs (Ben-Porat & Itzhaky, 2009). Also, contradicting with previous research, only one of the participants in the current study reported a negative world view related to working with trauma; while past research has a significant finding that several therapists who worked with clients suffering trauma saw the world as dangerous and unfair. They reported a view that society is violent, immoral, and hateful (Ben-Porat & Itzhaky, 2009). Therefore, the results are contradicting. Participants in the present study reported the work affected their personal relationships negatively but not their worldview. The opposite was true of the study by Ben-Porat and Itzhaky (2009) in which working with clients that faced trauma stimulated therapists' relationships, but their worldviews were negatively affected.

Additionally, almost all of the participants in the present study reported a lack of trauma-specific training, which in past research was found to be correlated with secondary trauma symptoms and burnout (Adams & Riggs, 2008; Sprang et al., 2007). Since the majority of participants described feeling unprepared to work with trauma, a lack of trauma specific training could be a factor that contributed to an increase in burnout related symptoms. More research would be needed to verify this interpretation, but past research has found a correlation that is less training led to higher rates of burnout (Adams & Riggs, 2008; Sprang et al., 2007).

Compassion Satisfaction

Compassion satisfaction has been studied previously to focus on the resiliency that therapists experience from moments of meaning, joy, and satisfaction after witnessing clients growing and overcoming trauma (Radey & Figley, 2007). Participants in the present study reported the most significant and positive experiences resulted from seeing clients improve, watching something click in session, and discharging a client from therapy with all of their goals met. While burnout and compassion fatigue led participants to feel run down, unmotivated and wanting to give up; compassion satisfaction brought on feelings of rejuvenation and energy. Participants described their work as something they are grateful to do. The findings on compassion satisfaction align with past research in which Ben-Porat and Itzhaky (2009) found that trauma work improved the counselor's lives and intensified their gratitude for life. Therefore, therapy work, although stressful and hard, brings feelings of joy from making a difference.

Self-care in past research was found to be a major contributor to resiliency in one's work. Self-care included leisure activities along with supervision and personal counseling (Warren et al., 2010). The responses of participants in the present study related to self-care were varied. While all participants wanted to be doing more self-care, 7 out of 11 participants found that they were too exhausted to do anything active after work. Other participants stressed the essentialness of self-care in their lives. Contradictory to past research, most of the participants in this study did not include individual therapy and supervision as important parts of self-care (Linley & Joseph, 2007). The implications of this finding will be discussed in the following section.

Implications for Therapists

With such descriptive narratives on the stress these eleven participants have suffered, it is imperative to emphasize the importance of organizational support. Agencies, educators, and supervisors should warn therapists of the potential for emotional exhaustion and personal suffering while also not forgetting to remind therapists of the positive impact this work can have on their lives. Employer support for therapists is crucial. Support for therapists could include providing personal therapy and supportive supervision. Supervisors must recognize the role they have in reducing burnout and vicarious trauma by offering support to therapists, allowing them to process the events they witness in sessions. Supervision must allow for discussions of therapists' personal issues, countertransference, issues with being present, feelings of incompetence, feeling unprepared, lack of support, and positive experiences. Potential methods that employers can provide to therapists includes relaxation techniques, coping skills, support groups, physical health/wellness programs, time off, mental health days, group bonding, retreats, etc. For example, Maltzman (2011) implemented a self-care model at a large social service organization. One part of the model included educating workers about secondary trauma and self-care during new employee orientation. Another significant aspect of the program highlighted the importance of letting go of work before going home (Maltzman, 2011). The organization allowed the workers a transitional period of uninterrupted private time to become focused on the here-and-now (Maltzman, 2011). The workers were taught other tips to let go such as writing a to-do list if they found themselves worrying about work at home, calling their work voicemail to leave the to-do list there, and cognitive techniques like thought-stopping (Maltzman, 2011). A second part of the plan included managing secondary trauma symptoms by becoming aware of triggers and utilizing stress management techniques such as meditation, yoga, exercise, and spiritual or religious support (Maltzman, 2011). Another major part was educating workers and

supervisors on the importance of supervision. Success was measured by the workers reports that the model was helpful (Maltzman, 2011). Another example is providing a mindfulness program at work for therapists. Mindfulness is an evidence-based practice that can be a form of self-care because studies have shown that there are mental benefits such as increased concentration and calmness as well as physical benefits like improved breathing rate and heart rhythm coherence (Chrisman et al., 2009; Harrison & Westwood, 2009; McGarrigle & Walsh, 2011; Wolever et al., 2012). Introducing similar support programs for therapists may help prevent and reduce negative consequences found in the present study and increase the positives.

Training is another area of concern for therapists who are working with trauma. Past research has found that a significant number of therapists were not trained specifically to work with clients who have faced trauma; moreover, there was a significant correlation between therapists' lack of training and experienced burnout symptoms (Adams & Riggs, 2008). In the present study, only two out of eleven participants reported that they were adequately trained in their graduate programs to work with clients who have experienced trauma. A graduate level course could be provided to address specifically counseling clients who are in crisis or have suffered trauma in the past. The hope is that counselors would gain knowledge/skills in treating PTSD, evidenced based practices for trauma, and the prevalence and prevention of vicarious traumatization of counselors. Students would hopefully obtain experience through role-plays and experiential learning techniques in which they can watch others work with clients who disclose trauma and practice the skills they have learned in the course. It is essential that new counselors are trained to work with trauma before they enter their internships.

Limitations and Future Research

The results of this study were helpful in understanding the lived experiences of participants; however limitations exist that are important to reflect upon to develop resolutions for future research. The first limitation is within the questionnaires, which included a definition and list of symptoms for burnout but did not have the same description for the question about secondary trauma. Through the three interviews, I discovered that participants were confused by the term secondary trauma until I explained further. Participants who chose to do questionnaires did not receive an added explanation. Results showed that participants were describing secondary trauma symptoms such as taking on a client's symptoms and anxiety related to the work but were answering no to the question about any experiences of secondary trauma. These conflicting responses led me to believe that there may have been confusion for this question. Future research on this topic should provide clarification for terms during data collection to avoid any confusion. In doing so, the results will be more accurate if participants are clear about the question. Researchers should especially be mindful of this limitation if using self-reflection questionnaires for qualitative research. Interviews allow participants to ask for clarification. However, in the self-reflection questionnaires I made an assumption that people would know the term, which limited the answers I received. Most participants responded to the question about secondary trauma with short one word answers, stating "no." All other questions elicited more detailed responses. Researchers might wish to define or explain all keywords in the study to participants to avoid such assumptions.

A second limitation is connected to the finding that many of the symptoms of burnout had a connection to agency/clinic work in general. The limitation lies again within the wording of the questionnaires. Some questions asked about the participants' experiences working as counselors without any trauma specification while other questions asked specifically about

working with clients who suffered trauma (Appendix). A clinic setting is a fast-paced and high-stress environment. Participants reported burnout symptoms resulting from excessive paperwork, back-to-back clients, and long hours that did not directly reflect working with clients who have suffered trauma. Finding that burnout is connected to administrative tasks brings forth a suggestion for future research that can aim to decipher how much of the negative consequences relate to trauma or administrative tasks.

Lastly, more than half of the participants were within their first two years of work in the counseling field with less experience. It might be that they have worked with fewer clients who have suffered trauma at this stage in their careers than more experienced therapists. Also, four out of eleven participants were still within their first year in the field and, therefore, were still building their first case load. Future research can receive narratives from therapists with various years of experience and might even aim to compare experiences of therapists who have been in the field longer with newer therapists. Finding differences and similarities between years of experience in the field can lead to increased understanding of burnout and secondary trauma. For instance, some participants in this study said they experienced burnout more while still in school. Implications of such findings of when therapists are more likely to experience burnout or secondary trauma could assist employers and supervisors in implementing supportive programs.

Conclusion

Therapists face both positive and negative consequences for the hard work they do. As someone who spends their days listening to back-to-back stories that involve detailed descriptions of trauma, it is important to gain awareness into the therapist's perspectives of their experiences. Past research has shown that therapists have historically reported instances of secondary trauma, meaning they may begin to have PTSD or trauma related symptoms

themselves just from hearing about the experiences of clients (Bride, 2007). Past research has also looked extensively into the consequences of therapist burnout from job-related stress (Stalker & Harvey, 2002). On the other hand, the work of a therapist is viewed as meaningful and can, therefore, produce positive results after watching a victim heal from trauma (Linley & Joseph, 2007). The current research aimed to gain awareness of what therapists face who are working primarily with trauma in a fast-paced clinical setting. Participants gave detailed descriptions of secondary trauma such as taking on a client's symptoms and taking the work home with them. They also reported several symptoms of burnout that vastly relate to working in a clinic, seemingly more so than working with clients who have faced trauma. Also, all participants in this study found the most satisfying part of their work to include seeing clients improve. It is imperative that counseling professionals, supervisors, and educators remain mindful of the implications of working with clients who have faced trauma and develop a plan of action to support therapists.

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Appendix

Interview and Questionnaire Questions

- 1) How long have you been working in the counseling field?
- 2) What field of study did you earn your educational degree?
- 3) What is the size of your caseload?
- 4) How many hours do you work each week?
- 5) Tell me about any positive experiences or consequences you have had related to working as a counselor.
 - a. How did those experiences affect your work?
 - b. How did those experiences affect your personal life?
 - c. What factors do you think influence positive consequences?
- 6) Tell me about any negative experiences or consequences you have had related to working as a therapist.
 - a. How did those experiences affect your work?
 - b. How did those experiences affect your personal life?
 - c. What factors do you think influence negative consequences?
- 7) Describe what it is like to talk to a client who is traumatized and in emotional pain.
- 8) How well do you think your educational program prepared you to work with clients who disclose trauma in session?
- 9) What are your thoughts on your personal self-care?
 - a. Are there self-care routines or methods you wish you were doing more of?
 - b. What do you currently do for self-care?
 - c. How many hours a week do you think you spend doing self-care?

- d. What do you do at work to manage the stress or take care of yourself?
- 10) Symptoms of burnout can include feeling disengaged, helpless, hopeless, loss of motivation, detachment, depression, fatigue, headaches, back pain, muscle aches, change in sleep or eating patterns, sense of failure, self-doubt, negative outlook, withdrawal from responsibilities, isolation, procrastination, frustration, and absenteeism. Tell me about any experiences of burnout you may have encountered.
- 11) Tell me about any experiences of secondary trauma you may have experienced.