Positive and Negative Impacts of Empathetic Engagement on Mental Health Workers

by

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Paper submitted in partial fulfillment of the requirements for the degree of

Master of Arts in Counseling Psychology
in the
Division of Arts and Sciences

City University of Seattle
2015

This thesis is accepted as conforming to the required standard

September 1, 2015

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This research paper is dedicated to my soul…

Welcome Home.
Abstract

This paper reviews empathetic engagement and its effect on mental health workers, in particular trauma therapists. This review is based on nine published scholarly research articles (six qualitative and three quantitative studies) and the broader literature. The nine articles utilized focus on the positive and negative effects of the empathetic engagement on trauma workers. These nine articles were analysed based on their methodological approach and how this approach differs in the information provided. The analysis focuses primarily on qualitative studies as this type of methodology provided a more in-depth look at the effects on trauma therapists. The analysis in this paper includes the strengths and weaknesses of each approach and provides ethical implications on the research conducted. This paper provides applications to practices, which includes topics on training, supervision, and self-care.
Acknowledgments

There are a number of people I would like to acknowledge for not only supporting me to finish this research paper, but for their support throughout my Master of Counselling journey.

I first want to thank my family for all their support, encouragement, and faith, especially my mom who spent countless hours being my thesaurus, word finder, and sounding board, who listened to me cry and complain when I struggled, and who continued to believe in me when I found it difficult to believe in myself.

I want to thank Dr. Colin Sanders for his time, supervision, and patience that allowed me to complete my research paper.

I also want to thank my co-workers Marita Fetalcorin, Darleen Fleetwood, Lana Burk, and Michell Chaffey for all their care and concern throughout my Master of Counselling journey.

I want to thank my friends and fellow students Dean Buhr and Hollie Campbell for their support, encouragement, care, patience, and beer and therapy that allowed me to finish this research paper. “Just keep swimming.”

I want to thank my partner Tim Kliparchuk for believing in me and standing beside me as I struggled to write my final paper.

Lastly, I want to thank Dr. Barbara van Ingen for all her unwavering support, encouragement, care, warmth, patience, and faith. I have so much gratitude, admiration, and respect for all that you do and I feel extremely blessed to have your support in my life.
Table of Contents

Introduction...........................................................................................................................................6
  Empathy in the Therapeutic Context .................................................................................................6
  Overview of Vicarious Trauma ...........................................................................................................7
  Overview of Vicarious Resilience .......................................................................................................8
  Research Question and Hypothesis .....................................................................................................9
  About the Author .................................................................................................................................9
  Intended Audience .............................................................................................................................10

Literature Review ..................................................................................................................................10
  Research Findings ...............................................................................................................................12
    Empathy ........................................................................................................................................12
    Therapist Perspective Change ..........................................................................................................14
    Therapist Self-Care ...........................................................................................................................17

Methodological Analysis of Current Research ......................................................................................18
  Roles of Qualitative and Quantitative Research ...............................................................................18
  Participants, Sampling, and Recruitment ............................................................................................19
  Data Collection ..................................................................................................................................24
  Data Analysis Procedures ....................................................................................................................26

Ethical Implications ..............................................................................................................................28
  Debriefing and Support .......................................................................................................................28
  Informed Consent and Privacy ............................................................................................................29
  Conflict of Interest ..............................................................................................................................30

Application to Practice ..........................................................................................................................31

Recommendations .................................................................................................................................35
  Training ............................................................................................................................................36
  Supervision .......................................................................................................................................37
  Self-Care ..........................................................................................................................................38

Conclusion .............................................................................................................................................40

References ...............................................................................................................................................42

List of Tables

Table 1. Reference List of Articles Reviewed and Key Points.................................................................11
Positive and Negative Impacts of Empathetic Engagement on Mental Health Workers

Introduction

Figley (2002) conducted research in the United States measuring compassion fatigue risk in mental health workers. The study indicated that 75% of mental health workers have a moderate to high risk of developing compassion fatigue. Many therapists may not have sufficient awareness of the effects of empathetic engagement. If the influence of empathy is harnessed, therapists can be pushed towards great personal growth; however, if this influence is left unattended, then the therapist can be overwhelmed by the negative experiences of their clients. Current research is conflicting regarding these benefits and dangers of empathetic engagement.

Empathy in the Therapeutic Context

Empathetic engagement is at the heart of effective therapy. Carl Rogers’ (1957) describes empathy as the ability to sense the client’s world view as if it were the therapist’s own (p. 98). He argued that the empathetic bond was one of several necessary and sufficient conditions to initiate constructive personality change within clients. Through this engagement, clients are able to bond with their therapist, feel safe, understood and cared about, and share their most intimate and personal thoughts, emotions, and actions to events that have happened in their lives (Harrison & Westwood, 2009). By being empathetic, therapists have the privilege of witnessing deep changes within their clients as they overcome major obstacles in life and discover their own strengths, hopes, and healing. While the therapeutic bond can be a very enriching experience for therapists, being empathetic can also be very challenging and dangerous as working with traumatized clients can be very demanding and emotionally draining.
Competing Concepts of Empathy’s Effect on Therapists

These opposite extremes of the effects of empathetic engagement have spawned two separate theories: one theory postulates that empathetic engagement is a major contributor to therapists developing trauma symptoms; the other posits that empathetic engagement aids in strengthening resilience processes. Both theories discuss consequences of empathetic engagement; however, they differ on whether empathy is beneficial or harmful to therapists. This paper explores this conflicting research regarding the benefits and dangers of empathetic engagement.

An Overview of Vicarious Trauma

An important issue to keep in forefront is that therapists are people too. The positive and negative effects of empathy will impact the humanity of the individual therapist and affect their emotional regulation, cognitive schemas, and world view. To better understand empathetic engagement and its effects, researchers first investigated the negative costs of caring through the concept of vicarious trauma. McCann and Pearlman (1990) first introduced vicarious trauma (VT) to explain the psychological consequences experienced by therapists working with traumatized clients. They described VT as profound psychological effects that can be painful and troublesome for the therapist and can persist for months, or even years, after working with traumatized clients (McCann & Pearlman, 1990, p. 133). These symptoms can parallel their clients’ trauma symptoms, including nightmares and hyper-awareness (McCann & Pearlman, 1990). These psychological effects often lead to negative long-term changes within the therapist and often target their cognitive schemas (McCann & Pearlman, 1990). Pearlman and Saakvitne (1995) stated that this negative transformation in the therapist occurred as a direct result of their empathetic engagement with the client’s trauma story (p. 31).
Within the concept of VT, there are several related terms that fall under this umbrella; burnout (Maslach & Jackson, 1982), compassion fatigue (Figley, 1999), contact victimization (Courtois, 1988), secondary post-traumatic stress reaction (Dutton & Rubenstein, 1995) and secondary traumatic stress (Stamm, 1999), which have all been developed to describe the impact that working with traumatized clients have had on mental health professionals (Devilly, Wright, & Varker, 2009). It is suggested that VT, along with related terms, develops through the direct empathetic bond therapists have with their clients (Cohen & Collens, 2013; McCann & Pearlman, 1990). Current research is now challenging this position, stating that empathetic engagement can be a positive influence in therapists’ lives. This concept has been studied and labelled as vicarious resilience (VR).

An Overview Vicarious Resilience

VR is a relatively new idea within the concepts of empathy and VT today. VR was developed by Hernandez, Gangsei, and Engstrom (2007) as a contrasting concept to VT. VR is a specific process that occurs in trauma therapists, referring to the positive transformations in the therapist that is a direct result of the empathetic engagement between them and their client (Hernandez et al., 2007, p. 237). VR is an important topic in trauma therapy today because it gives rise to therapist growth, counteracts therapist fatigue, strengthens therapist motivation, and promotes therapist self-care (Hernandez, Engstrom, & Gangsei, 2010, p. 67-68). As with VT, there is another related term to VR and it is vicarious post-traumatic growth (VPTG). All these factors contribute to how therapists manage to sustain themselves while working with traumatized clients through the empathetic bond.
Research Question and Hypothesis

Both VT and VR postulate that empathetic engagement has a significant effect on therapists; however, VT research highlights the negative impacts, while VR highlights the positive impacts. The question that develops from comparing this research is: why do some trauma therapists experience negative traumatic consequences while others experience positive growth through their empathetic engagement.

The author hypothesizes that both outcomes are possible, but are dependent on the degree of engagement in relation to the level of therapist’s resilience. The greater the resilience the therapist possess, the higher degree of empathetic engagement can be tolerated, which then leads to growth. However, if the engagement with the traumatic event exceeds the therapist’s resilience, then the effects of VT will result.

About the Author

The writer of this paper has worked exclusively with high risk-populations over the last ten years, including Aboriginal populations and homeless youth. During this time frame, the writer has focused on addiction and trauma and has experienced the positive and negative effects of the empathetic engagement. The writer has been moved by clients’ stories and has been afforded the chance to stand beside them in their moments of need. The writer has seen less experienced workers come and go as a result of some combination of fatigue, burnout, or trauma and have listened to more experienced workers speak about their personal growth and reflection as a result of their work. Both sets of experiences have been touching, yet perplexing and has piqued a curiosity in the writer as to how I can foster my own growth, rather than be overwhelmed by clients’ despair and have their despair become my despair.
Intended Audience

This paper is primarily intended for new trauma therapists to help raise their awareness of the potential pitfalls of working with traumatized clients. It may also be of interest to more seasoned mental health professionals to help them foster their own personal growth and support newer therapists around them in understanding this process.

Literature Review

A literature review was conducted using the key words trauma, trauma work, vicarious trauma, constructivist self-development theory, resilience, vicarious resilience, vicarious posttraumatic growth, well-being, empathy, empathetic bond, protective factors, prevention, qualitative research, and quantitative research. The writer used EBSCO Host through City University of Seattle’s databases and Concordia University College of Alberta’s databases to search for articles; specific databases, such as PsycINFO, PsycARTICLES, and Psychology and Behavioural Sciences Collections databases, were utilized to find specific articles. The writer also resourced Dr. Michael Kariwo to help find one specific article (Linley, Joseph, & Loumidis, 2005) using the University of Alberta’s databases. All articles were sorted by date of publication and those articles over ten years old were excluded. Articles were included if they contained information pertaining to empathy, vicarious resilience, vicarious posttraumatic growth, positive therapist well-being, and maintaining therapist resolution. The majority of the articles focused on therapists’ perspective, with the exception of Splevins et al. (2010) which focused on trauma interpreters’ perspective. Every article was comprised of a sample of mental health professionals (psychologists, psychiatrists, therapists, social workers, and trauma interpreters) and the research focused on their thoughts on trauma work and how it affected their lives and careers. The current research on empathy and vicarious resilience utilizes qualitative, quantitative, and mixed
methods research methodologies; however, it appears that the majority of the research done in this area utilizes a qualitative framework. The articles chosen for review in this paper were six qualitative articles (Arnold et al., 2005; Engstrom et al., 2008; Harrison & Westwood, 2009; Hernandez et al., 2007; Hunter, 2012; and Splevins et al., 2010) and three quantitative articles (Brockhouse et al., 2011; Linley & Joseph, 2007; and Linley et al., 2005). Table 1 lists the articles reviewed and their various key points.

Table 1

<table>
<thead>
<tr>
<th>Reference</th>
<th>Journal</th>
<th>Methodology</th>
<th>Setting</th>
<th>Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arnold et al. (2005)</td>
<td>Journal of Humanistic Psychology</td>
<td>Qualitative</td>
<td>North Carolina, United States</td>
<td>Licenced psychotherapists</td>
</tr>
<tr>
<td>Brockhouse et al. (2011)</td>
<td>Journal of Trauma and Stress</td>
<td>Qualitative</td>
<td>United Kingdom</td>
<td>Registered therapists</td>
</tr>
<tr>
<td>Engstrom et al. (2008)</td>
<td>Traumatology</td>
<td>Qualitative</td>
<td>United States</td>
<td>Mental health professionals</td>
</tr>
<tr>
<td>Harrison &amp; Westwood (2009)</td>
<td>Psychotherapy: Theory, Research, Practice, Training</td>
<td>Qualitative</td>
<td>British Columbia, Canada</td>
<td>Mental health therapists</td>
</tr>
<tr>
<td>Hernandez et al. (2007)</td>
<td>Family Process</td>
<td>Qualitative</td>
<td>Bogota, Columbia</td>
<td>Mental health professionals</td>
</tr>
<tr>
<td>Hunter (2012)</td>
<td>Family Process</td>
<td>Qualitative</td>
<td>Sydney, Australia</td>
<td>Therapists</td>
</tr>
<tr>
<td>Linley, Joseph, &amp; Loumidis (2005)</td>
<td>Psychotherapy and Psychosomatics</td>
<td>Quantitative</td>
<td>United Kingdom</td>
<td>Trauma therapists</td>
</tr>
<tr>
<td>Splevins et al. (2010)</td>
<td>Journal of Qualitative Health Reseach</td>
<td>Qualitative</td>
<td>England</td>
<td>Trauma interpreters</td>
</tr>
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</table>
Research Findings

In reviewing the above named articles, it is clear that we cannot discuss VR without talking about it in relation to VT. Within these two concepts, three major themes emerged from the literature reviewed: a) empathy; b) therapist perspective change; and c) therapist self-care. The theme of empathy developed first and initiated a cascading effect for the additional themes. Although the themes appear to be linked, they need to be conceptualized as separate entities.

Empathy

The first theme emerging from the literature is empathy. Eight of the nine articles (Arnold et al., 2005; Brockhouse et al., 2011; Engstrom et al., 2008; Harrison & Westwood, 2009; Hernandez et al., 2007; Hunter, 2012; Linley & Joseph, 2007; and Splevins et al., 2010) highlighted empathy as the most important concept and discussed its importance for therapist sustainability. Empathy is what forms the base of the connection between the therapist and the client, which creates the ability for the traumatic stories to impact the therapist. Within that idea, empathy can be viewed as positive or negative. VT postulates that empathy impacts therapist sustainability by acting as a risk factor, while VR argues that empathy is the building block for therapist growth. Hernandez et al. (2007) suggested that the positive transformations noted by therapists resulted from the empathetic engagement with their client’s trauma material (p. 237). Linley and Joseph (2007) reported that empathetic engagement was the best predictor for positive psychological changes and compassion satisfaction within trauma therapists; while Brockhouse et al. (2011) add that highly empathetic therapists tend to have greater flexible schemas and increased accommodation (p. 740). Arnold et al. (2005) indicated that empathy played an important role in therapist self-perception and related improvements to their interpersonal relationships (p. 257).
Even though the eight articles spoke positively about the presence of empathy, two of the articles (Hunter, 2012; and Splevins et al., 2010) noted challenges that are associated with empathetic engagement. Participants in Splevins et al.’s (2010) research acknowledged that empathetic engagement produced intense negative emotions in them, including rage, fear, anxiety, and deep sadness; however, without this empathy, these same participants would not have felt such strong positive emotions such as joy, happiness, inspiration, and hope with their clients (p. 1710). Hunter (2012) stated that in her research, while the therapeutic bond provided potential risks for the therapists, she found that the therapeutic bond appeared to result in therapist growth rather than vicarious traumatization. Hunter (2012) quoted one of her participant’s as saying:

It’s that profound privilege and honour of walking in the sacred spaces of people’s lives that I find very enriching, and often challenging. Being able to sit with people at depth and seeing the change at depth occurring in people’s lives, it’s just a wonderful thing… the kind of privilege of walking in people’s lives, hearing stuff they wouldn’t ordinarily share with other people, the creating of a safe place where people can discover their own truth. And just marvelling at just how people do that, the creativity of people, I find that incredibly awesome (p. 185).

Harrison and Westwood (2009) noted that trauma therapists who avoid or resist empathetic engagement with their clients may actually be damaging and counterproductive to the therapeutic alliance (p. 214).

Three of the articles (Harrison & Westwood, 2009; Hunter, 2012; and Splevins et al., 2010) highlighted the importance of maintaining appropriate boundaries as a deciding factor between the empathetic experience being positive or negative (traumatic). Harrison and Westwood (2009) discussed empathy as being an “exquisite” quality that can nourish growth within the therapist (p. 213), but advised that appropriate boundaries needed to be exercised, otherwise fusion or confusion would occur. Some strategies suggested by Harrison and
Westwood’s participants for maintaining clear boundaries included supervision, peer consultation, personal therapy, and self-care. Splevins et al. (2010) also noted the importance of role clarity and clear professional and personal boundaries, noting that failure to do so could result in client-therapist enmeshment (p. 1709-1710).

**Therapist Perspective Change**

A second theme that emerged from the literature was the idea of perspective change. Seven of the nine articles (Arnold et al., 2005; Engstrom et al., 2008; Harrison & Westwood, 2009; Hernandez et al., 2007; Hunter, 2012; Linley et al., 2005; and Splevins et al., 2010) addressed the concept of perspective change as a result of working with traumatized clients. VT suggests that some trauma therapists will be negatively affected by their clients’ trauma stories so much that they will change the way they view themselves, others, and the world; VT argues that this change is a direct result of the empathetic bond (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). Linley et al. (2005) pointed out that past research has focused solely on the negative effects of trauma work, thus ignoring any positive outcomes that therapists may experience. They reported that current research suggests that therapists are acknowledging positive changes as a direct result of working with trauma clients, including placing greater value on relationships, improved self-esteem, and a changed philosophy on life (p. 185). Splevins et al. (2010) also reported similar findings in their research, noting that participants described extra emphasis on relationships, less emphasis on material goods, and a greater sense of altruism (p. 1711). A participant in Engstrom et al.’s (2008) study noted that working with traumatized clients “gave [her] new eyes… It gave [her] a new way of looking at what we take for granted” (p. 17).
One common thread throughout several studies was the perspective change on spirituality and its place within the therapeutic relationship. Hernandez et al. (2007) quoted one participant as saying, “I always kept a distance from anything related to religious proselytism in my clinical practice but now I am curious about the role of other dimensions… sometimes we only focus on using psychological and social tools and this limits our work” (p. 234). Splevins et al. (2010) reported that participants noticed a shift in their spirituality in that they were more respectful, less judgemental, and valued people and their experiences more deeply. Harrison and Westwood (2009) reported that participants noted a deeper spiritual connection due to working with traumatized clients. Participants felt that their work was meaningful and part of something larger and that they were not alone in their efforts. Participants also reported that this deeper and renewed sense of spirituality allowed them to see growth in the wake of trauma and that people are resilient and can heal (p. 209).

A second common thread was the importance and value of learning from clients and appreciating the resiliency process. Linley and Joseph (2007) reported that the empathetic bond between therapist and client may foster positive changes in the therapist, by allowing the therapist to connect with the client, while witnessing the human spirit’s ability to heal. Participants from several studies (Arnold et al., 2005; Engstrom et al., 2008; Harrison & Westwood, 2009; Hernandez et al., 2007; Linley & Joseph, 2007; and Splevins et al., 2010) indicated how recognizing resilience in their clients allowed them to identify growth and development within themselves. One participant shared that seeing his own clients’ “triumphs over trauma” helped him to view positive changes within himself: “You know, if I can see their movement, I can also see my own” (Arnold et al., 2005, p. 250). Harrison and Westwood (2009)
reported their research participants as gaining a deeper sense of empowerment through witnessing resiliency in their clients. One participant is quoted as saying:

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

While the majority of the studies focused on the positive effects reported by therapists, Arnold et al. (2005), Hernandez et al. (2007), Hunter (2012,) and Splevins et al. (2010) spoke about the risks of working with traumatized clients. All of the participants acknowledged that they were affected by their clients in some way and recognized the need to make sense of changing emotions or schemas. One participant in Splevins et al.’s (2010) study stated that her trust in mankind has changed as a direct result of trauma work; however, she described this change as a positive one in her life because it made her feel less naïve and more aware of people around her. Arnold et al. (2005) noted similar findings, stating that their participants experienced changes in trust, cynicism, and hopelessness, but that it led to increases in hope and resiliency. Participants in Hunter’s (2012) study admitted to feeling less safe, less trusting, and lacking control over the world after working with traumatized clients, however these feelings allowed them to face uncomfortable truths that they might not have been able to face otherwise. Hernandez et al. (2007) clearly stated that VR is not about remembering every positive experience in therapy, but by reflecting on all the complex issues that are witnessed and experienced through the empathetic bond that empower and change therapists positively (p. 238).
Therapist Self-Care

The last theme that emerged from the literature was therapist self-care. Bamonti et al. (2014) report that self-care practices assist in the maintenance of strong professional functioning and decrease the risk of exhaustion and burnout in clinicians. They strongly argue that self-care needs to be recognized as an ethical obligation because of its important role in maintaining healthy functioning. Four out of the nine articles (Arnold et al., 2005; Harrison & Westwood, 2009; Hunter, 2012; Linley et al., 2005; and Splevins et al., 2010) draw attention to the importance of employing self-care when working with traumatized clients. The above articles drew attention to several coping strategies and techniques that therapists can use when feeling overwhelmed or distressed. These include: managing workload; extra education and training; supervision and peer support; supportive family and friends; healthy eating and exercise; and personal therapy. Personal therapy was the only strategy noted in all four studies, with Linley and Joseph (2007) stating that personal therapy was not only a protective factor against VT, but that it helped facilitate positive changes and personal growth in their participants. Arnold et al. (2005) reported that participants acknowledged positive changes in themselves after personal therapy, including gains in self-confidence, sensitivity, and compassion that positively affected their work.

The writer is surprised that only four studies highlighted the importance of self-care in their research. McCann and Pearlman (1990), who developed the concept of VT, stressed the importance of self-care as a means to transform VT symptoms into positive personal growth. In addition, Pearlman and MacIan (1995) strongly encouraged trauma therapists, both new and experienced, to practice self-care so that they can provide the best quality of care to their clients. Each of the nine articles cited in this paper quoted McCann and Pearlman’s research as a
foundation from which they based their own. The writer queries whether the other articles simply did not state this importance as it has been researched and written about extensively in these earlier studies.

**Methodological Analysis of Current Research**

This section will examine both qualitative and quantitative research designs and review the methodologies of the nine articles listed in Table 1. A synthesis on how research is currently being conducted specific to empathetic engagement and its role in VR will be accomplished by analyzing participants, sampling, and recruitment processes, data collection, and data analysis procedures. This analysis will include discussions surrounding strengths, weaknesses, opportunities, and threats that arose in conducting research pertaining to empathetic engagement and VR. This paper will also examine ethical implications, present future research questions, and give suggestions for future research practices.

**Roles of Qualitative and Quantitative Research**

The role of qualitative research serves to provide a narrow focus, which is rich in descriptive data that allows the reader to understand the participants’ personal experiences and comprehend the cost/benefit reality of working with traumatized clients. According to Creswell (2013), the role of the qualitative researcher has evolved over time, though some defining characteristics remain stable. These characteristics include conducting research in natural settings, using themselves as tools in the research, and reflexivity (p. 45-47). Hernandez et al. (2007) conducted their research in Bogota, Columbia to interview therapists who work directly with trauma victims of political violence and kidnapping. The purpose of conducting research in Columbia was based on multiple reports of mass killings and retaliations that were all politically charged, hence this population would help pave the way to organizing a new theory based on VR
The main researcher, Pilar Hernandez, is originally from Columbia, therefore she was able to use her native tongue to bridge language barriers between the participants; her fellow researchers were also bilingual which allowed them to complete interviews in a way that the participants could understand and would be easy to translate back into English (using yourself as a tool). The researchers clearly outlined their past work experience, including multi-cultural and cross-cultural psychology, which may help strengthen the relationship and encourage trust between the interviewer and their participants (reflexivity). Hunter (2012) also spoke about reflexivity in her study, stating that there was a personal file which detailed how the researcher’s assumptions had been affected by the data (p. 182).

In contrast, the role of quantitative research is to examine hypotheses pertaining to a particular phenomenon and test these hypotheses using statistical analysis. Essentially, the role of the quantitative researcher is to collect data using multiple measures and to analyze it using various descriptive statistics in order to prove or disprove the theory they are testing (Given, 2008). In comparison to the qualitative researcher, the quantitative researcher is less involved with the participants and more involved in the analyses of data. They seek to find numerical significance within the data, which then can be presented as unbiased results pertaining to the general population (Given, 2008).

Participants

Sample skew was seen across both qualitative and quantitative literature. The research conducted by Brockhouse et al. (2011), Engstrom et al. (2008), Hernandez et al. (2007), Hunter (2012), Linley and Joseph (2007), and Splevins et al. (2010) all reported a high percentage of female participants in comparison to male participants. This may be due to the fact that females represent a higher proportion of helpers in the helping profession; however, their results may not
be representative of the general population and studies may need to be replicated with a more male influenced study. In regards to qualitative research, sex linked skewing may not fully explore the male phenomenological perspective, therefore preventing a deeper analysis of the issue being researched. Furthermore, having a highly skewed sample in quantitative research in one trait or another, such as sex, socioeconomic status, and/or cultural background, poses threats to the findings as they may not be generalizable to the greater population.

Across the literature, it was noted that language accommodations were not prearranged for participants whose native tongue was not English. Language barriers may pose as a complication to research as understanding and translation may be lost in communication. This may pose as a threat to validity if the participants are unable to understand what the researcher is actually seeking. Arnold et al. (2005), Engstrom et al. (2008), Harrison and Westwood (2009), Hernandez et al. (2007), Hunter (2012) all sought to interview therapists working with traumatized clients, while Splevins et al. (2010) chose to work with interpreters who specialize in assisting traumatized clients. With the exception of Hernandez et al. (2007) and Splevins et al. (2010), the participants all spoke English and interviews were conducted in English; Hernandez et al. (2007) stated that they conducted interviews in both English and Spanish, and Splevins et al. (2010) indicated that for all but 2 participants, English was the participants’ second language. Language barriers may also be considered an ethical issue of Respect for Persons and Justice according to the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS) (2010) as this may affect fair treatment and participant autonomy (Canadian Institutes of Health Research et al., 2010, p. 8; 10).

Low response rates were observed across the quantitative literature. Haslam and McGarty (2010) state that low response rates can threaten the study’s internal and external validity,
therefore compromising the entire project (p. 111). Participant response rates varied immensely between the studies (Brockhouse et al., 2011; Linley & Joseph, 2007; Linley et al., 2005). Brockhouse et al. (2011) reported a 6.4% response rate, which was significantly lower than Linley and Joseph (2007) at 40% and Linley et al. (2005) at 56.3%. Other than cautioning generalizability, Brockhouse et al. (2011) did not provide any possible reasons for the exceptionally low response rate. The writer questions whether their sampling (convenience sampling) or recruitment techniques (sending an email using a therapist directory) were truly appropriate for their study. While Linley and Joseph (2007) used similar recruitment techniques, the researchers utilized random sampling in their study, possibly increasing their response rate and the generalizability of their findings. Another possible explanation for the low response rate could be that the researchers placed a higher focus on the negative effects of trauma work, instead of the positive, thereby possibility scaring therapists into thinking that they would have to share their vicarious trauma experiences; Haslam and McGarty (2010) state that this may be a problem of reactivity, where participants will refuse to participate if they are offended or object to the subject title (p. 111).

**Sampling**

Across both qualitative and quantitative literature, there was a universal use of non-probability sampling (Arnold et al., 2005; Brockhouse et al., 2011; Engstrom et al., 2008; Harrison & Westwood, 2009; Hernandez et al., 2007; Hunter, 2012; Linley et al., 2005; Splevins et al., 2010), with one exception (Linley & Joseph, 2007). Haslam and McGarty (2010) describe non-probability sampling as the selection of participants based on participant availability or because of the researchers’ personal judgment that the proposed participant will be representative of their study aims. Splevins et al. (2010) explicitly state that they chose non-probability
sampling because they sought specific experiences and opinions of participants to aid in the phenomenon being researched (p. 1707). Both Brockhouse et al. (2011) and Linley et al. (2005) sought trauma therapists to test whether or not a sense of coherence would be a moderating effect on positive growth in therapists. Strengths of non-probability sampling include, it is cost effective and it restricts the sample to what is being researched (such as Splevins et al. ’s 2010 article assessing VPTG specifically on interpreters that work directly with traumatized individuals). Weaknesses of this approach, especially in quantitative research, include poor estimations of sampling errors, increases in exclusion bias, and difficulties extrapolating data to the general population (Haslam & McGarty, 2010).

As to the one exception, Linley and Joseph (2007) stated that they had utilized an online Research Randomizer to recruit participants for their study, therefore they employed random sampling. Random sampling is an example of probability sampling, meaning that every person in the population has an equal chance of being asked to participate (Haslam & McGarty, 2010, p. 42). Strengths of probability sampling include it is easy to utilize and it creates a non-biased sample of participants, therefore decreasing researcher bias and increasing generalizability (Haslam and McGarty, 2010). Weaknesses of probability sampling include that it may be impractical to use with larger populations as identification and labelling may be time consuming and it can be fairly expensive to complete, especially if participants are located in several geographic areas (“Probability Sampling,” Statistics Canada, retrieved July 17, 2014 from http://www.statcan.gc.ca/edu/power-pouvoir/ch13/prob/5214899-eng.htm). Linley et al. (2005) reported that their participants were drawn from 18 countries that were served by the European Society for Traumatic Stress Studies (p. 186). While their research incorporated multiple
countries, their sample size of 85 participants is relatively small, so costs may not have been much of a factor.

**Recruitment**

A variety of recruitment techniques were observed throughout the qualitative and quantitative literature. Arnold et al. (2005), Engstrom et al. (2008), Hernandez et al. (2007), and Hunter (2012) used “snowball” sampling, wherein participants are recruited through an acquaintance of the researcher (Creswell, 2013). The strengths to this approach is that it allows for close proximity for the researcher to interview participants, as well as help find participants in areas of study that may have hidden populations. The weaknesses to this approach of sampling include researcher bias as only participants recommended from their acquaintance are being recruited for the study; the potential for alienating participants, therefore limiting sample size and generalizability as the participant sample may not accurately portray the intended population; and possibly decreasing external validity (Creswell, 2013; Evans, 1998; Haslam & McGarty, 2010). One difference noted in Engstrom et al. (2008), was that the torture treatment centre they sampled from corresponded with all 25 contracted mental health providers to inform them of the study; while the other articles state that they had agencies refer or recommend individuals, this centre more or less recommended everyone for the study.

Another recruitment method observed was recruitment through flyers. Harrison and Westwood (2009) and Splevins et al. (2010) stated that potential participants were recruited through flyers outlining the study that were distributed through agencies and professional networks. Benefits to handing out flyers or having them accessed through professional networks include allowing the study information to be passed onto many people, increasing randomization of participants, and its relatively cost effective, especially when the flyer is located online.
Drawbacks to this recruitment approach include limited information about the study, therefore losing possible participation due to lack of information, and participants not having access to the flyer area, consequently limiting participation.

Therapist directories were also utilized in the recruitment of participants. Brockhouse et al. (2011), Linley and Joseph (2007), and Linley et al. (2005) all stated that they recruited participants through various therapist directories in the United Kingdom. A possible disadvantage to this type of recruitment is that it is only one method of delivery. A number of participants may not have had the opportunity to partake in the study, therefore, the study may lack essential participants and be possibly considered exclusionary. Another disadvantage noticed by the reader is that some of the directories used were several years old. Brockhouse et al. (2011), Linley and Joseph (2007), and Linley et al. (2005) all required that their participants be registered trauma therapists; in the time frame that they utilized such directories, some therapists may have retired or changed fields of study. This then may have affected sample size, especially if non-trauma therapists were recruited using random sampling.

**Data Collection**

Data collection methods were similar for their respective qualitative and quantitative methodologies. The qualitative literature analyzed all completed semi-structured, face-to-face interviews, which were audiotaped and then transcribed (Arnold et al., 2005; Engstrom et al., 2008; Harrison & Westwood, 2009; Hernandez et al. 2007; Hunter, 2012; Splevins et al., 2010). Harrison and Westwood (2009), however, stated that they collected their data in three phases, which included an initial structured interview and then an open-ended individual interview. With minimal exceptions, all articles state that interviews took place at the participant’s place of work. Strengths of using semi-structured, face-to-face interviews include: allowing the interviewee to
go into great detail about the question being asked; permitting the interviewer a chance to ask probing or follow-up questions; allowing the interviewer to make notes about any non-verbal communication observed during the interviewer; and aiding in building rapport and trust between the interviewer and interviewee (Weiss, 1994). Weaknesses of using semi-structured, face-to-face interviews include: writing and re-writing sample questions to assess their validity to the research question; conducting interviews can be time consuming; and maintaining active listening throughout the interview so to ask appropriate probing and follow-up questions (Weiss, 1994).

The quantitative literature analyzed (Brockhouse et al., 2011; Linley and Joseph, 2007; Linley et al., 2005) utilized many of the same scales, including the Jefferson Scale of Physician Empathy (JSPE), Sense of Coherence Scale (SOCS), Posttraumatic Growth Inventory (PTGI), and Changes in Outlook Questionnaire (CiOQ). All of these scales employed Likert formatting (which are scaled answers ranging from 0 to 5) which likely made the scales easy to fill in and complete within a short time frame. Tavakol, Dennick, and Tavakol (2011) tested the reliability and validity of the JSPE with medical students. Their results indicated that the JSPE was not only a reliable and valid measure of physician empathy with both male and female medical students, but along with practicing doctors; however, they state that limitations to the JSPE were related to responder bias, socially desirable responding, and responder dishonesty. Haslam and McGarty (2010) also state these limitations when using scales in quantitative research, adding that using scales can also increase responder reactivity and mortality effects. In an article examining the reliability and validity of the SOCS, Eriksson and Lindstrom (2005) suggest that, overall, the SOCS appears to be a reliable, valid, and cross-culturally appropriate measure of obtaining information pertinent to how individuals manage stressful situations and maintain
well-being; however, Eriksson and Lindstrom (2005) also point out that sense of coherence tends to predict more positive outcomes in longer term situations, so using this scale with an older population might produce overly positive results, therefore potentially compromising generalizability.

**Data Analysis Procedures**

The data analysis procedures of qualitative and quantitative differ significantly. Qualitative data analysis is characterized by processing data through interpretation and categorization into themes; Quantitative data analysis conversely is processed through manipulation of numerical data and analyzed statically.

A number of data analysis methodologies were employed by the qualitative researchers. Arnold et al. (2005), Engstrom et al. (2008), and Hernandez et al. (2007) all employed Lincoln and Guba’s (1985) Naturalistic Inquiry to analysis, while Splevins et al (2010) utilized Smith et al.’s (1999) Interpretive Phenomenological Analysis; Hunter (2012) employed Strauss and Corbin’s (1998) analysis techniques for grounded theory; and Harrison and Westwood (2009) made use of Lieblich, Tuval-Mashiach, and Zilber’s (1998) typology of narrative analysis. Although Engstrom et al. (2008), Hernandez et al. (2007), and Hunter (2012) all conducted research based on the ground theory paradigm, they completed their analysis using different methodologies. From the writer’s point of view, all researchers were able to generate important themes in their studies, however, it appeared Engstrom et al. (2008) and Hernandez et al. (2007) were better able to describe their emerging theory of VR by comparing their findings to definitions of VT, by using participant testimonies to back up their theory of VR, and by providing clear recommendations for future VR research, as opposed to Hunter (2012) who
simply reiterated Hernandez et al.’s (2007) findings and did not expand in her summary or provide solid future recommendations.

Furthermore, the qualitative researchers (Arnold et al., 2005; Engstrom et al., 2008; Harrison & Westwood, 2009; Hernandez et al., 2007; Hunter, 2012; Splevins et al., 2010), all utilized “coding” in their data analysis. Coding is essentially the transformation of data into emerging themes through a process of constant comparison (Harrison, & Westwood, 2009, p. 207). To increase both descriptive and interpretive validity, Arnold et al. (2005) and Harrison and Westwood (2009) mailed their themes to their participants to verify the interpretation and to offer feedback on their analyses procedures. Hunter (2012) and Splevins et al. (2010) sent their data to external researchers to read through and see if they come up with similar themes. In addition to their participants, Harrison and Westwood (2009) also sent their data to an external researcher. In the process of coding data, Engstrom et al. (2008) and Hunter (2012) both reported that disagreements occurred amongst the researchers. To solve this issue, a thorough discussion was held to until a consensus was reached in the creation of thematic categories. A weakness of coding analysis occurs when researchers use a priori codes to guide their research. Using a priori codes effectively diminish the chance of themes emerging naturally in the data. If researchers use a priori codes, this may prompt them to change their research question until a question materializes out of their data, therefore biasing the data and reducing validity (Creswell, 2013).

On the other hand, the quantitative researchers (Brockhouse et al., 2011; Linley and Joseph, 2007; Linley et al., 2005), all used descriptive statistics in their data analysis, including Pearson product-moment correlations, t-tests, regression analyses, and alpha levels. The only common statistic reported between the three articles was alpha levels, signifying a strength in the quantitative data analysis. Alpha levels communicate to the reader the probability of error due to
chance in the study (Haslam & McGarty, 2010). If alpha levels are not reported, the results indicated may be questioned due to the researchers’ failure of reporting the probability of error due to chance.

**Ethical Implications**

There are a number of ethical issues that were identified throughout the studies (Arnold et al., 2005; Brockhouse et al., 2011; Engstrom et al., 2008; Harrison & Westwood, 2009; Hernandez et al., 2007; Hunter, 2012; Linley & Joseph, 2007; Linley et al., 2005; and Splevins et al., 2010). Some of these ethical issues include: debriefing and support for the participants, informed consent, privacy, and conflict of interest.

**Debriefing and Support**

A major ethical issue of concern is the apparent lack of support for participants that were asked to talk about their own personal experiences of trauma. Given that every one of these studies (Arnold et al., 2005; Brockhouse et al., 2011; Engstrom et al., 2008; Harrison & Westwood, 2009; Hernandez et al., 2007; Hunter, 2012; Linley & Joseph, 2007; Linley et al., 2005; and Splevins et al., 2010) are focusing on the impacts of trauma, it is reasonable to assume that participants may be re-traumatized by telling their own stories. There was little to no indication of support for the participants following their contributions to the studies, which may inadvertently have had an adverse effect on their mental and emotional health. At minimum, this issue should have at least been addressed in the debrief as according to the TCPS (2010) core principle of Concern for Welfare and the Canadian Code of Ethics (Canadian Psychological Association [CPA], 2000) core principle Responsible Caring.

Out of the nine studies, four of them (Arnold et al., 2005; Brockhouse et al., 2011; Linley & Joseph, 2007; and Splevins et al., 2010) specified in their research that they asked participants
to indicate whether or not they have had personal experiences with trauma, which included death of a loved one, serious physical illness, sexual abuse, domestic violence, and combat; only Splevins et al. (2010) clearly stated that an independent psychologist was made available to the participants should they wish to speak further about any distressing experiences evoked during the research. The TCPS (2010) core principle Concern for Welfare states that researchers need to acknowledge that their study may potentially have a negative impact on their participants (p. 9). In addition, the Canadian Code of Ethics (CPA, 2000), Principle II, Maximize Benefit II.23, Minimize Harm II.29 and II.36, and Offset/correct Harm II.44 all refer to the concept of taking care of participants through all aspects of the research process.

**Informed Consent and Privacy**

Another ethical issue of concern is obtaining informed consent prior to participant engagement in the research study. According to Pope and Vasquez (2011), informed consent is vital to respecting and maintaining individual freedom, autonomy, and dignity. Of the nine studies, only three indicated they had obtained informed consent. Engstrom et al. (2008), Hernandez et al. (2007), and Splevins et al. (2010) clearly stated that the participants were informed and agreed to the research at hand. The other six studies did not indicate compliance with this requirement. The Canadian Code of Ethics (CPA, 2000), Principle I, Informed Consent, I.20 and I.24, states that researchers must obtain consent for all research activities that may involve obtrusive measures and invasion of privacy, and ensure that their participants understand the purpose and nature of the activity. If the researchers failed to communicate about audiotaping the interviews, this would nullify participant consent and possibly infringe on their privacy. Thus, the Canadian Code of Ethics (CPA, 2000), Principle I, Privacy, I.39, I.40, I.41, and I.42,
may apply here, as these points relate to the collection, storage, and destruction of recorded materials for the purpose of research.

**Conflict of Interest**

Another ethical issue noted is the use of “gatekeepers” when recruiting participants. According to Creswell (2010), gatekeepers are the people who allow researchers’ access to hidden populations or key participants necessary to complete research. Three out of nine studies (Arnold et al., 2005; Hernandez et al., 2007; and Hunter, 2012) all utilized gatekeepers when recruiting participants for their studies. Hernandez et al. (2007) reported that participants were chosen through referrals from other psychologists who worked in government and non-government agencies; while Hunter (2012) reported that agency managers were asked to recommend therapists who would meet the inclusion criteria of the study. This creates an ethical issue as the gatekeeper may be in a position of power over the participant, thus possibly creating a dual relationship (being a manager and a recruiter for research), and potentially increasing the chance of participant coercion. The Canadian Code of Ethics (CPA, 2000), Principle III, Avoidance of Conflict of Interest, III.33, explicitly states to avoid dual or multiple relationships and other situations, such as research, that would create a conflict of interest that may reduce the ability to be objective and unbiased.

One ethical observation noted was that Linley and Joseph (2007) reported that participants’ responses were anonymous; however, participants were invited to provide their details separately for a chance to be entered into a draw for a $45 gift voucher of their choice. The Canadian Code of Ethics (CPA, 2000), Principle III, Avoidance of Conflict of Interest, III.32, states that researchers should not provide rewards sufficient enough to persuade individuals to participate in any activity that has possible or known risks. One could argue that a
$45 gift voucher is not a large enough reward to persuade people to participate in research, however, the writer believes that the fact that a reward is being offered is enough to reference the CPA’s thoughts on it.

Applications for Practice

Figley (2002) reported that 75% of mental health professionals are at moderate to high risk for developing compassion fatigue. This is an important issue because not only does it affect mental health professionals, but it impacts government and not-for-profit agencies, including hospitals, clinics, mental health programs, and school settings. Mental health professionals leaving their employment due to fatigue, burnout, or VT results in huge implications, including lack of continuity of care, higher costs associated with recruiting, hiring, and training, and impacts to the profession, including low morale and job dissatisfaction. Employees are coming into the trauma profession eager and enthusiastic, wanting to help people and create change, but are leaving due to lack of understanding, training, and support.

The writer conversed with several mental health professionals and noted similar concerns experienced by them. One nurse stated that working with high risk populations in the emergency room has affected her empathetic bond with some patients, noting that hearing the same stories and seeing the same parents over and over again has lessened her ability to connect with them. She noted that with less empathy comes less support and kindness to the patients, which in turn affects patient care, workplace morale, and nurses not feeling valued in their jobs. One counsellor added that lack of empathy not only affects the clients, but co-workers as well because there is lack of support and trust in the workplace. Other counsellors commented on lack of staffing, stating that co-workers are increasingly calling in sick or taking personal leaves, which places extra stress on staff in that they feel spread thin, over-worked, and less affective.
One counsellor mentioned that with less staff, there is less chances to debrief intense situations because the other staff are too busy trying to fill a vacant gap, therefore they find that they are taking their work home and needing to process it alone. In the writer’s own experience, working in addiction and trauma, I have felt frustrated with the lack of resources and workplace support. This has propelled feelings of inadequacy, not feeling valued, and not making a difference in clients’ lives. The writer believes that there is a gap in the work force between the research focussed on trauma and actual in-service training; the writer suspects that this particular gap is one of the reasons why workers are leaving the profession.

The research on trauma noted throughout this paper highlighted three themes: empathy, therapist perspective change, and therapist self-care. In the writer’s own experience, these themes have been instrumental in how I conduct myself as a counsellor. I employ a client-centred approach to counselling that heavily favors Rogerian theory. I believe empathy is the core that connects client to therapist and without empathy, change cannot occur. In reflecting on my ten years in the field, I have witnessed how the empathetic bond can be a powerful predictor of growth for therapists, in that they feel connected to their clients, they feel confident in their work, they can appreciate the smaller changes they see in their clients, and they feel honored to share in their clients’ lives; in saying this, I have also witnessed how the empathetic bond can be detrimental to the therapist, in that they feel frustrated with the client’s level of progress, they hear similar stories over and over again, they feel overwhelmed with exhaustion and burnout, and boundaries begin to slide. In my ten years, I have felt positive and negative effects of the empathetic bond. Because of empathy, I feel exceptionally honoured to be a part of my clients’ lives and to be able to share in their deep emotions. To be able to hear such pain and sorrow, but see such hope and joy as therapy progresses is just an amazing experience. I feel so much
compassion for my clients and it has made me appreciate how small changes can improve their quality of life. However, in saying this, because of empathy, I have worked harder than my clients and have made boundaries too flexible. I have needed to distance myself from a client because I felt I needed to preserve myself and it hindered the relationship. Despite the negative effects, I still believe that the empathetic bond is essential to building relationships, creating safety and security, and fostering change within our clients. New trauma therapists need to be informed of empathy and its benefits because it can promote clear and consistent boundaries, intimate and genuine connection, and perspective change. Hernandez et al. (2007) pointed out that some clients worry about sharing their story because they are afraid of what affects their trauma may have on the therapist. To counteract this, Hernandez et al. (2007) suggested therapists introduce the concept of VR while in therapy because it fosters transparency, mutual respect, and safe sharing.

The writer credits perspective change as the main motivator for coming into the helping profession. I originally wanted to be a RCMP officer and only enrolled in a Bachelor of Arts program as it was recommended by an officer I spoke to. During my undergrad, I was fortunate enough to be able to complete two practicums. My second practicum was at Alberta Hospital Edmonton, working on a psychiatric rehabilitation unit housing patients coping with schizophrenia, schizoaffective disorder, and other AXIS I and II disorders. During my eight month practicum, I worked with a client who consistently presented with flat affect and had little to no interactions with staff. Over time, I noticed a gradual shift in his interactions and participation on the unit. He began to play cards with staff and co-residents, he attended animal assisted therapy, and he even came out bowling. I found these small changes to be so motivating and inspiring, these small nuggets of change that presented as hope and optimism that created
such a massive shift in the quality of life in my clients is what prompted me to want to continue in the counselling field. Ten years later, I still feel motivated and inspired by small changes and it has helped me to encourage realistic and achievable therapy goals, witness resiliency in clients, and determine how to measure success. The writer believes that new therapists need to explore this concept of perspective change and how it can influence not only their approach to counselling, but how it can impact their lives, relationships, and beliefs. Hernandez et al.’s (2007) wrote that perspective change was so great for one participant that, “for the first time, she believed it was possible to recover from this kind of traumatic experience and that there was more to her work that dealing with anger, frustration, and pain” (p. 235).

Self-care is paramount to the sustainability of therapists in the helping profession. It creates balance and helps maintain professional and personal boundaries. Pearlman and MacIan (1995) stressed that trauma therapists need to actively practice self-care techniques in order to provide competent and ethical services to clients, as well as protect themselves and their non-professional lives (p. 564). One participant described self-care as “walking my talk” (Harrison & Westwood, 2009, p. 211). The writer spoke with two new counsellors about their journey and asked them questions about self-care and how they incorporate this into their lives. One counsellor talked about hearing self-care repeatedly throughout her education, but never really practiced it in her daily life. She stated that she knew it was an active practice, but was not really sure how to make it part of her daily routine. The other counsellor stated that working in the trauma field has made her extremely vigilant about self-care; she reported talking to her husband about its importance in her life and makes sure to do something active every day to clear her mind and replenish her body. In the writer’s own experience, I struggled with implementing self-care into my daily routine until I was six months into my practicum working with traumatized
clients. I spoke to my mentor who outright stated that if I did not start implementing self-care, I was doing a disservice to my clients. Because I really trusted my mentor, I began to look at self-care in a totally different perspective: self-care is not only necessary to help me be a better counsellor, but it helps me be a better partner, it helps me regulate my emotions, it gives me time to do something I enjoy, and it helps me feel better about myself. I believe that new therapists know the importance of self-care, it is preached from the moment you enter into the profession or enroll in education; what I think is missing is how to implement self-care into one’s life. Robin Cameron stated, “When you’re in the red zone of compassion fatigue, a bath ain’t gonna cut it!” (2003). New therapists need to be offered workshops and strategies on how to implement and maintain self-care practices, along with education on compassion fatigue, burnout, and VT symptoms and how to mitigate them when they are present. It may also be beneficial for new therapists to reflect on their reasons for engaging in trauma work and find ways to move through the pain and suffering of their clients without taking on the pain and suffering and be able to find support and resources to remain in the field.

**Recommendations**

Research demonstrates that VT is a significant issue across the helping profession. Quantitative numbers are showing that VT is a big enough issue to study because it is affecting a large amount of individuals in the profession. The writer is confident that if I interview five hundred therapists, a high percentage of them would agree with the themes outlined earlier in this paper. Empathy, perspective change, and self-care are common areas among therapists. Unfortunately, other than generalizing information, quantitative research does not give us depth to the issue; this is where we need qualitative research. Qualitative data is telling us exactly what
the issue is, therapists feeling traumatized by their clients, and how to resolve this issue and improve upon it, empathy and VR.

The writer offers several suggestions for both new and experienced therapists. These include training, supervision, and self-care. The writer also notes important areas of focus for future research.

Training

Training for new therapists is important because it provides a foundation in which they can grow. Training provides education, support, and options for sustainability in the field. Training needs to begin at the undergraduate and graduate levels because students need to understand the benefits and risks to joining the helping profession. Students often say that they enrolled in a psychology or counselling program because they want to help people, but are unaware of the potential pitfalls of helping. Providing courses on VT can help students learn to recognize symptoms of burnout and fatigue long before they are even in the counselling office. Additionally, once graduated, training needs to continue throughout employment. Addiction Counsellors employed through Alberta Health Services are required to complete a learning plan each year highlighting different workshops or training that they will be attending that will benefit not only their clients, but as well as colleagues and the worksite. There are workshops available through Alberta Health Services My Learning Link that focus on compassion fatigue and self-care; one such workshop is titled Caring for the Clinician. The Standards of Practice require that psychologists maintain or gain competency through on-going training, education, and supervision (College of Alberta Psychologists [CAP], 2013). The College of Alberta Psychologists is currently amending its Continuing Competence Program, which once passed regulation, will require psychologists to complete so many hours of training per year. The writer
believes that workshops need to further explore compassion fatigue, by educating clinicians about VT symptoms and ways that they can cope and alleviate these symptoms. The writer attended the Jack Hirose conference, “Healing and Treating Trauma, Addictions, and Related Disorders” this past November. This conference explored many aspects of trauma and how to approach it from different angles that would benefit the client; nowhere in the three day conference did they talk about VT or ways that therapists can cope with VT symptoms, nor did they talk about VR and how to foster it. The writer believes this would be an excellent conference to explore VT and VR with mental health professionals as research is showing a high percentage of people are experiencing or are at risk for experiencing detrimental effects. Supervisors and managers would also benefit from attending similar training so that they can recognize VT signs in their staff so that they can properly intervene and provide better support to their staff. Furthermore, supervisors and managers with additional education on VT would better understand resources available in the community to help staff, such as Employment and Family Assistance Programs (EFAP) and personal therapy.

One significant recommendation suggested in the above articles (Brockhouse et al., 2011; Engstrom et al., 2008; Harrison & Westwood, 2009; Hernandez et al., 2007; Hunter, 2012; Linley & Joseph, 2007; and Splevins et al., 2010) is that future research needs to examine the role that empathy plays in moderating vicarious growth and VR. Harrison and Westwood (2009) spoke of their surprise of seeing empathy as a protective factor against vicarious trauma symptoms, stating that engaging in the empathetic bond can create healthy and appropriate boundaries and foster mutual and reciprocal healing between the therapist and client. Brockhouse et al. (2011) suggested that while therapists may be educated on the detrimental effects of working in trauma, they are lacking the awareness of potential growth. They suggested
highlighting the importance of empathy during training as not only beneficial to the client, but to the therapist as well.

**Supervision**

The Canadian Code of Ethics (CPA, 2000) and the Standards of Practice (CAP, 2013) both cite the importance of continued supervision in the counselling profession to maintain ethical standards and competency. Supervision is not only important to new therapists, but for seasoned therapists, supervisors, and managers alike. Harrison and Westwood (2009) recommend that for the welfare of clients, therapists, and communities, no trauma therapist should work in isolation. Supervision provides new therapists with support and consultation, and can help prepare them for the difficulties faced in the profession and formulate ways to properly attack the issue. Supervision can also be a learning experience in that the supervisor can educate the supervisee about resources available. Supervision ought to be non-judgemental and afford the supervisee a chance to freely speak about issues going on. Pearlman and MacIan (1995) recommend that trauma therapists have supportive, confidential, and professional relationships so that they can process the traumatic stories they are hearing and find ways to move forward from the traumatic material. Supervision allows supervisors and managers the opportunity to recognize warning signs of compassion fatigue and VT symptoms in staff and to provide support through debriefing, training, and resources, such as EFAP. Recognizing early symptoms can help supervisors and managers prepare for sick days or extended personal leaves so that other staff do not feel overworked or burdened; it can also lead to increased awareness of VT throughout the worksite, which may increase empathy between colleagues. Improved awareness of VT and its detrimental effects, along with VR and its advantageous effects, may increase employment satisfaction and retention.
Self-Care

Both past and current research argues the importance of continued self-care throughout the counselling profession. The Information for Applicants Handbook (CAP, 2011) defines four major components of competence: knowledge, skills, judgement, and diligence. Within the scope of diligence, self-care is mentioned, stating that psychologists are encouraged to engage in self-care practices to help avoid adverse conditions, such as burnout and fatigue, that could potentially alter judgement and affect client care. Self-care is a major component to the trauma profession, and while its importance is repeatedly discussed, some therapists are simply not following through with this aspect of the job. The writer believes that self-care needs to be addressed as a part of supervision and employee learning and productivity plans. I think by incorporating self-care as job duty or responsibility, more new therapists will be inclined to engage in it.

Throughout the trauma research, it should be noted that many participants acknowledged experiencing trauma in their own lives. McCann and Pearlman (1990) noted the importance for therapists to be aware of unresolved traumas and how they can impact the therapeutic alliance. One recommendation suggested (Arnold et al., 2005; Linley & Joseph, 2007; and Linley et al., 2005) was the need to examine therapists’ own personal trauma history and how it relates to positive changes within the therapist. Arnold et al. (2005) reported that seventeen of their participants (roughly 80% of their sample) indicated that they had experienced at least one event in which they regarded as traumatic. As compared to other studies, Pearlman and MacIan (1995) reported that 60% of their sample answered yes to the question, “Do you have a trauma history?” and Wasco and Campbell (2002) noted that 50% of their sample answered yes to being a survivor of sexual assault. Splevins et al. (2010) reported that all eight of their participants
(100% of their sample) indicated that they had all experienced at least one distressing or traumatic event in their life (p. 1708). The writer suspects that if other researchers’ had inquired about personal trauma history, a moderate to high percentage of participants would acknowledge this. Linley and Joseph (2007) reported greater levels of personal growth amongst therapists who had personal trauma, suggesting that personal trauma may not necessarily be a risk for vicarious trauma, but a facilitator of vicarious personal growth (p. 398). The concept of personal therapy was addressed in these articles and was offered as a suggestion for self-care. The writer believes that stigma may affect counsellors from attending to their own counselling. While personal counselling is often recommended in undergraduate and graduate school as a way to understand the counselling process and to increase empathy with clients, it is not met with the same benefits in the work force. The writer has seen some supervisors or managers offer EFAP programs as a way to divert attention from the main issue or negatively comment to staff how have needed to use sick time to attend personal counselling. The writer offers to follow counsellors that would benefit from personal counselling that even a tow truck needs a tow truck.

**Conclusion**

The intention of this research paper was to review the conflicting data on empathy and how it affects mental health workers. The writer concluded that past research focused primarily on the negative effects of empathy, so therefore the writer concentrated on newer research and the positive effects of the empathetic bond. From the writer’s analysis, three themes emerged from the research: empathy, therapist perspective change, and self-care. The writer also methodologically analyzed how research in the field is being conducted and noted several ethical implications. The writer offered applications for practice citing the three themes and made recommendations for training, supervision, and self-care.
In summary, it is clear that symptoms of VT, compassion fatigue, and burnout are major concerns amongst mental health professionals today. It is important to address these concerns with information surrounding the advantageous benefits of VR and how it can promote change in the therapist, approach to counselling, and the workplace. The writer hopes that this paper can help remedy missing information on empathy, VT, and VR and that it can foster positive change in new and experienced therapists.
References


http://cap.ab.ca/pdfs/HPAStandardsofPractice.pdf

http://cap.ab.ca/pdfs/infoforapps.pdf


