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Providers of Support to Survivors of Torture and Their Coping with Vicarious Trauma

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ABSTRACT

As part of a larger research project, the present study deals with vicarious trauma (VT) and coping among therapists treating refugees who are survivors of torture. In a qualitative-phenomenological research design, a semi-structured interview format was used to investigate the experiences of VT and the methods of coping by a group of 10 therapists (2 males and 8 females). The findings indicate that empathizing with the traumatic experiences of survivors may have contributed to the experience of VT among the therapists. It is also revealed that, VT tends to affect therapists on multiple levels including, emotional, cognitive, spiritual, behavioral and physiological domains. Therapists used a variety of problem- and emotion-focused coping strategies to deal with the impacts of VT. The results suggest a number of areas for future research in VT and the need for cross-cultural training to deal with the emerging psychological difficulties of survivors of torture.

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DEDICATION

Dedicated to my mother Sedigheh Oudji (Afunian) and my father Abdulkhalegh Oudji whose love and respect for life, education, and human equality has been my inspiration.

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CHAPTER ONE: INTRODUCTION

> Those of us who enjoy peace and freedom, without having had to suffer for them, have the moral duty to ensure that the persecuted, the wounded, and the tortured, receive care, gratitude, and the possibility of recovering their human potential
> My friends, you are fulfilling a commendable mission. It is inspired by love for humanity. (Dr. Oscar Arias, 1991, cited in Jaranson, 1995, p. 256)

Refugee Trauma

During the last fifty years, there have been massive movements of immigrants and refugees throughout the world. Human-created disasters such as war, organized violence and torture have forced many people to leave their homelands and resettle in other countries. Refugees share with other immigrants the stresses of resettlement including adjustment to foreign customs and language, the experience of culture shock, and the clash between their norms and values, and those of the host culture (Williams & Berry, 1991). However, they also may have experienced unique stressors due to prolonged wars, persecutions, and dangerous escape from their own country. Unlike immigrants who chose to leave their country, refugees have had to flee their homeland forcibly because of traumatic and life-threatening experiences such as torture (Jaranson, 1995).

Systematic torture and organized violence have been reported in more than 60 countries around the world (Chester & Jaranson, 1994). It is estimated that 5-35% of the world's 14 million refugee population have been exposed to torture at least once (Basoglu, 1992). Canada has been welcoming refugees from various parts of the world. Earlier in 1977, a Canadian Center for Victims of Torture was organized in Toronto for the assessment and treatment of tortured refugees. In Calgary, Canada where the present research project was carried out, an estimated number of 3000 refugees traumatized by

torture were reported since 1991 (Calgary Catholic Immigration Society, personal communication, 1999). The World Medical Association has defined torture as,

> The deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason. (Amnesty International, 1985)

Survivors of torture are left with pervasive and devastating physiological, psychological, social, spiritual and emotional effects. For most of us, the horror of torture is unimaginable, yet for the refugees who are survivors of torture it is a cruel reality. Certain aspects of torture are believed to be responsible for the complex psychological impairment it may have on its survivors. First, torture is not accidental injury resulting from a natural disaster. Second, torture is usually a deliberate infliction of pain by one human being upon another, with the primary goal of the humiliation and breakdown of the person at the psychological, emotional, spiritual, political and behavioral levels (Jaranson, 1995). The immediate impact of torture may be severe and painful bodily injuries, social and economical disturbances, a sense of terror, helplessness, vulnerability, loss of control and uncertainty. The long-term impact may include responses involving negative changes in affect, cognition, behavior and general well-being of the individual. These responses may appear from months to years after the events resulting in a syndrome known as post-traumatic stress disorder (PTSD) (American Psychiatric Association [APA], 1994; Figley, 1995; Meichenbaum, 1994). Refugees who are survivors of torture may also question their world-view about themselves and others in relation to trust, safety, security, human goodness, a just world and religion (McCann & Pearlman, 1990).

Counseling Traumatized Refugees

Given the unique stressful situation and experience of refugees before, during, and after fleeing from their homes, many of them arrive cut off from the resources and social support systems in their country of origin. They may require particular attention from a multidisciplinary team of caregivers who can aid them to manage and overcome the negative psychological, physiological, social and spiritual effects of their trauma (Bojholm & Vesti, 1992; Supply & Service Canada 1988; Vesti & Kastrup, 1994; Westermeyer, 1986, 1989). One of the primary interventions for refugees who are survivors of torture has been counseling and psychotherapy; however, there is a paucity of training and information made available through graduate programs in the fields of psychology and counseling. Although therapists may be familiar with the area of traumatology and have dealt with survivors of sexual and child abuse, random violence and natural disasters (e.g., earthquake and flood), the experience of clients who are survivors of torture presents a unique issue. Therapists have to be prepared to address both trauma effects and its symptoms, as well as understand the pre-trauma life and culture of the refugee clients (Arthur & Ramaliu, in press). Thus, dealing with survivors of trauma from other cultures may present an additional source of stress.

Attention has been given recently to the potentially stressful nature of working with trauma survivors and particularly the indirect effects of clients' experience on therapists. There is evidence that therapists who work with trauma survivors are at risk for becoming vicariously traumatized (Figley, 1995; McCann & Pearlman, 1990; Stamm, 1995). Listening to torture survivors' painful stories certainly can create strong emotional responses by therapists. Stories of survivors of torture typically contain graphic accounts of stressful life experience that involves threat, injury, mutilation, humiliation, degradation, defilement, and destruction (Basoglu, 1992; Jaranson, 1995; Jaranson & Popkin, 1998). On the one hand, therapists may respond with a deep sense of empathy, and on the other hand they may respond with disbelief or cynicism regarding

the survivors stories. This general psychological reaction has been called vicarious traumatization "....a process through which the therapist's inner experience is negatively transformed through empathic engagement with client's trauma material (Pearlman & Saakvitne, 1995, p. 279).

Rationale for Study

Researchers and clinicians have been familiar with the concept of burnout, a type of occupational stress which gradually appears as a result of long term emotional involvement with clients (Maslach, 1982). However, job demands may be more serious and unique in their effects when therapists deal with clients who have been traumatized. Working with refugees who have been traumatized by torture poses a number of issues for professionals. First, they may be unprepared to deal with such a challenging population; and second, they may be unequipped to cope with the vicariously negative effects of their clients' traumatic experiences.

In the study of VT, much emphasis has been placed on its manifestations; however, it is imperative that we learn more about various ways of dealing with its negative impacts at personal, professional and organizational levels. Therefore, the goals of this study are to explore (a) the subjective experience of VTamong therapists working with a sub-group of traumatized refugees who are survivors of torture, and (b) the coping methods used to counteract the negative effects of these experiences. Because the nature of the present research was exploratory, a qualitative-phenomenological research design was selected in order to focus on therapists' subjective experiences of vicarious trauma and coping (Creswell, 1998).

It is hoped that through creating an awareness of our human responses to clients' traumatic experiences and expanding our repertoire of coping strategies we can enhance our own professional functioning as therapists as well as help the recovery process for the survivors.

Organization of the Thesis

Chapter two provides a literature review of the theoretical and conceptual framework for understanding stress and coping leading to the discussion of occupational stress among therapists. Particular emphasis is given to the concept of VT, its impact on personal and professional lives of therapists, and coping responses to manage VT. Chapter three describes the methodological framework of the study, which is based on a qualitative-phenomenological research design. The chapter also describes specific procedures used to collect, analyze and synthesize the data collected for this study. Chapter four reports the findings of the present study in the form of thematic description, supported by quotations from the participants' interviews. Finally, chapter five provides a discussion of the findings, limitations of the study and implications of the study for future research and counseling practice.

CHAPTER TWO: LITERATURE REVIEW

The purpose of this chapter is to review theory and research related to the experience of VT by professional mental health practitioners, and their methods of coping. First, the concepts of stress and coping are examined to provide a basis for the ways in which we understand, prevent, and deal with occupational stress in counseling roles. Second, the chapter focuses on the experience of VT among therapists who deal with survivors of trauma. Third, the issues of empathy and countertransference are discussed in relationship to the therapists' sense of vulnerability to experience VT. Finally coping strategies used by therapists to deal with their experience of VT will be outlined.

Transactional View of Stress and Coping

A variety of theories have been suggested in the study of stress. Some of these theories are the diathesis-stress, psychodynamic, learning, social stress, control and holistic theories (see Rice,1992). However, stress has generally been studied and defined in three different ways. Stress has been considered as (a) the response of the individual to demanding situations (response view), (b) the accumulation of the demands in the individual's environment (stimulus view), and (c) the interaction between factors within the individual and within the environment (transactional view of stress). Although the response and stimulus models focus on processes internal to individuals or events external to them respectively, the transactional model emphasizes a bi-directional interaction between the individual and the environment (Hiebert, 1988; Lazarus, 1991, 1993; Lazarus & Folkman, 1984). This transactional conceptualization of stress has received the most attention in the current literature and research, and will be the major focus of this chapter.

Stress is viewed as a transaction between individuals and their environments, in which individuals appraise demands of the situation as well as their available resources for coping. If the perceived demands exceed resources perceived to be available for coping with them, the individual experiences psychological and physiological stress

responses (Lazarus & Folkman, 1984). Therefore, stress is not just a response or a stimulus as originally defined (Holmes & Rahe, 1967; Selye, 1976); it is a process of transaction that requires continuous appraisals by individuals during interactions with their environment (Lazarus & Folkman, 1984).

Transactions involve an assessment process called cognitive appraisal (Cohen & Lazarus, 1983; Lazarus & Folkman 1984). The initial assessment of potential threat is termed primary appraisal, while the evaluation of available resources is called secondary appraisal. The process of primary appraisal concerns potential danger in the situation, whereas secondary appraisal considers the question of "what can I do about it?" During the secondary appraisal, people assess resources available to them and evaluate coping strategies to determine whether they are sufficient to meet the perceived demands.

The experience of stress often depends on the outcome of primary appraisal. When people perceive a balance between demands and resources, they may experience little or no stress; however, when their appraisal shows an imbalance and they believe that demands exceed resources, they may feel a great deal of stress (Hiebert, 1988; Lazarus & Folkman, 1984; Rice, 1992). Events that are appraised as stressful receive further appraisal involving three implications: harm-loss, threat, and challenge. Appraisal of harm-loss involves real or anticipated damage of something that has personal significance. Threat appraisal refers to the expectation of further harm. Challenging situations are viewed as opportunities to achieve growth and mastery. Stress appraisals tend to depend greatly on harm-loss and threat (Hobfoll, 1989). Hiebert (1988) pointed out that during the appraisal process, people first decide whether it is possible to make the demands less stressful, and then attempt to change the situations by reducing these demands, and/or enhance their coping skills to deal with them more adaptively. Appraisal continues as coping responses are tried; if the first ones do not work and the stress persists, new responses are initiated, and their effectiveness is evaluated (Lazarus,

1991). Conversely, if the coping strategies are effective in eliminating stress, individuals stop initiating new coping responses.

A major criticism of the transactional theory (Lazarus, 1991; Lazarus & Folkman, 1984) is presented by Hobfoll (1989) who points out that the concepts of *situational demand* and *coping capacity* are not sufficiently defined. According to Hobfoll, the definition of these two concepts is circular; that is the extent to which an event is demanding depends on coping capacity while the adequacy of coping capacity is dependent on demand. Hobfoll suggests an alternative model based on the concept of conservation of resources. He states that people value and conserve many resources related to objects (home or business) condition (power or marriage) personal characteristics (self-esteem) and energies (time or money). When people experience loss of resources they attempt to replace their loss or reappraise. Hobfoll's theory seems to use similar cognitive concepts to those of Lazarus such as reappraisal. Moreover, the concept of loss by Hobfoll is also quite similar to the concept of harm proposed by Lazarus. The choice of the transactional theory in the present study is consistent with Rice's (1992) conclusion that "while it is important to keep in mind potential weaknesses in a theory, we cannot and should not quickly abandon a strong and well-research theory on the basis of speculation alone" (pp. 22-23).

In sum, the transactional view considers stress as a multidimensional process involving individual and environmental variables, as well as the mediating efforts of appraisal and coping. How the individual perceives and responds to different events is the critical factor in determining the experience of stress, not just the event itself.

Factors Influencing Appraisal of Stressors

Whether an event is appraised as stressful or not during the process of primary appraisal is influenced by factors that relate to both the individual and the situation (Costa, Somerfield & McCrae, 1996; Krohne, 1996; Lazarus & Folkman, 1984; Lepore & Evans, 1996). For example, research indicates that individuals who have a high sense of

self-esteem are more likely to perceive that they have the resources and are able to interpret the stressful event as challenging rather than threatening (Cohen & Lazarus, 1983; Hobfoll, Freedy, Green, & Solomon, 1996; Hobfoll & Leiberman, 1987). Another example involves individual's belief system: a person who has "irrational" (unhelpful) beliefs is also more likely to appraise most situations as threatening or harmful (Ellis, 1987, 1993). Considerable stress can also be brought about by conflicting motives (Rice, 1992) as well as internal processes such as unresolved conflicts that may be conscious or unconscious (Freud, 1933). Other factors such as gender, age, cultural values, socioeconomic status and previous experiences with stressful situation can also significantly influence our perception of stressful events (Arthur, 1998; Arthur & Hiebert, 1996). A key point to consider is that the degree to which any situation is appraised as stressful varies for each person.

Situational factors tend to involve three basic characteristics which contribute to perceived stressfulness of the events. These are controllability, predictability, and the extent to which some events challenge the limit of our capabilities and self-concept (Lazarus & Folkman, 1984; Rice, 1992). The more people perceive a situation as uncontrollable (the lack of ability to prevent or eliminate it), the more likely they perceive it as stressful. According to Lazarus & Folkman (1984), our perception of control is as important to our assessment of the stressfulness of the events as is the actual control of them. Animal and human research has demonstrated that the perceived or real control of stressors can significantly affect the appraisal of stress and the development of a sense of helplessness and hopelessness which may promote depression or other psychological difficulties (Brown & Siegel, 1988; Geer & Maisel, 1973; Levy & Heiden, 1991; Sanderson, Rapee, & Barlow, 1989; Seligman, 1975; Taylor & Aspinwall, 1996; Thompson, Sobolow-Shubin, Galbraith, Schwankovksy, & Cruzen, 1993; Wiedenfeld et al., 1990). When people can predict the occurrence of events in their lives, they can usually reduce the intensity of stress associated with them, even if the events can not be

controlled (Lazarus & Folkman, 1984; Rice, 1992). Predictability allows people to become engaged in some kind of activity that can help them to feel less anxious. Some events are basically controllable and predictable, but are still experienced as stressful because they challenge our beliefs and capabilities to cope with them. For instance, people may get involved enthusiastically and voluntarily in some events such as marriage or migration, but they still may feel stressed. Events that are perceived as positive and challenging may involve a number of significant changes and adjustments (Moos & Schaefer, 1986). Other factors such as novelty, ambiguity, imminence, and duration of the events can also influence the individual's appraisal of the situation.

Summary. Stressful situations create emotional and physiological responses that are highly uncomfortable. This in turn motivates us to take actions to reduce, eliminate or manage the discomfort. The process by which we attempt to manage stress is called coping. In the following section, throughout this discussion, functions and methods of coping with stress, as well as their effectiveness will be highlighted.

Coping with Stress

Coping is defined as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1984, p. 141). This definition implies that coping is not static but involves constant efforts to manage the situations perceived to be stressful. In addition, the individual's appraisal of the situation (i.e., challenging, threatening, or harmful) largely influences the coping response, which in turn may alter the initial appraisal. The process of appraisal allows us to account for individual differences in the response to the same event. For example, hearing graphic stories about traumatic events such as rape or torture may create stress for some people and yet merely present a fact of life for others. Coping is also influenced by individual differences such as gender, age, socioeconomic status, level of education and life experiences. When people appraise a situation as stressful, the effects of stress may vary

depending on how each individual copes and manages the event. The word *manage* in the definition of coping is emphasized because it indicates that coping efforts can be varied and do not necessarily lead to a solution of the perceived problem (Lazarus & Folkman, 1984).

Functions and Methods of Coping

Coping is our goal directed efforts toward managing the perceived demands of the environment; therefore, it plays an important role in mediating the effects of stress. The negative impact of perceived stressors can be reduced when we have a large pool of coping resources and when we apply effective coping methods (Sutker, Davis, Uddo, & Ditta, 1995). The transactional model discussed earlier emphasizes that coping consists of all of the cognitive and behavioral efforts that people make to manage the demands of a situation. People have a variety of strategies for coping with stress. Researchers have organized commonly used strategies on the basis of their functions: (a) dealing with the problem itself (problem-focused coping) and changing the demands causing the stress or (b) regulating the emotional distress (emotion-focused) caused by the demands (Carver, Scheier & Weintaub, 1989; Lazarus & Folkman, 1984; Zeidner & Endler, 1996).

Problem-Focused Coping

Problem-focused coping aims at managing the situation by changing the stressful event, or altering one's interaction with that event (Lazarus & Folkman, 1984). Such strategies can be directed at the situation or at the self in an attempt to solve, reconceptualize, or minimize the effects of a stressful situation such as taking actions that are directed at the problem. One example is problem solving activities. These efforts involve gathering information about the problem, planning alternative solutions, evaluating these solutions for their effectiveness, selecting and implementing an idea and finally re-evaluating its effectiveness after a period of time. Another example is seeking and obtaining social support for instrumental reasons. With instrumental support comes

feedback, advice and new approaches to stress, all of which make it easier to develop and use helpful plans that can minimize or manage the problem (Lazarus & Folkman, 1984).

Emotion-Focused Coping

Emotion-focused coping involves individual's efforts to manage the emotional distress linked to situations perceived as stressful. Such strategies involve activities related to affect regulation. One method includes behavioral strategies that involve changing one's responses in ways that reduce the impact of stressors before, during or after the experience of stress. The most common behavioral coping strategies involve some form of physical or mental exercises as well as mood altering substances such as tobacco, alcohol and drugs. It is important to note that although at times these substances can be appropriate coping aids and reduce one's emotional arousal, if abused, they can become a stressor themselves and lead to adverse effects on health (Carey, Kalra, Carey, Halperin, & Richards, 1993; Carver et al., 1989; Moose, Finney, & Cronkite, 1990). Moreover, when people depend on alcohol or narcotics to help them face stressors, they may attribute success to the drug, instead of their own efforts and skills (Bandura, 1989). Such perceived loss of control over stressors as a result of drug use may in turn make those stressors even more threatening and disruptive. On the other hand, individuals with high levels of self-efficacy tend to perceive and approach demands as challenging situations and in an active and persistent manner (Bandura, 1989). Non-chemical methods of reducing stress such as physical exercises, progressive relaxation training, and meditation among others have been shown to be effective measures in controlling stress (Brown, 1991; Dubbert, 1992; Gelderloos, Walton, Orme-Johston, & Alexander, 1991).

Two other important emotion-focused strategies are emotional discharge and intrapsychic processes. An example of emotional discharge is talking about the problem and seeking emotional support. The perception that one has emotional support, and is cared for and valued by others, tends to be an effective buffer against the negative

effects of many stressors (Anderson, 1992; Taylor, 1995). With emotional support comes moral support, sympathy, or understanding from others. Another example of emotional discharge is writing about the problem. Pennebaker (1990) has found that writing about negative feelings may reduce people's stress and benefit their health since writing helps the individuals to organize and assimilate their own thoughts and feelings more carefully than talking.

People also use a variety of intrapsychic processes that may involve cognitive and behavioral efforts to manage their emotional reactions. One cognitive strategy is cognitive restructuring which aims at reappraising and reinterpreting the stressful demands and helps to generate more hopeful emotional state by thinking more constructively and positively (Ellis, 1993; Meichenbaum, 1994). This reframing process is particularly helpful in regulating emotional arousal. For example, a therapist listening to graphic and horrible stories of a traumatized client may become overwhelmed with the presenting information and experience feelings of anxiety, confusion, depression as well as frightening, catastrophic thoughts about the situation. He/she may ask "What if it happens to me or my loved ones?" Subsequently, the therapist may attempt to reduce and replace catastrophic thinking by reframing the meaning of the situation and replacing it with constructive thoughts such as " All I can do is the best I can" (Ellis, 1993). Although this strategy does not eliminate stressors, it can help perceive them as less threatening and thus make them less disruptive. Taylor (1983) suggests that people who have desires and skills for reframing a situation perceived to be stressful, can generally find a way to do so since there is almost always some aspect of one's life that can be viewed positively.

Other intrapsychic processes involving cognitive strategies are called defense mechanisms. Freud (1933) originally developed the concept of defense mechanism to refer to people's unconscious processes when dealing with their anxiety by avoiding (physically removing oneself from the presence of stress) or denying (mentally escaping

stressor by ignoring or trying to explain it) their experience of reality. These processes are emotion-focused and do not change the stressful situation; rather, they help to prevent people's negative emotions from overwhelming them. Examples of defense mechanisms are repression, projection, rationalization, denial, intellectualization, suppression and displacement. Most people use defense mechanisms on a fairly regular basis and they are considered normal coping patterns that help us until we are ready to deal more directly with the stressful situation. However, when they become the dominant mode of responding to difficulties, they can lead to personal maladjustment. Defensive coping is considered relatively maladaptive because it may involve self-deception and reality distortion (Bolger, 1990). Studies show that a little illusion is necessary for good mental health. Studies by Taylor (1989) also show that illusion may sometimes be adaptive for mental and physical well-being. She notes that in comparison to depressed subjects, normal subjects have overly favorable self-image and overestimate the degree to which they control chance events. However, according to Baumeister (1989) there is an "optimal margin of illusion". Extreme distortions of reality are unhelpful and non-adaptive, while small illusions are often helpful. Vaillant (1994) points out that some defense mechanisms such as humor and altruism can be more adaptive than others (e.g., denial) in helping people to cope with perceived stressful events.

When people perceive that the demands are not controllable and must be endured for the time being, emotion-focused coping becomes predominant. In contrast, problem-focused coping becomes predominate when people believe that they can do something about the situation (Lazarus & Folkman, 1984). Gender differences in coping styles have been debated. The premise that women tend to use emotion-focused coping more frequently, while men tend to use problem-focused has received mixed results in research (Ptacek, Smith, & Zanas, 1992). These results may be due, in part, to differential distribution of resources and/or women's lack of status within traditional roles in our society (Arthur, 1998).

In sum, when dealing with a stressful situation, most people use both problem-focused and emotion-focused coping. Although emotion-focused coping may help in creating emotional balance, people still require problem-solving efforts to manage the demands. (Auerbach, 1989; Billings & Moos, 1984). The important point is that whether we use problem-focused or emotion-focused coping, we are active participants directing our actions toward a goal. What types of skills and strategies we use in changing our problem or regulating our emotional response and how skillfully we employ those strategies depends largely on the context, range of experiences, and capacity for self-understanding. Commonly used strategies can be classified according to their problem- or emotion-focused coping functions (for review of a sizable but inconsistent body of literature on different strategies, see Carver et al., 1989; Lazarus & Folkman, 1984; Rice, 1992; Zeidner & Saklofske, 1996). Regardless of the type of strategy used, efforts are made to manage stress effectively. At this point we may raise the question to what extent these different coping strategies are effective.

Effectiveness of Coping Strategies

No single method of coping with stressors is always effective: in reality, most people use a variety of strategies in dealing with any given demand (Lazarus & Folkman, 1984). People who effectively manage stressors tend to be those who are able to adjust their coping methods to the demands of changing stressors and situations (Carver et al., 1989; Costa & McCrae, 1989). People's cognitive, emotional, and behavioral coping responses are interrelated and one does not function without influencing the other. Whatever mode of coping people use, it is important to emphasize that they are purposeful and actively planned to deal with stress in the short and long term.

A review of the literature on stress and coping indicates that successful coping involves (a) facing problems directly and making a conscious effort to rationally evaluate options, (b) appraising the stressful situation and coping resources realistically, (c) learning to organize and at times inhibit, potentially disruptive emotional reactions to

stress, and (d) making efforts to ensure that our body is not vulnerable to the damaging effects of stress (Epstein, 1990; Zeidner & Endler, 1996; Zeidner & Saklofske,1996). No coping strategy can guarantee a successful outcome. Some coping responses may turn out to be ineffective in some circumstances and adaptive in others; therefore, expanding our repertoire of coping resources and strategies can enhance our ability to cope with stressful situations more effectively. The outcome of certain strategies depends on personal and contextual factors, reliance on different coping responses and resources as well as a match between demands characteristics, appraisal, and coping efforts (Carver & Scheier, 1994; Zeidner & Endler, 1996).

Summary. Overall, research on stress and coping described in this chapter provides the reader with background information for understanding the nature of stress and coping. It also leads us to the discussion of occupational stress and to specific issues related to the helping profession, such as how therapists who work with survivors of trauma deal with their work related stress. In focusing on occupational stress more directly, the rest of this chapter will attempt to deal with these issues.

Occupational Stress Among Therapists

A major type of stress which is investigated in the present research is related to occupational stress of mental health professionals. Occupational stress can be defined as the interaction of work conditions with characteristics of the individual worker in such a way that the demands of work exceed the ability of the individual to cope with them (Ross & Altmaier, 1994). For most people, stress associated with their job is often transitory and has a minimum impact on their general well-being. However, for some people, the stress can become intense and continue for long periods of time. Furthermore, the demands of their job can produce additional stress in two ways. First, their work load may become too high and unmanageable; and second, some kinds of activities they carry out may be perceived as more stressful than others. For example, professional mental health providers may see or hear about other people's suffering,

empathize with their feelings and thus feel vulnerable themselves. Their empathic response may be related to immediate physical safety, long-range security, self-esteem, or many other things that one values for the self or others. In addition, they often deal with unpredictable, uncontrollable situations that challenge their capabilities. Therefore, they must learn and develop effective coping tactics to deal with their intense experience of stress (Figley, 1995; McCann & Pearlman, 1990; Saakvitne & Pearlman, 1996; Stamm, 1995). It has long been recognized that individuals in the helping professions are at risk of experiencing burnout, a particular type of occupational stress that, in part, arises from caring about and contact with clients (Freudenberger, 1990; Maslach, 1982; Pines, 1993).

Burnout

Burnout, a term used to describe prolonged occupational stress, is defined as a "syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do 'people work' of some kind" (Maslach, 1982, p. 3). Emotional exhaustion refers to feelings of being emotionally overextended and depleted of one's emotional resources; depersonalization involves a negative or extremely detached response to the recipient of helper's care and services; and reduced personal accomplishment refers to a decline sense of competency and achievement in one's work.

Burnout tends to appear gradually through a general erosion of the spirit when caregivers such as therapists struggle to maintain high levels of empathy and caring in therapeutic relationships where there is likely to be unrealistic expectations. In the process of burnout, the therapist becomes emotionally exhausted by continuously empathizing and working with clients' difficult experiences (Pines, 1993). It is this emotional exhaustion that seems to be the main factor in the experience of burnout. According to Maslach (1982), "a person gets overly involved emotionally, overextend him- or herself, and feels overwhelmed by the emotional demands imposed by other

people. The response to this situation (and thus one aspect of burnout) is emotional exhaustion" (p. 3). This kind of exhaustion, however, is unique in that ordinary periods of rest cannot relieve the fatigue. A therapist may take a few days off only to come back the following days still depleted of energy and enthusiasm. As exhaustion progresses, other changes occur. According to Freudenberger (1990) other significant signs of impairment are cynicism, depression, loss of intimacy with friends and family, loss of motivation, and detachment. A significant factor in the experience of burnout is the end result in which highly committed and motivated people may lose their initial enthusiasm and motivation to work. Tragically, burnout robs clients of truly compassionate care when they need it the most and may lead to poor care. As a result of burnout, individuals may leave their jobs or their professions. Beyond the individual effects, burnout has costs to organizations and the larger society (Cherniss, 1995; Kahill,1988; Maslach, 1982).

Research has indicated that burnout is experienced by people who entered their careers with high ideals, motivation, and commitment (Blair & Ramones, 1996; Maslach, 1982; Pines, 1993). According to Pines (1993) "the cause of burnout lies in our need to believe that our lives are meaningful and that the things we do are useful, important, even heroic" (p. 391). Events that undermine this belief can result in burnout. Maslach (1985) has suggested that time limitations, intensity of the client's situation, and long-term involvement in the mental health field can place counselors at risk for burnout. It has been also suggested that taking on additional work responsibilities can contribute to the experience of burnout (Freudenberger & Richelson, 1980).

Summary. Like other kinds of occupational stress, burnout is an extremely serious health problem among professional mental help providers (Sutherland & Cooper, 1990). Burnout is also one of the most discussed reasons for the deterioration of effective services among experienced therapists. Moreover, it is a major professional concern (Cherniss, 1995; Kahill, 1988; Maslach, 1982). In a study of Canadian psychologists,

Kahill (1986) found that 6.3% experienced burnout. It appears that the pressure and challenges of the helping professions place unique demands on these individuals; and without some strategies to buffer themselves from its influence, and without efforts to revitalize their energies, these helpers will eventually burn out. The effects of job demands on these professionals may also be more serious and unique when they deal with traumatized clients because, during the process of helping, professionals may become traumatized vicariously (Figley, 1995; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Stamm, 1995; Wilson & Lindy, 1994).

The following discussion focuses on the effects of trauma work on therapists who work with traumatized clients. First, a discussion of traumatic events and their subsequent impacts on primary survivors of trauma will be presented. Second, the concept of VT will be introduced. Finally, the concepts of empathy and countertransference will be discussed in order to explain the special work demands on therapists that can contribute to experience of VT.

Vicarious Trauma

One of the most obvious sources of stress are traumatic events that nearly everyone appraises as threatening. These events are unpredictable, threatening and involve extreme stress that is beyond the limits of usual human experience of suffering (Holtzman & Bornemann, 1990; Meichenbaum, 1994). Traumatic events such as natural disasters (e.g., earthquakes and floods), accidental disasters (e.g., car, train and airplane accidents), and intentional human-created disasters (e.g., rape, torture, and war) may overwhelm people's sense of safety, security, and trust (Figley, 1995; Janoff-Bullman, 1992; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Stamm, 1995; Wilson & Lindy, 1994). The traumatized individuals may experience long-term changes in affect, physiological, behavior, and mental functioning; therefore, they may require professional interventions to deal with the impact of traumatic events (Danieli, 1994). However, these

changes are greatly influenced by individuals' personality characteristics, coping resources and circumstances, before, during and after the traumatic experience.

The immediate impact of traumatic events may be physical injuries, economical loss, social disturbances, as well as a sense of terror, helplessness, vulnerability , loss of control and uncertainty (Baum, Cohen & Hall, 1993). The long-term consequences can be debilitating responses involving changes in affect, cognition, behavior and general well-being of the individual (Meichenbaum, 1994; Ver Ellen & Van Kammen, 1990). These responses may appear from months to years after the events resulting in a syndrome known as post-traumatic stress disorder (APA, 1994). PTSD is a delayed stress reaction that recurs repeatedly, even long after the traumatic experience. PTSD is characterized by (a) emotional symptoms including anxiety, survivor's guilt and emotional apathy; (b) cognitive symptoms including hypervigilance, difficulty concentrating, and flashbacks of the events in dreams and memories, and (c) behavioral symptoms such as insomnia and social detachment (Allodi,1990; APA, 1980, 1994; Figley, 1985, 1988, 1995; Meichenbaum, 1994). Stressors are more likely to result in experience of PTSD if they are sudden, severe, repetitive and intentional (Meichenbaum, 1994).

The field of traumatic stress has received a significant attention in the past decade Two main factors influencing the recent interest are (a) greater awareness of the negative long-term effects of traumatic events on individual's mental well-being, and (b) the inclusion of the diagnosis of PTSD in the third edition of the Diagnostic and Statistical Manual of Mental Disorder (DSMIII) (APA, 1980). Although the experience of PTSD has been widely associated with the experience of Vietnam veterans, it has been recently applied to other cases of severe stress (Figley, 1995).

Although there have been many studies of individuals who experienced trauma directly, research has only recently focused on those who were traumatized indirectly

(Figley, 1995; Figley & Kleber, 1995; McCann & Pearlman, 1990; Pearlman & Mc Ian, 1995; Stamm, 1995). However, the diagnosis of PTSD, Criterion A1, clearly refers to the indirect effects of trauma in stating that "...learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate" (Criterion A1, APA, 1994, p. 424) can be traumatizing as well. There is also supportive evidence that family members, friends and others in close contact with the traumatized individual can experience the debilitating effects of the trauma (Arvay & Uhlemann,1996; Figley, 1985, 1995; Figley & Kleber, 1995; McCann & Pearlman, 1990).

Recently, researchers have suggested that helpers who repeatedly listen to and share the details of the painful experiences of trauma survivors may experience the effects of traumatic events indirectly and develop, emotional, cognitive and behavioral symptoms similar to those of PTSD (Arvay & Uhlemann, 1996; Figley, 1995). Such secondary effects which have been variably called secondary traumatic stress (Figley, 1995), compassion fatigue (Figley, 1995) or vicarious traumatization (McCann & Pearlman, 1990) are characterized by stress resulting from helping or wanting to help a traumatized client and "...can be disruptive and painful for the helper and can persist for months or years after work with traumatized persons" (McCann & Pearlman, 1990, P. 133). Earlier, Miller, Stiff, & Ellis (1988) chose the term emotional contagion to describe an affective process in which "an individual observing another person experiences emotional responses parallel to that person's actual or anticipated emotions" (p. 254). McCann & Pearlman (1990) view VT as an occupational hazard and assert that it can result in symptoms similar to those in burnout such as depression, despair, cynicism, alienation, psychological and physical symptoms, withdrawal, and a heightened sense of vulnerability, all of which are significant signs of impairment.

Although all of these authors provide various definitions to describe the secondary effects of stress of working with traumatized clients, they contend that (a) merely

knowing about the clients' traumatizing experiences, and (b) empathic engagement and wanting to help the traumatized individual can result in psychological and emotional changes in therapists. Such a change is mainly due to the "transformation of the therapist's or helper's inner experience....to hear someone's story of devastation or betrayal, our cherished beliefs are challenged and we are challenged and we are changed" (Saakvitne & Pearlman, 1996, p. 25). The concept of VT can help in understanding how accumulative exposure to clients' traumatic stories can negatively impact therapists.

The concept of VT which was originally developed by McCann & Pearlman (1990), is based on their constructivist self-development theory (CSDT). This theory provides a framework for understanding how traumatic events affect and change self or personality of the survivor. Recognizing that the changes experienced by helpers parallel those by trauma survivors, it is important to understand which aspects of self become more vulnerable to changes so that we are able to identify the ways in which trauma work impacts therapists personally. Therefore, the basic outline of the theory can help the reader to understand how trauma work influences the therapists and contribute to the experience of VT.

Constructivist Self-Development Theory

A basic assumption of the CSDT is that as a result of trauma work, therapists are likely to experience disruption in their sense of identity, world-view, and spirituality (McCann & Pearlman, 1990). McCann & Pearlman assert that therapists' fundamental assumptions about the world, others, and the self will be challenged and changed as a result of their awareness of traumatic events. Intense psychological crisis can happen when therapists experience varying degree of discrepancy between their cognitive schemas and that of the clients (McCann & Pearlman, 1990). Hearing and seeing that other human beings can inflict the trauma on another person, challenges and defies one's cherished view of a just world and a good human nature. Consequently, therapists' cognitive schemas about safety, trust, control, esteem, and intimacy related to self or

others may be seriously challenged and transformed negatively. According to Pearlman and Saakvitne (1995) "therapists cannot do this work without experiencing assaults to their usual ways of viewing themselves, the world, and other people" (p. 295).

Summary. People's previous knowledge, experiences, beliefs and values about the world provide them with a framework by which they perceive and interpret new information. When faced with new and contradictory experiences, their prior theories and understanding become insufficient in guiding their actions and may result in cognitive dissonance (Janoff-Bulman, 1992). Psychotherapy with survivors of trauma is a complex process in which therapists and clients experience intense and difficult emotions in order to move forward through painful memories and experiences. "For a psychotherapist, it is the process of the trauma therapy, including repeated exposure to trauma material in the context of empathic connection with the survivor client, that creates vicarious traumatization" (Pearlman & Saakvitne, 1995, p. 299). In the following section I examine how specific qualities of the therapist and therapeutic relationship involving empathy and countertransference can contribute to VT.

Contributing Factors to Vicarious Trauma

Empathy in the Therapeutic Relationship

Empathy is a vital part of all therapeutic relationships that help in establishing and maintaining rapport as well as making clients feel comfortable so they could work with the therapists in a trustful working relationship. Therapists show empathy when they accurately understand the way in which the client perceives and emotionally experiences events (phenomenological world of the client). Empathy also involves therapists' immersion in their clients' worlds and communicating their understanding to clients (Rogers, 1951). Therapists need simply communicate a sense of understanding and trust in clients' own resources for self-understanding. Trust is the foundation of every personal and professional relationship and must be earned gradually if any change is to occur. This implies confidentiality, honesty and consistency essential for creating a

strong therapeutic basis for clients. When working with survivors of traumatic events, a major goal of therapeutic intervention is the re-creation and enhancement of trust and security in interpersonal relationship. Traumatized clients have already experienced harm and deception in an arbitrary and unpredictable fashion. It is, therefore, vital that therapists do not add to clients' sense of vulnerability and betrayal (Janoff-Bulman, 1992; Jaranson & Popkin, 1998; World Health Organization [WHO], 1996).

Empathy is defined as responding to another individual's experience with a vicarious understanding that is similar to the other person's experience (Eisenberg & Fabes, 1991). According to Figley (1995), the more the therapists empathize with the survivor, the more vulnerable they become to the negative effects of vicarious trauma. For example, most of the symptoms such as intrusive thoughts, nightmares and generalized anxiety reported by therapists reflect those of their clients. Indeed, listening to painful descriptions of horrific stories and maintaining an empathic response to the stories told by clients can result in negative emotions and other psychological reactions. Although, "the process of empathizing with traumatized person helps us to understand the person's experience of being traumatized, but, in the process, we may be traumatized as well" (Figley, 1995, p. 15). Figley attributes therapists' vulnerability to (a) the extreme intensity associated with trauma work, (b) therapists' empathy for clients painful experiences, (c) therapists' personal experience of traumatic events (especially similar events) ,and (d) reawakening of unmanaged trauma of the therapists as a result of clients' narratives.

Many traumatized clients seek counseling in a state of profound emotional distress. The therapist's task, therefore, involves helping them to clarify their confusion and make sense of their "shattered assumptions" about a "just world". Therapists who are in close contact with traumatized clients, however, face a number of challenges during their therapeutic relationships. In addition to working with clients to overcome or manage their psychological difficulties, therapists must struggle with their own intense

psychological responses. According to Wilson & Lindy (1994), empathy is a "complex enterprise in which the therapist must also be aware of his or her own partial identification with the clients' phenomenological framework. In other words, therapists working with these patients must take into account the process of countertransference" (Wilson & Lindy, 1994, p. 7). In recent years, attention has been given to therapists' affective reactions and the countertransference process of working with traumatized clients (Boehnlein, Kinzie, & Leung, 1998; Danieli, 1988; Wilson & Lindy, 1994). It is, therefore, essential to understand issues related to therapists' countertransference and the therapeutic outcome.

Therapeutic Relationship: Countertransference

The term countertransference refers to emotional reactions of a therapist toward a client. Countertransference is a phenomenon involving affective (anxiety, guilt, shame) and cognitive (fantasies, mental associations) reactions (Wilson & Lindy, 1994). The manifestations of countertransference problems include therapist's inability to empathize with client's "normal" response to "abnormal" events, failure to clarify different aspects of the client's stories or to facilitate a full account of the client's experience, and premature or inadequate closure of the interview process. During countertransference, therapists may begin to favor or disfavor clients because the clients are perceived as similar to significant people in the therapists' life. In working through countertransference, therapists may experience some unconscious and unresolved issues of their own. If therapists fail to recognize the operation of countertransference, therapy may not be effective (Boehnlein et al., 1998; Kinzie & Boehnlein, 1993; Pearlman & Saakvitne, 1995; Wilson & Lindy, 1994). Because of the emotional intensity of this type of therapeutic relationship and the vulnerability of the clients, it is imperative that therapists become aware of and be on guard against crossing the boundary between personal involvement and professional caring.

In discussing countertransference, Wilson & Lindy (1994) described two major kinds of emotional reactions experienced by therapists who work with traumatized individuals. These reactions are (a) overidentifying with the clients' issues on the one hand, and (b) avoiding or withdrawing from the clients on the other. Consistent with Wilson and Lindy's discussion, a survey of psychiatrists who work with traumatized refugees reported some major countertransference reactions in their professional and personal lives (Kinzie & Boehnlein 1993). These authors reported that the most common professional experiences were an excessive identification with clients, sadness, depression, anger, irritability, a hyperarousal state and intolerance toward clients with less stressful lives than traumatized refugees. Personal reactions included a sense of (a) intolerance for all violence, (b) vulnerability, and (c) resentment against non-caring societies that allow such violence to happen. In another study of 122 psychotherapists, Van Wagoner, Gelso, Hayes & Diemer (1991) found that therapists reacted to clients' transference issues and clients' demonstration of intense negative emotions by becoming angry and detached.

Catherall and Lane (1990) have discussed the impact of countertransference on therapists who are themselves Vietnam veterans treating other trauma survivors of the Vietnam war. They contend that therapists' coping strategies associated with the two roles of warrior and therapist can create internal conflict in the therapists. The veterans therapists may become unempathic and insensitive to the clients' painful stories. On the other hand, therapists may become overinvolved with veteran clients, and lose their objectivity. Brief experiences of countertransference reactions are considered as therapists' humane response; however when they become a long-term pattern of adaptation they can become counterproductive (Kluft, 1989; Pearlman & Saakvitne, 1995; Wilson & Lindy, 1994).

Summary. Recognizing that VT may be a response to working with clients who have experienced trauma, it is important to know what therapists can do to protect

themselves and prevent the potential debilitating stress that accompanies working with clients' unique and challenging issues. For anyone working with survivors of trauma, including therapists, there appears to be a need to develop a greater awareness of the negative impact of trauma therapy. Moreover, it is vital to develop and/or enhance coping strategies that can prevent, minimize or manage stressful experiences associated with vicarious trauma.

Therapists and Coping with Vicarious Trauma

Although the evidence of VT as a major source of stress for professional caregivers working with trauma survivors is now widely recognized, the nature of coping with VT has only recently been investigated by researchers (Cerney, 1995; Dutton & Rubinstein, 1995; Dyregrov & Michell, 1992; Pearlman, 1995). One study by Dutton & Rubinstein (1995) suggested two categories of personal and professional coping strategies of individuals working with trauma survivors. Examples of personal strategies are "taking time " to play in addition to work, developing a network of emotionally supportive personal relationships, taking time for self exploration, attending to personal needs, and utilizing personal therapy as a means of coping with the effects of working with traumatized clients. On the other hand, professional coping strategies include using peer supervision and consultation, working with others rather than in isolation and diversifying one's professional practice. The authors also suggested that the personal histories of the workers (e.g., previous experience with abuse) may influence both their reactions and learned ways of coping with vicarious trauma. In another study with emergency personnel, Dyregrov and Michell (1992) reported coping strategies such as distracting activities in order to restrict reflection, consciously suppressing their emotions while interacting with the client, actively avoiding thinking about the ramifications of the event, and limiting exposure to stressors. However, neither one of these studies investigated the extent to which these strategies were effective.

Other researchers have developed some guidelines and recommend various approaches for coping with VT (Cerney, 1995; Pearlman & Saakvitne, 1995; Saakvitne & Pearlman, 1996; Yassen, 1995). They suggest three groups of coping strategies at the personal, professional and organizational levels for self-care and prevention when dealing with traumatized clients, based on suggestions by trauma therapists and responses to questionnaires.

Personal Coping Strategies

Coping strategies at the personal level aims at preventing or managing the negative effects of VT that may be manifested at the physical, cognitive, interpersonal, behavioral and spiritual levels. These strategies may involve physical and psychological activities. Physical strategies may consist of basic self-care and self-nurturing activities such as physical exercise, massage, warm bath, adequate sleep and nutrition. Psychological strategies may involve maintaining a life balance through relaxation (e.g., downtime), contact with nature (e.g., gardening), engaging in artistic and creative activities (e.g., writing poetry and cooking), spiritual practices (e.g., meditation and self-reflection) and developing/enhancing skills such as time management, cognitive restructuring, interpersonal communication and assertiveness (Yassen, 1995).

Pearlman & Saakvitne (1995) suggested four personal strategies including identifying disturbed schemas, maintaining a personal life, using personal psychotherapy and identifying healing activities. Identifying disturbed schemas involves therapists' efforts to learn more about their own sensitive need areas that are troublesome and difficult to deal with. These need areas are generally related to safety, trust, esteem, intimacy, and control as identified in CSDT (McCann & Pearlman, 1990). Maintaining a personal life can be accomplished through balancing between work, play and rest. Using personal psychotherapy can help by enabling therapists to explore and focus on their own psychological needs and their origins. Finally, healing activities such as creative arts, keeping a journal, traveling, listening to music, and spending time with family, friends

and children can serve as helpful coping strategies. Both Yassen (1995), and Pearlman & Saakvitne (1995) suggested that performing community service and engaging in political and social activism or in non-trauma volunteer work may provide the therapists with an outlet to counter their inability to undo the traumatic event and overcome their feeling of helplessness.

Professional Coping Strategies

In the professional realm, many activities are suggested to overcome the effects of VT (Cerney, 1995, Pearlman & Saakvitne, 1995; Yassen, 1995). One professional strategy is arranging supervision and ongoing consultation with an experienced trauma-therapist. Professional consultation is particularly important for those with a personal trauma history since it provides them with a safe and supportive relationship where they can explore and share issues and concerns. Another strategy is to develop professional connection by attending workshops and meeting with colleagues to share coping strategies. The development of a balanced work is also recommended: limiting the number of sessions or the number of trauma clients in a day, spacing of sessions throughout the week, making time for collegial contact, balancing clinical work with other activities such as teaching, research, writing, and even taking a sabbatical from trauma work. Finally, professional strategies may involve setting boundaries and renewing oneself by remaining aware of the importance and meaningfulness of one's work with traumatized clients (Pearlman & Saakvitne, 1995).

Organizational Coping Strategies

Although personal and professional strategies have been discussed by many researchers (e.g., Chestman, 1995; Dutton & Rubinstein, 1995; Pearlman, 1995; Pearlman & Saakvitne, 1995), there is a paucity of information on organizational strategies. This may be due to the fact that organizations are still unaware of the problems associated with VT and have not yet carried out any substantial measures to overcome them. Pearlman & Saakvitne (1995) suggested three organizational strategies

including (a) providing a comfortable, and private therapy office, (b) arranging for adequate resources for professional development, opportunities for regular supervision and consultation, and (c) developing adjunctive services such as access to medical professionals, self-help groups, newsletters, books and films.

Summary. With our awareness of the negative impacts of trauma work, it is vital for caregivers to initiate plans and activities to deal with its effects . Therapists who work with survivors of trauma need to actively take preventative measures in order reduce their vulnerability to VT. Personal, professional and organizational coping strategies suggested here are designed to minimize the potential negative impacts of VT. The extent to which these strategies are effective in counteracting VT are discussed in the following section.

The Effectiveness of Coping Strategies

Only a few studies have investigated the extent to which coping strategies have been effective and helpful in dealing with VT (Chestman, 1995; Pearlman, 1995; Schauben & Frazier, 1995;). In one study, Pearlman (1995) surveyed 117 psychologists about the extent to which 24 activities were helpful in coping with the effects of VT. She found that taking vacation, social activities, and emotional supports from colleagues ranked first, second and third respectively as helpful activities. Journal writing and yoga were reported as the least helpful among these 24 activities. Among other findings, socializing, exercising, spending time with family were more helpful than engaging in social justice activities and massage.

In a study of female counselors working with sexual violence survivors, Schauben and Frazier (1995) classified coping strategies into the most and the least frequently used categories. The most frequently used strategies included active coping such as focusing on doing something about the problem, seeking emotional support from friends or relatives, planning for taking actions, seeking instrumental support by asking other's advice about what to do, and humor. On the other hand, the least frequently employed

strategies were alcohol or drug use, denial in believing that the trauma has happened and getting involved in behavioral disengagement (e.g., I can't deal with it and I quit trying).

Finally, in a survey of therapists belonging to three psychological associations Chestman (1995) found that coping behavior varied with percentage of trauma clients in the case load. Those therapists with higher ratio of trauma clients talked less to family and friends about work but attended more conferences and were involved in other professional activities. Chestman suggests that increased professional activities by the therapists could be considered as an attempt to have a sense of community while protecting significant others from exposure to secondary trauma.

Summary. Trauma literature indicates that trauma therapy can affect therapists negatively and that its effects are different from those related to general psychotherapy. Psychotherapy with traumatized clients places special demands on therapists and can create conflicting thoughts and feelings. Listening to clients' traumatic stories can trigger distressing and frightening emotions such as sadness and anger in therapists. The process of empathy and countertransference can increase therapists' vulnerability to VT and influence their objectivity. Therefore, therapists need to be aware of their own emotional reactions and find helpful and effective ways to manage various vicarious responses to trauma.

The Current Study

This review reveals that literature on trauma therapy is framed in terms of psychological and coping responses to traumatized clients in general and traumatized sexual abuse in particular. The experience of VT and coping strategies among therapists working with other population of traumatized clients has not been addressed adequately. For example, there is little research on therapists working with traumatized refugees who are survivors of torture. It is important to differentiate between types of trauma and explore the experiential effects of VT among therapists accordingly. In order to increase our understanding of the meaning of the phenomenon of VT from the perspective of

those therapists experiencing it, a phenomenological study that focuses on the personal experience of therapists working with survivors of torture was undertaken.

While VT can influence caregivers working with any traumatized population, this thesis focuses on therapists' experience of working with refugees who are adult survivors of organized violence and torture. This group of traumatized individuals have come under pressure to escape physical, psychological, economical and political threats to their survival (Lefley, 1989). Similar to other immigrants, these sub-group of refugees have experienced "culture shock", the clash between their norms and values and those of the host culture (Williams & Berry, 1991). However, striving to settle and adjust to their new environment, they must also cope with stressful experiences of violence, trauma, and loss in the home country.

Given the unique situation and experience of refugees before, during, and after fleeing from their homes, many of them tend to be highly stressed and traumatized. Therefore, they may require particular attention and empathic understanding from a multidisciplinary team of caregivers who can aid them to work through the negative psychological, physiological, social and spiritual effects of their trauma (Supply & Service Canada 1988; Vesti & Kastrup, 1994). Members of such a multidisciplinary team may themselves be at a high risk for experiencing VT due to the stressful nature of their work (Arvay & Uhlemann, 1996; Figley, 1995; McCann & Pearlman, 1990). Questions are raised whether therapists counseling clients who are survivors of torture are impacted by their work: How does working with refugee clients who are survivors of torture affect therapists and how do therapists cope with its effects? It is hoped that this thesis explores these questions and contribute to this very important research area.

Summary and Conclusion

The main aim of the present chapter was to review research on stress and coping among caregivers, particularly mental health professionals working with traumatized clients. Theoretical and research background on stress and coping was presented.

Although theorists have originally conceived stress as a stimulus or as response, more recent development in the stress area has emphasized a transactional approach in which the interaction between the individual and the environment is taken into consideration. The transactional perspective brought about the concept of cognitive appraisal of both the stressful situation and the resources available to the individual to cope it. Two types of coping were discussed: Problem-focused coping which deals directly with the stressful event and emotion-focused coping which involves efforts to manage the emotional distress related to the situation perceived as stressful. The question of the degree of effectiveness of different coping strategies was also explored.

The review of studies on stress and coping was followed by the discussion of occupational stress. One type of occupational stress is burnout which involves physical, emotional and mental exhaustion as a result of job involvement. Signs of impairment of the care-giver are cynicism, depression, loss of intimacy with friends and family, loss of motivation and detachment.

Another type of occupational stress is vicarious traumatization experienced by care-givers including therapists. Although it is recognized that trauma survivors may experience PTSD, little attention has been given to those who are vicariously traumatized by their contact with the trauma survivors including therapists. A major theory that helps to explain VT is the constructivist self-development theory which suggests that trauma work may disrupt the therapists' sense of identity, world-view and spirituality as a result of a discrepancy between therapists' cognitive schema and that of the client. Finally, studies reviewed in this chapter dealt with the coping strategies used by professional helpers to manage the effects of VT such as personal, professional and organizational strategies.

Overall, review of the literature indicates that although there has been increasing awareness of issues related to the effects of, and the coping strategies to deal with VT, there is little research on therapists dealing with refugees who are survivors of torture.

The following chapters report findings from the current study that explored the experience of VT and coping with its impact among therapists working with a sub-group of refugees who are survivors of torture.

CHAPTER THREE: METHODOLOGIY

Research Design: A Qualitative-Phenomenological Method

In this chapter, the methodological framework of the study which was based on the qualitative-phenomenological methods is outlined and a description of the research process and method of analysis is provided. Although there are a variety of research frameworks and methods to facilitate a researcher's inquiry for a phenomenon, the nature of the inquiry influences a researcher's choice of a particular method. My quest for exploring the experience of "support providers" to survivors of torture and their ways of coping reflected my desire to create an atmosphere that would allow for an in-depth exploration of therapists' experiences with VT. A qualitative-phenomenal research perspective was chosen in order to focus on the subjective meaning participants attributed to their experience of VT and coping; that is how the phenomenon was experienced (structural description) and what was experienced (textural description) by participants (Berg, 1998; Creswell, 1998; Moustakas, 1994).

Two of the most central tenets of phenomenology are (a) the quest to understand human experience, and (b) the importance of knowing the experience in a holistic fashion. In employing a qualitative-phenomenal perspective, my overall goal was to achieve authentic and accurate descriptions of the participants' experience which had a meaning within their specific situation or context. According to Gama (1992),

> Qualitative research might be defined as a general term encompassing a variety of strategies for investigations carried out in the natural environment, dealing with information that is not reduced to its numerical magnitude, presenting findings that are not described by quantification, and attempting to understand and describe the problem holistically and within its sociocultural context. (p. 4)

Such an approach to research focuses on narrative accounts, description, interpretation, context, and meaning, while attempting to understand the phenomenon from the participant's perspective (Berg, 1998).

Osborne (1994) pointed out that phenomenological method enables the researcher to investigate the human inner world and to explore conscious experience directly. In the present investigation, a phenomenological research design enabled me to inquire into participants' subjective experience of VT and to gain an appreciation of their unique coping strategies. In addition, it allowed for an in-depth exploration of participants' holistic experiences (systemic, integrated) to include emotional, cognitive, behavioral and spiritual domains at both the professional and personal levels.

In the area of VTresearch where there is little background information on working with particular group of traumatized clients, an exploratory research such as the present one was important because it provided experiential data from the therapists themselves. A qualitative-phenomenological approach was deemed appropriate for the present study since previous investigations have not carried out a study of the coping strategies of therapists dealing with traumatized refugees who are survivors of torture.

Role of the Researcher and the Participants

One of the significant characteristics of qualitative research is the relationship between the participants and the researcher. The nature of the researcher-participant relationship in qualitative research has an important impact on the collected data and its interpretation. It is suggested that the researcher and the participants influence each other in varying degrees. In qualitative studies the researcher usually becomes closely involved in the participants' experience in order to be able to interpret their experiences. It is therefore necessary for the researcher to be open to the experience of the participants, rather than being influenced by her/his own perceptions. Participants also become involved by assisting in determining research questions, guiding data collection,

and interpreting data. This, in turn, provides more of a power-sharing partnership where the participants can also play an active and involved role (Marlett, 1998).

According to Creswell (1998), a phenomenological approach enables researchers to avoid preconceived ideas from their own personal experience or their previous knowledge because they can ask participants to describe as well as clarify their experiences (i.e., experiential meaning). Perhaps, it could be argued that since I am becoming a therapist, I was already entering from a certain set of a priori assumptions about the experiences of VT and coping with it. However, my argument is that my background helped me to establish an advanced empathic relationship with participants of the study and therefore, created a more genuine understanding throughout the research process. My assumptions, perhaps, mirrored more appropriately the experiences of the participants. Thus, I was not only making my predisposition clear, I was also engaging in an intimate understanding of similar and yet unique experiences which assisted the interviewees to become more forthcoming about their experiences with VT and coping.

Summary. The phenomenological approach allows researchers to explore the meaning of a phenomenon for the individuals who have had the experience. In addition, it allows participants to share a comprehensive description of their experience. Since the aim of this inquiry was to explore the experience of therapists working with survivors of torture, a phenomenological method seems particularly suitable. In the following sections, I have summarized the major procedural steps of this study including, characteristics of participants, procedures for selecting participants, interviewing procedures, data analysis procedures as well as issues related to credibility of the research design.

Participants of the Study

A sample of 10 professional mental health practitioners including 2 men and 8 women were recruited on a voluntary basis. Among these participants, five were clinical psychologists, three social workers, and two counselors. The average age of the

participants was 39.7 years, ranging from 28 to 53. Participants were members of a multidisciplinary voluntary team who have provided consultation and therapeutic counseling services to a traumatized sub-group of refugees who are survivors of torture. Participants have been affiliates of the Host Support Program (HSP) for Survivors of Torture and Organized Violence which is sponsored by the Calgary Catholic Immigration Society (CCIS). The accessibility of these caregivers, their willingness to take part in the project, their mental health related background and, most of all, their prior therapeutic interaction with a survivor of torture-related trauma determined the nature of the sample of the present research project. The participants were given pseudonyms and code numbers from one to ten in order to protect their identities. Table 1 provides demographic characteristics of the therapists in the study.

It is important to point out that participants' professional work is not exclusively in the field of trauma to deal with traumatized clients. Some of refugee clients were referred to them because they were displaying PTSD symptoms, while others were accidentally identified during the therapy for other presenting issues.

Procedures for Selecting Participants

A general invitation letter was forwarded to immigrant surveying agencies and other practitioners known to the HSP for Survivors of Torture in Calgary, Canada (Appendix A). The letter invited community-based volunteers and professionals to participate in the study entitled "Providers of Support to Survivors of Torture". Interested individuals were asked to contact the coordinator of the HSP or the principle investigator directly and indicate interest in participating in the study. A total of 15 volunteers and mental health practitioners were recruited to participate in the study. Out of the 15 individuals (5 volunteers and 10 professionals) only the experiences of the ten professionals who took part in the study are reported in this thesis.

Upon recruitment, participants were phoned by the principle investigator or the researcher assistant (the author of this thesis) in order to set up an interview timetable

Table 1

Demographic Characteristic of the Participants

Pseudo-name	Profession	Work Setting	Years in Practice	Number of SOT Clients	Sex	Age	Continent of Birth
Mary	Social Worker	CCA	11	5-10	F	42	North America
John	Psychologist	Private Practice	20 +	15-20	M	53	North America
Heather	Psychologist	Private Practice	10	1-5	F	48	North America
Susan	Psychologist	Government	4	N/A	F	41	North America
Debra	Psychologist	CCA	11	20-25	F	35	Central America
Jim	Psychologist	CCA & Private Practice	22	40 +	M	48	Eastern Europe
Joan	Social Worker	CCA	5	20-25	F	28	Eastern Europe
Rose	Counselor	CCA	7	1-5	F	38	Eastern Europe
Betty	Counselor	CCA	2	5-10	F	35	Asia
Kathy	Social Worker	CCA	7	40+	F	29	North America

Note. CCA= Community Counselling Agency

SOT= Survivors of Torture

and designate locations. Each participant was also mailed an interview protocol (Appendix B), two copies of a consent form, one of which was to be signed and returned to the principle investigator (Appendix C). A demographic questionnaire was also included asking them to indicate their age, sex, country of origin, professional specialization, work setting, number of years in professional practice and an estimated number of survivors torture clients they worked with (see Appendix D). All interviews were conducted in either the participants' offices or an office at the University of Calgary.

Interviewing Procedure

Data were collected primarily through one-to-one interviews. Each participant was interviewed once, for a duration of 1-2 hours. The exact duration of each interview was initially set for one hour; however, there were no actual time restrictions and the length of each interview was determined by the amount of interaction between the researcher and participant. All interviews were audiotaped. Although follow-up interviews were outlined in the letter of invitation, the participants or the researcher made no request for such interviews. Interviews began in October 1987 and ended in May 1988.

Semi-structured interviewing was chosen as the primary data collection method since it was well suited to this exploratory study where the goal was discovering rather than verification, prediction or establishment of causal relationships (Creswell, 1998). This approach was also appropriate for providing detailed accounts of participants' experiences while allowing the researcher to maintain some framework of organization, preventing a "mish-mash" of information that lacked coherence. According to Kvale (1996) semistructured interview design ".... has a sequence of themes to be covered, as well as suggested questions. Yet, at the same time, there is an openness to changes of the sequence and forms of questions in order to follow up the answers given and the stories told by the participants" (p. 124). This is compatible with a phenomenological interview which involves an informal, interactive process that utilizes open-ended questions.

Open-ended questions and prompts enabled participants to make detailed comments about their experience with VT and coping.

An interview guide (questionnaire) developed by the principle investigator was used during the interview. It indicated the general topics to be covered in sequence of appropriately worded open-ended questions in order to obtain participants' insights into their work. For example, broad questions, such as the following helped to facilitate obtaining substantive descriptions of the participants' experiences: Describe what is rewarding to you about working with clients who are survivors of torture; describe your reaction of being affected by the survivor's experience of trauma; and what have you found to be helpful coping strategies for working through difficult experiences in working with survivor clients? Participants were given the freedom to elaborate or digress from the interview protocol if they desired to do so.

It was important that participants were able to talk about their experiences in a relaxed and supportive setting that encouraged candor (Kvale, 1996). Therefore, determining whether I should reflect meaning, or predominantly use the soliciting skills of questioning and probing was a constant struggle for me throughout the interview. However, it became clear during the interview, that an influential guiding force was my authentic attempt to listen intently to what they were saying.

During the interview, in addition to the open-ended questions, each participant was also shown two tables adapted from Yassen (1995), that highlighted various symptoms of secondary traumatic stress reported by therapists working with traumatized clients. These symptoms were categorized according to their cognitive, emotional, behavioral, spiritual, interpersonal and physical effects. Participants were asked to review the tables and indicate whether they had experienced some or all of the listed symptoms. Tables were shown to participants in order to understand their experience of VT and various symptoms associated with it.

Each interviewee was provided with a context for the interview by a briefing before the interview and a debriefing afterward. During the briefing period the interviewer described the purpose of the interview, the use of a tape recorder, and answered participants' questions and concerns such as confidentiality issues or availability of the recorded materials to them. Debriefing provided participants with opportunity to bring up issues they may have been thinking about or concerned with during the interview. For example, two participants were concerned about their expression of emotions such as crying during the interview. During the briefing and debriefing period, the tape recorder was turned off.

Analysis of the Data: Interview Analysis

According to Moustakas (1994) phenomenological data analysis proceeds through the methodology of reduction, the analysis of specific statements and themes, and a search for all possible meanings. Therefore, attempts were made to present the textural (what) and the structural (how) meanings of participants' experiences in brief descriptions that represented the experience of all the participants in a study, while setting aside all prejudgements of the researcher's experiences. As Creswell (1998) stated:

> Phenomenological analysis requires the researcher to state his or her assumptions regarding the phenomenon under investigation and then bracket or suspend these preconceptions in order to fully understand the experience of the subject and not impose an a priori hypothesis on the experience. (p. 277)

All material on the 10 tapes from the interviews were transcribed verbatim by a professional transcriber, resulting in 229 pages of transcription. Verbatim transcription conveyed the context of the conversation and provided as much detail and meaning as possible. Each tape was identified with the date of the interview and interviewee's assigned code number and pseudonym in order to safeguard confidentiality. The

transcriber was instructed to include in the text nonverbal communications, such as laughter or pauses in conversation in order to capture participants' affective expressions. In order to retain the meaning of the text, no editing or censoring of the material took place during transcription. The format of the transcript that included numbering of each line of the transcripts helped to organize data and facilitated reading them and referring to them later on. Each transcript was then read in attempt to begin the process of phenomenological data analysis as outlined by Kvale (1996), Creswell (1998) and Moustakas (1994).

Coding by Topic

Coding by topic was a useful way to start data analysis since it allowed a large amounts of data to be organized into manageable and meaningful topics. Coding is "assigning tags or labels to the data, based on our concepts. Essentially, what we are doing is condensing the bulk of our data sets into analyzable units" (Coffey & Atkinson, 1996, p. 26). However, before coding the statements of participants, I started a preview of the entire data set by reading the 10 interview transcripts in order to become familiar with their contents with no preconceived ideas. Another purpose of the preview of the entire data was to find some order in the interview transcripts. Reading through all transcripts provided me with a sense of the overall data. At the same time, I wrote reflective notes in the margins of the transcripts in order to help me in the initial stage of exploring the database and interpreting possible meanings of different statements (e.g., whether the material is relevant or irrelevant to the questions I raised in the study). My notes included key concepts that were described throughout the pages of the interview transcripts and identified different topics including both the experience of VT and attempts to cope with it. Throughout the interviews I also kept a personal journal recording my observations and reflection about participants' issues (e.g., participants' deep desire to share their feelings of hurt and disgust at perpetrators or respect and

admiration for survivors). My journal was a collection of reflections that helped me to understand my personal responses to hearing the participants' narratives.

Horizonalization of Data

The second step of analysis involved the process of *horizonalization* of data. During this process I identified statements in the interviews about how participants were experiencing VT and how they were coping with its impact (describing the meaning of their experience). Coded portions of the interview data were used for the textural descriptions (of what was experienced) and the structural description (of how it was experienced). I then developed a list of these statements eliminating repetition and overlap. The next step involved capturing the meaning (essence) of what the interviewee had described. During this difficult and critical step, I was able to discern relationships, patterns, and themes that ran throughout each transcript. I began this process by reading, rereading, and reflecting upon the significant statements in order to obtain the meaning of the participants' statements and to develop thematic statements from the content of the interview data. Then, the contents of interviewees' statements were sorted out into "meaning units". These meaning units were directly related to research questions and were identified in the narratives of each participant. They were statements, phrases, or short sections of text that represented participants' experience of VT and their methods of coping. The selection was then paraphrased to capture its underlying meaning. The aggregate of formulated meanings was organized into clusters of themes. These clusters represented themes that had emerged from and were common to all of the participants' descriptions. Three clusters of themes were identified as follows:

1. Motivation factors for working with survivors of torture.
2. Impact of working with survivors of torture
3. Personal and professional coping strategies

Pertinent data from each transcript related to identified themes were then summarized in a table format. As a final validation, a copy of participants' transcribed

interview and a summary of themes related to their interview transcripts was mailed to participants in order to make sure that I had fully captured all points that were most important to them. All participants responded positively to the summaries and, therefore, there was no need for clarification, addition, deletion or further interviews.

The final stage of analysis involved narrowing the focus of the analysis to the experience of VT and ways of coping. Therefore, contents of the interviews were further clustered into common sub-themes from which this author organized narrative descriptions.

In sum, recognizing that there were different approaches to qualitative analysis, and that I was guided to some extent by the conventions within my own academic discipline, the texts I studied, and my previous personal experiences, it was important to adapt systematic and comprehensive approaches as the needs of this research data suggested rather than attempt to follow any single approach rigidly. It was also important that the analysis of the research method provided order and credible rigor to the data.

Credibility of the Study

> The question of validity is one of meaning: Does the ultimate depiction of the experience derived from one's own rigorous, exhaustive self-searching and from the explications of others present comprehensively, vividly, and accurately the meanings and essences of the experience? (Moustakas, 1990, p. 32)

Qualitative research has been often criticized for not adhering to traditional norms of reliability and validity. However, establishing their own terms and procedures, methods for reliability and validity have been always used in qualitative research (e.g., Eisner, 1991; Lather, 1993; Lincoln & Guba, 1985; Richardson, 1990; Wolcott, 1994). For example, Lincoln & Guba use terms such as 'credibility', 'transferability', 'dependability' and 'confirmability' in order to establish the trustworthiness of a study; they used them to replace the familiar terms in quantitative research of 'internal validity',

'external validity', 'reliability' and 'objectivity' respectively. Creswell (1998) used the term verification to describe validity and reliability to underscore "qualitative research as a distinctive approach, a legitimate mode of inquiry in its own rights" (p. 201). He views "verification as a distinct strength of qualitative research in that the account made through extensive time spent in the field, the detailed thick description, and the closeness to participants in the study" (p. 201).

Thus, qualitative research does not dismiss reliability and validity, but attempts to put them in a broader perspective. Even though qualitative research uses different terminology, Creswell (1998) identifies and discusses eight verification procedures. Creswell recommends that in qualitative research at least two of these eight procedures should be used in any given investigation. In the present study, I made many attempts to ensure the verification or the trustworthiness of the data by following a number of these procedures. According to Creswell, in a procedure termed "member checks", the researcher seeks the participants' view for the credibility of the data. Participants of this study were provided with their original transcription of the interview and a summary of their points of view categorized by identified themes. They were asked to verify accuracy of the meaning of their experiences and whatever that was felt to have been missed. Moreover, similar to the "triangulation" procedure in which multiple sources are used to corroborate the evidence, the data were derived from participants representing various types of professions (psychologists, counselors, social workers, researcher and academician who worked in different settings such as private practice, public agencies and a teaching institution). Furthermore, participants were not restricted by a stringent time limit during the interview and were subjected to "prolonged engagement" in order to establish rapport and trusts. This in turn enabled me to obtain "rich, thick description" of the experience of VT from participants and the methods they used to cope with it.

Summary. Ultimately, however, the reader determines the trustworthiness of the data by becoming a critic (Eisner, 1991). In critiquing the text, it is important for the

reader to revisit the purpose of the research inquiry. One major purpose of this inquiry was to deepen the reader's understanding of the meaning (experience) of VT and coping with its effect from the perspective of therapists who work with survivors of torture. The aim of this inquiry was also to contribute to the existing knowledge of the coping strategies used in dealing with VT. Hence, as you become engaged in reading this thesis you may ask the following questions: Does the research make sense? Does it explore and discuss the phenomenon from a balanced perspective including relevant literature and lived experiences of participants? Is the data thoughtfully and comprehensively interpreted? Are the concepts clear and understandable? (Eisner, 1991).

In the following chapter the findings and analysis of the interviews are presented in the form of thematic descriptions supported by quotations from the participants.

CHAPTER FOUR: PRESENTATION OF THE FINDINGS

A major goal of phenomenological inquiry used in the analysis of the present study is to explore and understand the phenomena and identify, through thematic analysis and description, the essential structures (common framework) and meaning of the experience of participants (Creswell, 1998). Therefore, my primary aim in this chapter is to describe identified themes that may illuminate on the meaning of VT and the methods of coping used to counteract its negative impact on participants of the study. I will use excerpts from participants' transcripts in order to support identified themes. The excerpts have been edited by omitting pauses, repetitions and other idiosyncrasies, but the wording of the participants was kept intact. I will also provide comments and information in parentheses to indicate emotional expressions such as laughter and crying of participants. When required, I present my personal comments in brackets in order to clarify ambiguous statements.

In general, narratives provided by professionals participating in this study demonstrated diverse reactions, challenges and experiences, which illustrate common themes about various aspects of VT. These themes provided a common framework for the experience of the participants. An analysis of the discourse identified the following three themes that represent the participants' experiences of working with survivor clients:

1. Motivating factors for working with survivors of torture.
2. Impact of working with survivors of torture.
3. Personal and professional coping strategies

Within each of the main themes, sub-themes were also identified. These themes and sub-themes are summarized in Table 2. In the following section, the thematic descriptions and supporting statements from the participants interviews are presented.

Table 2

Themes and Sub-Themes Emerging from Participants' Transcripts

Theme I. Motivating Factors for Working with Survivors of Torture

- Professional responsibility: Helping as a therapist
- Social and human responsibility
- Ethical-moral responsibility
- Personal and professional enrichment

Theme II. Impact of Working with Survivors of Torture

- Preliminary Effects
  - Impact on the professional level
  - Impact on the cognitive level
  - Impact on the emotional level
  - Impact on the spiritual and Religious level
- Symptoms of Secondary Traumatic Stress
  - Cognitive symptoms
    - Flashback of images
    - Diminished concentration
    - Self-doubt
    - Whirling thoughts
    - Confusion
  - Emotional symptoms
    - Feeling shock
    - Anger & rage
    - Powerlessness, anxiety, sadness & depression
    - Guilt, shame & helplessness
  - Behavioral symptoms
    - Nightmares
    - Impatience
    - Exhaustion

(table continued)

Table 2 (continued)

Physical symptoms

Stomach pains, headache & rapid heartbeat

Spiritual symptoms

Questioning the meaning of life & anger at God

Theme III. Personal and Professional Coping strategies

Problem-Focused Coping Strategies

Establishing boundaries
Seeking instrumental support
Using proactive strategies

Emotion-Focused Coping Strategies

Self-care and self-nurturing behaviors
Seeking support for emotional reasons
Turning to religion and spiritual activities for support
Focus on emotions and venting of emotions
Emotional distancing
Acceptance
Positive reinterpretation
Mental disengagement
Behavioral disengagement

Motivating Factors for Working with Survivors of Torture

In this section, I present participants' response to my inquiry about their motives for working with survivors of torture clients. For all participants, this work appeared to be more than simply doing a job. They were motivated by other factors such as a sense of deep understanding for, and moral and personal responsibility to do something about their clients' pain and suffering. Representative statements from the interview transcripts revealed that motives underlying working with survivor clients consisted of both commonalties and differences from one participant to another. The following citations from the discourse of participants indicate four primary motives, including (1) professional responsibility, (2) social and human responsibility, (3) ethical-moral responsibility, and (4) personal and professional enrichment.

Professional Responsibility: Helping as a Therapist

As I listened to participants, I realized that a major aim of the therapists in working with survivor clients was to help them to deal with their psychological scars and move forward as effectively as possible. Participants used their professional knowledge, skills and commitment, in addition to their high levels of energy and enthusiasm, to help their clients manage and overcome their emotional and spiritual pain.

> There is such an overwhelming need, and the pain is powerful: It is like wanting to stop the bleeding. **-John**

> I guess what holds me in this kind of work altogether is helping people find ways out of their pain. Their dilemma is very intriguing to me. **-Mary**

> Helping someone who really needs the help of the counselor ....they came here as refugees and they are scared and they don't know about the future, they are very insecure. **-Betty**

> When I see that they benefit in a strong way from the therapy. That is the thing I'm getting from this. **-Jim**

> Seeing people doing better....knowing that they are

> adapting in the new society. **-Joan**

> Well I think it was, like if I don't help them who will help them, and probably I just engaged in my helping role and I just couldn't say no, and of course it was tough once I started doing it. I just wanted to help. **-Debra**

Participants believed that therapists had a professional responsibility to find appropriate and creative ways of addressing survivor clients' issues. Their professional commitment reflects themes of liberation that lead to outcomes of resolution and hope for clients.

In addition to counseling, John provided professional assessment of refugees' mental health which was used for immigration purposes. His professional assessment was critical and could influence clients' refugee claims. Therefore, he experienced an overwhelming sense of responsibility to represent their situations in a sensitive and accurate manner.

> I know that my yakking is going to make the critical difference for the Board. I feel responsible. **-John**

Susan described her work as an extension of herself as a person. She believed that as helpers, we ought to put our actions where our beliefs are; otherwise it would be all just words. She was, however, clear about her helping goals that were in the client's best interest.

> Ensuring that the people that are experiencing these traumas access appropriate and adequate care and that has always been the focus of my work....That is a mandate within my work, within who I am; and I bring that into any position I enter into. **-Susan**

Although some of work-related motivations are universal and shared by most people when they enter the work force (e.g., to have significant impact, to be successful, and to be appreciated), some of the motivations are profession-specific and shared by the group of people who choose a particular profession. In addition, some of the motivations are personal and unique to the individual worker. As I reflected on participants' statements,

it became very clear that these professionals were highly motivated individuals who had chosen their career with high hopes and expectations of what their work could provide.

Social and Human Responsibility

In addition to their professional involvement, participants had voluntarily offered many hours of their expertise in counseling survivor clients through the Calgary Catholic Immigration Society's host support program. The tasks and activities to which participants were committed to, reflected who they were at a very deep level. They appeared to have come to their profession with visions of creating a positive difference in people's lives regardless of their cultural differences. The following statements indicate that their motivation goes beyond professional responsibility to achieve more social and humanitarian ideals:

> People have talked about this around sexual abuse for adults, they talk about this around rape....if you work around refugees you are going to become even more of an advocate, if your are working cross-culturally you are going to come up against the difficulties people have because of their cultural membership; and part of transforming to becoming an intercultural therapist means that you could take a social advocacy and you take on the force of people because of their collective experience within the mainstream culture. **-John**

Recognizing that everyone has a right to be secure from violence and abuse, participants moved closer to making real the vision of justice and equity for all. They believed that they had a social and human responsibility to change and stop violence.

> I don't think that we are an island here within Calgary, within Canada, within North America, things that happen around the rest of the world affect us deeply. And in fact, we are affected even more because of the fact that we have people from these countries who are being integrated into our society and, it is important to honor and share with them things that are important to them, including the fact that they have had to survive torture. **-Heather**

Participants were quick to acknowledge that with their professional role came responsibility and they described how they exercised their sense of duty.

> It is a social justice issue for me as well.... Ensuring that people have equal access to services and to participation in life, that they have equal access to public health outcomes; that they have equal access to freedom and opportunities to live a safe, non-violent life; and I think when they get to Canada physically maybe, they have those options, but I don't think psychologically they do and so in their minds they are still living in a violent world. And I think that is important not only for their own outcomes, but it is important for Canadian outcome, because people carrying that kind of thing can lead down to generations; it can lead them to antisocial behaviors and so it impacts all the way down the line, and that is what I mean by social justice, ensuring that these things don't impact negatively on those surrounding the people that are undergoing it, but also the people that are undergoing it themselves. **-Susan**

Participants believed that human rights were universal and they must be enjoyed by everyone, everywhere. They believed that by standing up for survivors, they were also standing up for themselves.

> As service providers we help our clients as well as fight against cruelties, trying to make the world a little bit better than it is. **-Joan**

Participants described moments of human connection as they witnessed pain and suffering. The social justice issues they dealt with, created strong sense of social and human responsibility to influence existing beliefs and practices.

Like other participants, Jim saw his helping role as instrumental in helping him to be an activist who could take some helpful steps towards wrongdoing of his generation and others in the society. Jim's sense of social and human responsibility was also mixed with guilt feelings.

> I didn't take a part in this war, and therefore it isn't my responsibility but in some way I feel that my generation, ...has something to do with this war....We didn't stop it,

> my generation, and in that sense I feel that it's my duty to help the people who went through that time. -**Jim**

Participants described their sense of concern based on the principles of compassion and caring, a genuine compassion based on respect for others and the realization that others have the right to be happy and overcome suffering. Participants could see the suffering of others and therefore developed a genuine sense of concern for their rights and welfare.

Ethical-Moral Responsibility

Like many therapists, participants chose their profession because they were hopeful about reserving human dignity and the possibilities for a better world. They believed that for change to happen in any community, the initiative must come from the individual. Therefore, they clearly saw their role as instrumental in making positive changes in the lives of clients. These participants saw work challenges as part of ethical-moral responsibility.

> To promote a kind of tolerance and understanding among different ethnic groups here....to help them establish connections...When you are a psychologist you just work with different kinds of problems, people that are suffering; that's your choice you made years and years ago. -**Jim**

Participants challenged themselves to see more sharply, to hear more clearly and to feel more empathically. They believed that it was important that they rededicate themselves to completing the circle of human rights.

> For me, as a Canadian to start to get my head around what people have experienced and some of the horror stories that they have experienced that I cannot possibly begin to understand; but I think it is important that we do at least recognize that they are there and that we've got to deal with it at some level. -**Susan**

Like others, John talked about his passion for peace, justice, and God, which has led him to step out in defense of those who were victims of violence and prejudice. He

believes that as therapists we have to commit ourselves to helping others. For him the act of helping is an extension of both moral and spiritual ethics.

> I feel that I have responsibility....I believe that we have the responsibility to live well in this world as imperfectly as we do that....for me, the spiritual path is very close to the path of action....so what I get out of it is the sense that I'm doing something that is proper. I guess that is very, very simplistic and may sound kind of moralistic...It is very much a personal ethics, a sense of personal ethics, it is a part that I take really seriously. **-John**

As I listened to the participants and reflected on their statements, it became clear to me that, beyond their professional responsibility they had a genuine purpose in life in making sure others live a fair life too.

Personal and Professional Enrichment

In addition to the negative impact of their work, participants also talked about a sense of enlightenment as they were challenged to find creative and new ways in order to help their clients. In many different ways they were able to rediscover their own strength when being confronted with issues that they had not faced before. Their work with survivor clients involved considerable amount of learning and growth. Furthermore, participants felt a sense of personal and professional satisfaction as they observed their clients adjusting to their new lives.

> Working with trauma makes me much better professionally, because I have to think deeper, I have to think faster, I have to have more precise solutions.**-John**

> It has been very enlightening and I think it has assisted me in being a better counselor in a lot of ways. Personal growth definitely is something that will impact on your ability to be a better clinician. **-Kathy**

Participants described their clients' levels of empowerment as they described their own. Paying attention to clients' adjustments and noting the positive impact they had on their clients' lives was a very enriching experience for most of the participants. They

found a lot of affirmation in what they were doing and experienced a sense of accomplishment and joy as they observed clients through their journey of healing.

> It is almost like they are in a hole....and once you see them coming out of there, that is rewarding for me. **-Debra**

> When they come back [after the therapy is over] and say 'thank you'....I feel that I am appreciated. **-Joan**

> It is a good challenge to work with them, to try to help them to return to their previous level of functioning. **-Jim**

One of the important aims of therapy that challenged participants was rebuilding survivors' trust in authorities. For Rose and Betty the real reward came when their clients began to trust them. They saw that with their help clients gradually dealt with built-up fear, anger, confusion and sadness, and emerged happier with more confidence and trust in others and themselves. The triumph of these clients was inspiring to them both in their professional and personal lives.

> The first sign of reward; it was some kind of shine, some kind of warmth in her eyes, and I remember after seven or eight sessions this lady told me, you know, I trust you now; after six or seven sessions, it was the first reward ...When this person became aware of her value again [value of trust] **-Rose**

> When you see change in your client's mental and physical health, that is rewarding. Helping the clients to trust other people's motives, in particular authorities motives, is one of the most challenging issues for the therapist. Therefore, when the clients begin to trust you and share their most inner experiences with you, you feel privileged and indeed rewarded. **-Betty**

Although researchers have tended to focus on the negative effects of working with traumatized clients, namely VT, participants described many different ways that their work lead to positive changes and personal growth. Both positive and negative effects, as a result of their interaction with survivor clients, have changed participants' attitudes about human potentials forever. For example, participants had become more aware of

the human resiliency and potential. Like other participants, Kathy was marveled by the ways that many clients faced their ordeal, and yet emerged on the other side as stronger people.

> The amount of human strength and resilience to overcome multiple traumata...the ability of these women to live a healthy and productive life, despite having come from tremendous difficult circumstances....seeing these women and their family grow, settle and start a new life in Canada has been a rewarding experience for me. -Kathy

Participants repeatedly indicated that working with survivor of torture clients was meaningful and enriching. They felt privileged to witness clients' strength and resilience through their healing process. Nevertheless, participants also described their struggles and difficulties as they worked with survivor client.

Impact of Working with Survivors of Torture

The second thematic clusters presented here concern the impact of working with survivors of torture. In this section, information is presented in two parts. The first part which I call *preliminary effects* includes participants' spontaneous responses to my inquiry about the impact of working with survivor clients. The second part is subtitled *symptoms of secondary traumatic stress* and provides excerpts of participants' responses related to their professional and personal experience of various symptoms at cognitive, emotional, behavioral, physical and spiritual levels.

Preliminary Effects

Although I originally asked the participants about the impact of their work with survivor of torture clients at the personal and the professional levels, their responses suggested that the personal and professional roles were interconnected; and it was misleading to describe them as two unrelated experiences. According to all participants, there really could not be separation between their jobs and their personal lives. The social justice issues they dealt with at work were part of their personal values.

The following excerpts present the impact of hearing graphic and painful stories of clients for participants. The impact tended to be on the professional, cognitive, emotional and spiritual levels. On the professional level, participants expressed how their lack of cross-cultural training and experience with refugees who are survivors of torture brought about a sense of doubt about their competency. On the emotional level, the traumatic stories of the clients, evoked feelings of helplessness, anxiousness and pain. Effects on the spiritual level, brought about a sense of renewal, a search for inner life, and an increase in reflection about the self and God. The cognitive effects included a change in the perception of the self and the world as well as a disturbance in cognitive schemas about the negative side of humanity.

Impact on the professional level. Participants talked about feelings of frustration and inadequacy when dealing with cross-cultural issues, role overload as well as conflicting feelings between professional role boundaries and personal values. The complexity of clients' traumatic responses and the challenges of understanding them in the clients' cultural context was overwhelming and difficult even for experienced therapists like Kathy, Jim, Joan, Debra and John who had worked with a relatively large number of survivor of torture clients. These participants and others with less experience felt the limitations of their intervention techniques and skills when counseling their culturally different clients. They believed that existing North-American template did not suit the needs of their culturally different clients.

> Our template that we use for Western White doesn't necessarily fit the cultures that we are going to be working with, more and more in the future. **-Heather**

> Lack of cross-cultural interviewing protocols, assessment protocols and counseling protocols. **-John**

Participants believed that when working with survivors of torture, the therapeutic approach could not be limited to one school of thought; rather, it must be based on the individual client's experience, losses, and needs within his or her cultural context.

participants discussed the need to develop a greater framework for understanding the issues of traumatized clients who are culturally different and in particular refugees who are survivors of torture.

> I find a lot of times the sessions can be very draining because I am really searching for, especially when it is in a cross-cultural context, I am searching very hard for what works for this person within their cultural context. **-Mary**

Nearly all participants dealt with the issue of professional competency and believed that therapists lacked adequate training, expertise and support to deal with the unique issues of refugees who have been traumatized with torture.

> I think that we have a very big issue on our hands in Calgary. We have a lot of families coming in from war countries and I don't think that a lot of us, including myself are appropriately trained and ready to deal with that and I think this is a challenge to the counseling community in Calgary. **-Kathy**

Participants were considerably challenged because there were so many factors that they had to take into account in working with survivor clients, which were different than in their traditional practice with other clients. They needed to be aware of all variables that were influencing their clients. For example, cultural value differences, clients' lack of trust, language barriers, and most of all the complexity of trauma therapy; all of that they had to take into account throughout the therapy.

> When this person doesn't trust anyone, has no language, it is one thing for us to get the information but it is quite another for us to make it safe for those individuals to actually see us let alone anyone else. **-Heather**

> There is a sense of overwhelmness when you are dealing with clients who have had multiple traumatic experience in a fairly long period of time. You ask yourself, where do I begin? Do I focus on the post- or current trauma? It is how you put the pieces of the puzzle together that can be very overwhelming professionally. It can also be overwhelming personally, because our work is extremely personal. People might say that, if they are very professional, it doesn't

affect them. I don't believe that at all (she chuckles). -**Kathy**

Participants frequently found themselves fulfilling different roles than of a supportive therapist in order to help their clients. For example, in addition to helping clients to deal with their emotional and psychological issues, Betty shifted roles from being a supportive counselor to a settlement and/or crisis counselor. She had to step out of her traditional supportive role and help clients with their basic and instrumental needs such as housing, medical care and employment. Subsequently, she felt overwhelmed with the additional and conflicting responsibilities.

> Before I could do the counseling I had to step out of my role as a counselor and help them with settlement issues....basically just like you work with a little kid. You have to hold their finger and I had to take them to places and hook them with other agencies. -**Betty**

Like Betty, Debra and Joan, other participants believed that their therapeutic approach had to be as involved and engaged as possible without violating therapist-client boundaries. However, keeping personal and professional values in harmony with professional boundaries was a challenge and at times a dilemma for participants.

> I cannot leave her until I help her to feel safe, until I ground her....These types of sessions took a lot out of me, and it is no wonder I felt burnout. I go home feeling like not doing anything and just sitting there on the couch and not making supper or look after my own kids. -**Betty**

> One of the things that has helped me is just being myself and not worrying about the old school of thought of not feeling, keeping a distance or not getting involved....you don't do anything when you do that. Like if you are yourself and you show them 'yes it was painful' and I can see your pain [crying]-**Debra**

> Not forgetting that I am a helper and in the first place, I must be in my mind not my heart. -**Joan**

At times most of us may find our attitudes and personality are incompatible with the expectations of our assigned roles. Maintaining personal and professional boundaries

was even a greater dilemma for Betty who provided house visits to some of her refugee clients. She continuously struggled with the major task of bringing her personal, political, and spiritual ideals into harmony with the boundaries of her job.

> I fall into situations where they really needed the help of the doctor and had no means of traveling, so I say to myself 'should I take the sick child to the hospital or should I say, you wait until I phone and ask someone from another agency come and take you there'. So it was always the dilemma of checking with myself and lots of times my personal side and not my professional side wins; so I drive them in my car knowing that I don't have special insurance to drive clients in my car. **-Betty**

All of the participants described a deliberate process of compartmentalizing their professional and personal identities; however, their personal feelings were not constrained by a compartmentalized professional identity. On the whole, the impact of being more personal and genuine in their work was described as satisfying and as a major contributing factor to their own personal and professional growth.

Impact on the cognitive level. As a result of their exposure to the realities of traumatic materials, participants experienced some internal strife including a disruptive and painful change of the perception about the self, others and the world. For example, their cognitive schemas about safety, trust and humanity were greatly disrupted by continuous exposure to the realities of people's cruelty to one another. Most of the time, they responded with a sense of disbelief and horror.

> I walk down the street or I notice people who I believe to be of a different culture....and thinking more on a level of 'gosh this person may be walking around with an incredible wound that perhaps can or cannot be touched....living in a country where the very people whom you should be able to turn to, to keep you safe from being battered in your own home....the very people who have in fact, violated and battered or tortured and killed you or members of your family. **-Heather**

> They were tortured so badly, they had electrical lines on their legs, they had hanged them upside down for

> twenty-four hours, they had constantly beaten them with a stick on their legs....and how that gives you a feeling of how people have to do this to the same mankind ?-**Betty**

The use of metaphor "digest" was Rose's unique way of describing her experience as a process that influenced her entire being. She needed ample time as well as conscious efforts in order to make sense of her new awareness.

> I couldn't believe that something like that could happen today. We are almost at the beginning of the 21st century and yet a human being can use rape as a tool to harm another human being....I needed time to just digest it....because your whole body, your whole life involved in that. -**Rose**

Participants found themselves paying more attention to their own values, and attitudes. They found that being exposed to a different world-view encouraged an openness to differences in values. They were challenged to reflect on their own assumptions about what it meant to be human. This included looking at many previously unexamined assumptions and values which they inevitably brought to their work but were challenged by their clients experiences. This personal exploration led to a greater levels of flexibility of their beliefs and values about a just world, human goodness, safety and security.

> This really challenges my view of the world, the idea that the world can be socially psychotic but an agreed upon thing in which, the most outrageous of that are utterly normalized, rewarded, paid for...how come people can do these profoundly destructive things and then apparently carry on as fairly normal human beings you know, in the absence of psychopathology, in the absence of craziness, how can these things occur? That to me is one of the big dilemmas. -**John**

> To hear someone talking about living in a country where even their very home and the very rights we take for granted are not honored. It is a whole other invasion, similar but different to someone who has had other kinds of trauma like sexual abuse. Boundaries that are crossed....people who live in countries where they can be tortured at any time or violated at any time....There is no heaven in other words. -**Heather**

Learning about, understanding, and working with survivor clients was a difficult professional and personal experience. How participants felt and how they viewed their survivor clients was very important in their work because it had an implication in how they viewed themselves, others and the world around them.

> There are people in this world that would be so cruel and would enact these sorts of things and yet there are people who survive it. So I think that is the hardest part for me, listening to the stories and seeing the struggle that people continue to go through given their experiences. -**Susan**

Working with survivor clients confronted participants with the harsh reality of human potential for committing atrocious acts. Participants described how their belief and values about a safe and just world was affected negatively and changed for ever. With their awareness came about a sense of vulnerability. It was evident that participants were affected deeply and experienced a variety of conflicting thoughts and intense emotions that were quite similar to those variously cited in the literature on burnout and VT. For instance, participants found themselves feeling shocked, angry, powerless, sad, guilty, and anxious and at times even numbed in reaction to the perpetrators of violence in the world. Consequently, they felt intense empathy for the pain survivors had to endure.

Impact on the emotional level. Therapy with survivors confronted participants with the harsh, painful reality of cruelty and inhumane acts. Counseling survivor of torture clients raised intense and complex feelings as well as a deep sense of empathy in participants. Yet, empathy became a source of vulnerability to emotional pain. Hearing survivors' painful stories as well as empathizing with them, participants experienced strong emotional reactions including disillusionment, shock, hurt and, anger at people and societies that could commit such horrible and atrocious acts.

> If you have any empathy, it hurts you at the very core of your being that is hard to talk about [long silence in order to manage emotions]. I sort of see myself as a pencil or an

> instrument through which people speak, so when I am talking to others, and I am relaying experiences that I have heard from people who have undergone torture or trauma and I am trying to get the message across and to let them know how this feels, I like to let them know in the words of the person; how they described it, and sometimes that is really difficult to get through; it is even difficult to read the words. Because it hits you in a place that is so deep and so painful that, I don't really know how to deal with that all the time. **-Susan**

> The torture, the bad times they went through....the physical torture....feeling that you don't belong anymore to the community because your spouse or your father or your mother or yourself belong to someone who is from the other religious group so people just look at you different; you are not accepted anymore, your personal values, your personality is limited to your ethnic background and it's, it's hard. **-Jim**

Participants spoke easily about the most difficult aspects of their job while working with survivor clients. For nearly all of the participants, memories of certain narratives brought about intense emotions of anger, sorrow, hurt, shock and fear.

> I find myself getting really angry at people who deny.... I have a hard time with people who deny even that it happens or that it matters **-John**

> At the beginning it was very hard because I also felt helpless. I felt that there wasn't anything I could do. I was almost taking the role they were taking. The role of 'oh I can't help you, oh I can't help her; but what do I do?' and then it affected me a lot like emotionally I would just go home and cry, cry, cry, cry. **-Debra**

> You can feel pain [emotional pain], you can feel it through your heart to your leg. **-Rose**

> The impact of these people's pain sometimes stays with you after you go home. **-Betty**

Feelings of disbelief, shock and fear was a common experience for participants as they listened to the stories of survivor clients. Listening to clients' horror stories of violence and torture created a sense of fear and vulnerability to violence in participants

> It is always shocking to hear the horrible things that happen to people. I don't think I'll ever get desensitized to that, and probably shouldn't anyway. -**Heather**
>
> It is a shocking moment to hear their stories. -**Joan**
>
> I was shocked the first time....how could this happen, how could somebody do this to another human being. - **Debra**
>
> Well I think it's always hard to hear the stories, to a certain degree....hearing about the atrocities that humans commit against other humans. Sometimes I have felt like..., I am a bit tense about going into the interview. It's like I don't know if I want to hear all of this awful stuff.... to work to bring them [clients]out of that depression and despair, to begin that , is very draining, you know. -**Mary**
>
> In the beginning I felt a sense of fear which I hadn't felt before. Living as women, we may feel fear for a variety of reasons. For example, fear of violence, or fear of trusting authorities in the case of a woman who has been assaulted. It was the awareness of what human beings are capable of doing that made me fearful. With my awareness came a sense of reality and vulnerability. I started to internalize my clients' experiences and say to myself 'my God what a horrifying situation,' so I had to work through those feelings as well. -**Kathy**

Becoming aware about other people's trouble and suffering will be more emotionally stressful if the trouble has personal relevance to the helper. As participants thought and felt "it could be me or my loved ones" they found it easier to empathize with the survivors as well as experience similar symptoms as their clients.

As participants experienced feelings of shock and disbelief, they became more aware of human vulnerability to violence. They experienced a deep sense of loss of their way of life. Subsequently, an increased attention and search for the meaning of life and suffering was a common experience for the participants.

Impact on the spiritual and religious level. Working with survivor clients stimulated a deeper encompassing self-reflection than participants' mainstream practices had. They

saw individuals who persevered in order to overcome their trauma and to reestablish their lives. They saw that over time, clients dealt with their fear, anger, confusion and sadness and emerged with more confidence, pride and happiness. Participants discovered that people can be more resilient than they had ever dreamt of. Subsequently they experienced a kind of spiritual transformation from feelings of sadness and anger to hope, joy and a renewed sense of purpose and meaning of life.

> I am always renewed by the incredible human spirit, the strength of the human spirit that I see, that people can go through these incredibly traumatic experiences and come out the other end and still be decent, loving individuals....when you are having your own rough days....to think about them in context of somebody who has had to walk for months across mountains to escape something in bare feet. I mean that, those images I hold in my mind to give me strength on the days that I don't want to go on.-**Susan**

> see the beauty or the nice part of life. Doing this kind of work, dealing with survivors of torture, makes me feel more down to earth as individual, more realistic about what life is, and how life can affect people. -**Joan**

However, nearly all participants were confronted with their conflicting thoughts about the existence of a kind and just God who could observe such atrocities and unjust acts silently and passively. Participants described how they felt angry and betrayed by a God who they had been believing and trusting for many years.

> First of all, I thought 'why does God do this on the earth; why does he have to bring violence and injustice in people's lives?' They don't need this, and I began to wonder about God's intention after all. I began to wonder if there is God -**Betty**

> It has made me reassess or question human nature, and human capacity. I say to myself 'my God, you know human beings are able to do that [torture] to each other' and of course, working with women, you see that women end up being prey to sexual violence in a situation like war or political violence. So I find this very difficult to deal with and at times it can make me question God. How low can people go? How far will they

> go to harm others?.... How can there be a God? What is the meaning of life?....I think over time as clinicians we either work it out for ourselves, or we get out of the field. -**Kathy**

Paradoxically, Betty and Kathy also began to compare their own life's blessings with those of their clients and became grateful to the same God who was unjust to their clients.

> I personally felt that I was thankful to God for giving me a good life and giving me a chance to be in a safe country where I don't have to worry about my life, my husband's life or my children's life. -**Betty**

> A greater sense of appreciation for national peace....It does make you think twice and kind of feel happy to be here [in Canada]. -**Kathy**

An understanding of trauma lies in recognizing the duality of human thoughts and feelings. As participants blamed God for clients' pain and suffering, they experienced tension and despair about humanity and life. On the other hand, focusing on God's kindness and blessings enabled participants to maintain a sense of peace and hope about life.

Symptoms of Secondary Traumatic Stress

In order to understand participants' experience of VT and various symptoms (manifestations) related to it, they were shown two tables listing personal and professional impact of secondary traumatic stress. Thus, the reader will find some overlap between the content of this discussion and the narratives in the previous section (e.g., emotions of shock, anger, and depression).

Early in their work with survivors of torture clients, nearly all participants experienced behavioral symptoms related to VT such as nightmares and exhaustion. Their exhaustion manifested itself in feelings of confusion, overwhelmness and burdened with their job. Cognitively, they found themselves flooded with many of the torture scenes clients had described to them. The flashback of torture images resulted in

difficulty to concentrate effectively. Participants also experienced feelings of self-doubt and struggled with a sense of incompetency. They questioned the value of their work and the effectiveness of their skills and abilities to help survivor clients. Physical symptoms were also experienced. For example, Participants reported headaches, stomach pains and irregular heart beats.

In addition to their more immediate response, participants' work with survivors had a long range impact on them as individuals and therapists. From a personal standpoint, they found that witnessing to survivors pain had touched them in much deeper way than books or workshops on the horrors of organized violence and torture. Subsequently they questioned the meaning of life and God.

When participants were shown Yassen (1995) list of symptoms associated with secondary traumatic stress, they pointed out specific symptoms in the tables and reported others within a narrative framework. Most of these symptoms were previously reported in the preliminary enquiry and therefore, will be presented without many additional commentaries. Participants' reported symptoms are grouped according to the typology of impact of secondary traumatic stress suggested by Yassen (1995).

Cognitive Symptoms

As participants pointed out at symptoms and described their experience, it appeared that they have experienced many of the well-known post-traumatic symptoms such as flashback of images, diminished concentration, self-doubt and others listed by Yassen (1995).

Flashback of images. For some participants, listening to clients' graphic stories of pain and suffering created visual flashback of images of violent and atrocious acts.

> Cognitively, I think the flashback of images will fit, however, not because this person [client] is describing in great detail the images, but that I would extrapolate from anything I had read or heard or even visually seen or portrayed in a movie. -**Heather**

> In the beginning I remember having difficulty with what I like to term 'vicarious flashbacks' and so after a session, I would be imagining the horror that someone has recounted to me. I imagine that is what is termed trauma imagery by researchers. **- Kathy**

Diminished concentration. Some participants experienced reduced levels of concentration (immediately after listening to clients' narratives) because they felt overwhelmed with clients' stories of pain and suffering.

> There might have been some decrease in concentration, perhaps immediately after having seen this person. The next client after that person might have, and I have some repercussions where I found myself thinking about the situation this person had first told me about, and having that interfere with the second client. **-Heather**

Self-doubt. Looking at the symptoms of secondary traumatic stress, Susan and Rose recognized feelings of self-doubt and questioned their professional competency to deal with the issues of refugee clients who were survivors of torture. In addition, not knowing the outcome of the counseling , Rose questioned the value of her work and its effectiveness.

> Under cognitive I would think self-doubt comes up 'Do I have the ability to work with this population? Do I have the ability to speak for this population? **-Susan**

> Self-doubt, because you begin to ask yourself 'am I doing something good or not?' You cannot see the progress after a few session or after a few months so you began to wonder if you are suited to work in this profession. **-Rose**

Whirling thoughts. A few participants became considerably preoccupied with the thoughts of survivors' stories.

> Whirling thoughts **-Jim**

Confusion. Participants experienced a sense of confusion as they listened to stories of violence and cruelties of one human being against another one.

> Confusion as to why people do this [act of violence] to other human beings. -**Betty**

Emotional Symptoms

Feeling shocked. One of the most difficult learning experiences for participants was the awareness that people could intentionally do worse things to each other than they could imagine. As they listened to their clients, participants stroved to stay calm and contain their shock and revulsion.

> Of course some shock. It is always shocking to hear the horrible things that happen to people. I don't think I'll ever get desensitized to that and probably shouldn't anyway. **-Heather**

> I was shocked first time. How could this happen? How could somebody do this to another human being? **-Debra**

The initial periods of shock and disbelief were easily turned to feelings of anger and rage.

Anger and rage. As participants listened empathically to survivor's graphic stories of pain and suffering, they experienced feelings of anger and rage towards perpetrators who could intentionally inflict pain on other human beings.

> Definitely anger and rage. Rage and anger at the inhumanity of man to man. That makes me really angry, not anger at a specific person or at a regime; rather angry at the human spirits that would allow this kind of stuff to happen. Sometimes overwhelmed with the scope of the problem, with the scope of the trauma the people have experienced.-**Susan**

> I don't really relate to these things [pointing at all listed symptoms]. I tend to feel more angry. -**Mary**

> overwhelmed probably because of imagining coming from that kind of a situation and having to deal with that and going into other situations which were highly abusive, and having to imagine how overwhelming that would feel, how would you separate those things out....that's a hard one sometimes. **-Heather**

Participants described how their feelings of anger and rage at perpetrators gradually turned to feelings of powerlessness and sadness as they felt helpless to influence perpetrators or the situation.

Feelings of powerlessness, anxiety, sadness and depression. One of the stressors that affect therapists and other human care-givers is a lack of control over client outcome. In addition to their lack of control of client's therapeutic outcome, believing that they had no control to affect the client's social and political systems created strong feelings of powerlessness in the participants.

> Emotionally, a lot of these things come up, a feeling of powerlessness. **-Susan**

> Sometimes I have this feeling [powerlessness] and I say to myself 'why do I feel like this? You see I alone can't change the world the way I want to....we have to be as a society all together fight against the cruelty. The second reason that I justify my powerlessness is the fact that you do have limitations according to your [job] mandate, limitations about what to do and how to help an individual and so on and those are jurisdiction things. I mean you can go against them, and sometimes I feel like I can't help more than I'm helping. The other thing to justify my powerlessness is the fact that, it doesn't matter how much professional skills you have. You are a, social worker, psychologist, a doctor or whatever: this kind of job does need a team work. This individual [client] is not suffering just from mental health issues where a psychologist can practice his skills or not only medical issues where a doctor can do his job, but it's a complex [variety] of things. I am just by myself sometimes and I feel powerlessness. **-Joan**

> Yes, I felt powerless. I felt that I wish I had the power to fix things in this people's life because, when you hear about the pain they are going through, whether you are a therapist or not a therapist, the human inside feels that, how can you help those people, how you can make it better you know. **-Betty**

> Powerlessness, sadness, depression. **-Debra**

Participants talked about the importance of autonomy and personal control and loss of it as they struggled to come to term with their lack of control over perpetrators' atrocious acts. They felt that there was not much they could do to prevent or stop these atrocities from happening in the world.

Guilt, shame, and hopelessness. Another sub-theme that appeared throughout the interview was the experience of guilt, shame and hopelessness as participants felt helpless to take actions to effect (reduce or eliminate) pain and suffering in the world.

> Guilt, it is an interesting thing....not personal guilt, but the guilt of our generation and what could we do if we could do anything. To stop it? **-Jim**

> When your are dealing with survivors of torture, it is difficult to label your feelings as shame or guilt because it is a mixed feeling. **-Joan**

> Anxiety and guilt, but it's not a high level of anxiety; sadness and shame. **-Rose**

> Hopelessness, because in some situations the court decides whether they are staying in Canada or not, so as a therapist you feel helpless and hopeless because there is nothing more you can do for them except supporting them and helping them manage day by day **-Betty**

Participants' feelings of shame, guilt and hopelessness were reflected in a variety of behavioral symptoms.

Behavioral Symptoms

Participants described a variety of behavioral symptoms as they dealt with their conflicting thoughts and emotions. Many described nightmares that were closely related to their work with torture issues.

Nightmares. John went on to tell three different stories to illustrate his struggles with understanding torture issues. John's stories described painful nightmares of his son's torture and his attempts to rescue him.

> I understood where he went. I understood that he had disappeared into the hole of torture and that is what had happened to him. So I went over to catch him, to somehow bring him back...so the dream directly connects to my reading of Lifton....I was also reading literature on the impact of war on children. **-John**

Impatience. Many participants felt impatient and angry at the slow pace of progress to effect refugees' lives. They were particularly annoyed with the lack of follow up at governmental levels.

> How slow we move to impact the way to help people going through this; I think that we have known what some of the issues are for a long time. For example, Report of the Canadian Task Force on Mental Health Issues Affecting Immigrant Refugees in Canada came up in 1988, the recommendations were there and the political will wasn't there so nothing gets done, and so that makes me impatient and probably angry too. **-Susan**

Exhaustion. Participants described how they experienced emotional and physical exhaustion as they dealt with the issue of torture and its detrimental effects on clients' lives.

> I would say exhaustion but I can't say that that's completely right just for this issue, like it might be kind of my exhaustion comes from just working in this area to begin with because it's so huge and there are so many pieces out of it that are important and hard to get at and you get tired of doing this work from time to time. **-Susan**

> very tired, exhaustion, I felt I couldn't even go home, after some of the sessions. **-Debra**

Physical Symptoms

Participants' internal experience of stress, gradually was manifested in a range of physical symptoms.

Stomach pains, headache and rapid heart-beat. In addition to emotional pain, some participants also experienced physical pain and suffering.

> I know when I am hearing stories and I'll have physical reactions, I'll have stomach pains or get a headache sometimes for listening to it. My heart will beat erratically, but that is just when I am actually hearing the stories, or if I am repeating a story sometimes that will happen -**Susan**

> A headache every time I left the session. -**Debra**

> I did feel tired because it took a lot out of me. -**Betty**

Participants' awareness of their clients' pain and suffering also impacted their spiritual beliefs.

Spiritual Impacts

Participants described changes at deeper levels than their physical symptoms. They questioned the meaning of God, life and its value for themselves and others.

Questioning the meaning of life and anger at God

> I have always been, not very religious but very spiritual and then, in working with them and in not trying to convince them but trying to look at the meaning of their lives, it also made me look at the meaning of my own life. -**Debra**

> questioning the meaning of life. -**Joan**

> Loss of meaning....Why God does this, and I kind of like lost the trust in God for a while. -**Betty** .

> Questioning the meaning of life and the existence of God is very common for people in our field because if there is God how can these things happen? So I think those are normal prosthesis that we continue to struggle with although not with the same degree of intensity that we questioned them when we first became involved in working with traumatized clients. -**Kathy**

The type of learning that participants needed to engage in to answer such questions was a deeply personal one and related to the growth of their soul or "psyche."

Many of post-traumatic stress reactions reported by participants required coping skills that could help them manage these psychological reactions. As I listened to the participants, I became more interested to explore how they coped with the negative impact of their work. In the following section participants' coping strategies are outlined.

Personal and Professional Coping Strategies

Coping by psychotherapists and counselors is about managing and balancing between professional and personal role demands. As participants of the present study became more aware of the negative impact of their work on their psychological and physical well-being, they used a variety of strategies to cope. For participants managing their work stress involved many dimensions, including psychological, spiritual, physical, family and work adjustment, as well as effective leisure time use.

In this section, I cite excerpts from the narratives of the participants to illustrate a variety of coping methods they used to deal with the impact of working with survivor clients. The coping strategies used by participant are classified according to their problem- or emotion-focused functions. The classification system I used to organize participants' coping strategies are based on Carver, Scheier & Weintraub (1989) and Yassen's (1995) classification of coping strategies.

Problem-Focused Coping Strategies

Participants used a variety of problem-focused strategies in order to manage the demands of their job directly. These strategies included establishing boundaries, seeking support for instrumental reasons (e.g. information, advice and assistance) and using proactive strategies.

Establishing boundaries. Just as important as building rapport in therapeutic relationship, is the need to maintain appropriate boundaries. For participants, boundaries

simply meant that they knew where the helping relationship ends and the client begins. Most of all, they were mindful not to cross the boundaries of their helping role by attempting to rescue or control the clients.

> What you have to learn about being a therapist right from the beginning is how to compartmentalize and in a sense where you can help someone with the problem and where you can't. -**Mary**

> Being clear about personal and professional boundaries for myself as well as the clients....So it was very clear that I was helping them as a therapist, not as a friend. -**Betty**

> I guess in time you develop the ability to in some way separate your professional work and your private life. -**Jim**

Participants learned the importance of caring for themselves and the wisdom in recognizing their emotional limits. For example, they made sure that their case load did not include a disproportionate number of survivors of torture clients.

> It happened in the beginning [of her career] and then I realized that I have to make sure that I space out visiting survivor of torture clients instead of scheduling three or four of them for the same day. -**Kathy**

> Scheduling clients in a way that I see them on alternate weeks, so I avoid feeling worn-out and burnout with all the stress of the work. -**Betty**

Participants also discussed the importance of mindfulness and awareness of their own values and beliefs. This in turn helped them to maintain a balance between their personal and professional roles.

> We might have different beliefs about violence, different stands about the situation, but our own beliefs, expectations and stands should not be reflected in the therapy....I had to be very careful, making sure that none of my own beliefs are reflected on the way I do therapy with them. -**Betty**

> Now you have another role, you have to gain whatever strength you have and do the job....this person needs your help, so the better you do your job, the more improved he or

> she will be.-**Joan**

Realizing their limits in dealing with survivors' issues was important as well as humbling. It was important for participants to remind themselves that they could not erase clients' past pain or prevent their future encounters with suffering. However, they could help clients to make appropriate judgments and decision for their current lives.

> we are not responsible for what has happened. We are also not responsible for any decision they are going to make in the future....We must trust that they can make their own judgment and decisions. -**Betty**

All participants stated that recognizing their professional limitations while maintaining ethical standards was a task that became easier with experience. However, they also acknowledged the potential for role confusion and the inevitable tension it generated was inherent in the treatment of survivor clients.

Seeking instrumental support. According to participants, an integral part of their work with culturally different clients involved understanding the historical, cultural, political and socioeconomic context of the clients. Participants continuously made efforts to acquire more knowledge about their clients' political and sociocultural issues as well as to enhance their understanding about the effects of torture on clients. This in turn helped them to design more helpful interventions for clients.

> Educating myself about war and its impact. For example, how to deal with the grief, or how to deal with sociological horrifying things that are involved. -**John**

> Reading more about the area....Gaining a better understanding empowers the therapists. -**Heather**

> If I feel that it is hanging on a long time for whatever reason then I would read something specific about that. -**Heather**

> Seeking information and educating myself about other's political and sociocultural factors. -**Mary**

Joan told me that reading related literature helped her to understand some of her own psychological responses to clients' stories better.

> The literature does provide me with feedback, it mirrors certain work experiences of mine....it helps me to see what to expect in certain situations and how to deal with them. ...the literature helps me to understand why I might experience feelings of guilt.-**Joan**

In addition to taking steps to educate themselves, participants also asked for advice, direction, suggestion, or feedback from other colleagues.

> Talk to somebody or share my thoughts with someone and get support around that. -**Heather**

> Seeking support from colleagues, friends and family members.... because they help you to see different pictures. -**Rose**

> Sometimes I ask my colleagues for professional advice during personal leisure visits-**Jim**

> Well, I can say that even if I did have another profession, I would be impacted by the things that happened over there because of circumstances, but somehow I managed to gain some help from the people that I am working with.-**Jim**

> Consult with colleagues about how to handle a situation.-**Joan**

> Debriefing with a colleague; someone else who is bound by the same confidentiality. -**Betty**

Collegial support provided participants with reassurance and validation. It also enabled them to obtain different perspectives on issues that they were struggling with.

Using proactive strategies. When we experience social injustice we may become social activists by taking active roles in order to influence the problem itself. This was true for participants who have coped with their frustration and sense of helplessness by developing proactive strategies. For example, they volunteered their professional expertise and services to survivors of torture through Calgary Catholic Immigration Society programs. Participants described how their efforts as social activists helped them

to manage feelings of frustration, powerlessness and helplessness as they were able to make public statements in support of survivors and let the public know about what was happening. Through their direct involvement they maintained a sense of hope and purpose in their work.

> To find out more about it, to find out what people need and find ways to help them out....because if I feel that I have done something to help then that removes some of the anxiety for me in terms of these people being left out there, hanging in the wind basically. **-Susan**

> When I was young I was quite politicized, so I was around a lot of refugees....looking at the torture and understanding that there were great acts of cruelty in the world seems to have been around forever with me....for me the act of witnessing was part of the psychologists role....to open our mouths about what we see, and if psychologists help people to tell secrets, then the act of witnessing for psychologists means you describe back to the world, to hold up a mirror to the world, of what it is and how it does things and how the actions especially in the public arena affect individuals. **-John**

There is nothing implied in participants' statements that suggest they are reacting to their emotions. They did not appear to be at the mercy of their emotions such as anger, and depression; rather, they faced the problems and took actions to cope with their intense psychological reactions by becoming involved and taking helpful actions.

Emotion-Focused Coping Strategies

Participants became engaged in a variety of emotion-focused strategies to manage or prevent their negative emotions from overwhelming them. They recognized feelings of anger, sadness and helplessness and the need for dealing with them. Most of these strategies involved behavioral and cognitive efforts.

Self-care and self-nurturing behaviors. There is a large number of small acts of self-nurturing behaviors that can serve to cultivate a more caring relationship with

ourselves and subsequently with people around us. For participants, successful coping with their work related stresses, especially those experienced daily, involved making life style changes that prevented further stress and at the same time promoted enhanced states of well-being. Just as participants offered a variety of small gestures of caring and nurturing methods to their clients, they did the same for themselves. All ten participants nurtured themselves through the following simple activities on a daily basis.

> Exercise, rest and doing fun things. **-Heather**
>
> I exercise a lot, five days a week....walking or biking on weekends and take time for me. **-Susan**
>
> Working out a few times a week, I know that really helped me to burn the energy. **-Debra**
>
> Eating well, and exercising daily. **-Mary**
>
> Through favorite physical activities such as swimming I relax. **-Rose**

Participants were unanimous in stating that it would be difficult to feel good about themselves if they were feeling physically weak, tired, or ill. They acknowledged the role of physiological imbalances often caused by stress and believed that looking after their physical well-being had a direct impact on their psychological well-being.

Taking time to get involved in simple and yet soul nourishing activities was important to all participants. They took time to be with family members and reflect on their daily experiences. These activities helped them to revitalize their minds and bodies.

> Gaining pleasure in the family, wife, in the friends, in the work, in the readings and in other areas of life....going fishing with friends or whatever, that sort of shelters from that kind of emotional experience I had. **-Jim**
>
> Taking time for myself in order to reflect on the meaning of my experience...and to deal with what goes on

> inside me....To digest the whole situation. **-Rose**

> When I go home after four draining sessions, I go home and tell my husband 'I am sorry, I am not cooking supper today, let's all go out because I really feel tired'. **-Betty**

Engaging in creative endeavors such as gardening and meditating allowed participants to reconnect with their own bodies and mind.

> Gardening is one of the most healing things for me....It is wonderfully rejuvenating. **-Heather**

> I engage in yoga and relaxation exercises so I become more focused on life again. **-Betty**

Kathy also became engaged in writing poetry that helped her to express her inner most feelings.

> Self care is extremely important. I go to the gym and work out, sit in a hot tub and just relax and write poetry. I sometimes use writing as a means of catharsis to sort of let out all my feelings. I simply walk outside and let fresh air sort of blow over me. **-Kathy**

Participants discussed the importance of understanding and responding to their basic physiological needs. Just as participants helped their clients to find ways to cope with their situations, they reminded themselves to do the same. Participants viewed the conservation of physical and psychological energy as a vital antidote to face the effects of their daily work stress. Through these various techniques they were able to relieve some of the tension associated with their work.

Seeking support for emotional reasons. Often participants did not have to go far to embrace emotional support. Participants' support system included family members and close friends that they could trust and confide in. They were also the ones who accepted participants in all their moods and roles. Their caring and concern as well as their acceptance and respect provided participants with a sense of comfort, reassurance, belonging and love in times of stress.

> They are [his children] pretty good healers for me. I try hard not to be clingy or not to suck them....I just sort of go and absorb them you know. **-John**

> Receiving emotional support from my partner. He helps me to put things into perspective. **-Kathy**

> Letting my family know how I feel that day, so they don't expect much from me and know that I might get grouchy if they push me to the limits. My husband and children are very understanding and supportive. **-Betty**

Family members can play an important and healing role in one's life during the good times and the bad.

In addition to family members' support, participants also talked about the support they received from their friends and colleagues who listened empathically and acknowledge participants' feelings of shock and anger.

> If something has really had an impact on me I will go and speak to colleagues or to family members and share that with them so that I could have some support. Even just saying to somebody 'oh my God, imagine going through that kind of scenario.' **-Heather**

> I talk to my husband a lot about it....with my colleagues in the team has also helped me a lot. **-Debra**

> Sometimes I go back to my co-worker and share what I have heard. **-Joan**

> When I hear a really devastating story, I just go and grab a colleague and I tell him, because I think you have to discharge sometimes, because something is just unbelievable **-Mary**

Some participants' emotional support system included their pets.

> I get a lot of strength from my family and friends and animals .... At night you can be in whatever mood you want to be in, but they are [animals] at the door and they are happy; they want to see you and they don't want anything from you except to be hugged or patted....it is just that total acceptance and you don't have to explain anything and you don't have to get involved

> plus they get you moving in different ways. My dogs force me to go out walking and playing with them. -**Heather**

Participants described how turning to family, friends and colleagues for emotional support comforted them when under stress. This, in turn, enabled them to deal with their intense emotional responses adaptively.

Turning to religion and spiritual activities for support. Support for many participants included getting involved in religious and spiritual activities. Spirituality is a belief in a higher power that allows us to make meaning of life and the universe that may or may not be connected to a formal religion. Like many other people, participants were aware of the potential benefits of spirituality as a means for coping with hopelessness and feelings of powerlessness.

Spiritual rituals are in particular a kind of activity that can be important and helpful when they are meaningful to us and we know why we are doing them. For example, Debra told me that some of her clients never had any chance to mourn the loss of their loved ones. Debra found them in extended bereavement; and since they had neither grave sites nor date of death, they did not mourn for the dead. Therefore, she planned spiritual rituals such as lighting a candle, praying and helping clients to give themselves permission to say goodbye to their loved ones and put a closure to their painful memories.

> Saying goodbye to them [dead person] and still to allow themselves to remember them and to remember the good things. This was a very important ritual for clients to find a way to process what had happened for them. -**Debra**

Debra explained that this rituals had two functions. First, it served the psychological purpose of recognizing the continued grief that clients felt. Second, it helped Debra to work through her sense of helplessness and grief as a result of her indirect witnessing of clients' pain and suffering.

Participants coped spiritually in a number of ways. Some found spiritual relief in praying to God while others reflected on the meaning and purpose of life. Participants

had formed a philosophy of life that validated their experience and helped them make sense of the complexities and paradoxes inherent in their jobs. They saw life as both good and bad, hopeful and at the same time sabotaging. It was apparent to me that the participants I interviewed had struggled with this confusion and disharmony and had learned to live with its disparities. Their spiritual tendency had moved them toward a deeper knowledge, love, meaning, hope and compassion as well as a greater level of creativity and growth.

> I really try to get grounded, in terms of my philosophic bibs, like one of my assumptions, like what do I believe, what is good, what is bad, what is the purest of beauty. Sometimes that is what I need. Uh, I go back to the things that I collect. I mean I collect glass ....and feathers and I go back and look at them....and I go 'this is very beautiful, this is very beautiful'....so it is just sort of meditations on beauty and meaning. **-John**

Participants discussed the importance of their "special life purposes" that help them fulfill their religious and spiritual needs and provided them with a sense of completeness. Common examples of these life purposes included raising a family, succeeding in their career and/or making a contribution to their community. For participants, life purpose tended to have two major functions. First it allowed them to feel more complete and whole; and second, it allowed them in some ways to contribute to the betterment of others. For these participants helping others to find their path and regain their strength was a religious and spiritual journey

> Purposefulness of what I am doing, feeling of being useful.... The people I am seeing, they give me a lot of support, that gives me a feeling that I am doing a good job. **-Jim**

> My religious morals and values help me to go through many conflicting emotions and difficult times. **-Betty**

Participants' discussed how their spiritual beliefs, whether formal or informal provided common ground on which they were able to connect with themselves and their

clients more effectively. Their spiritual activities brought them closer to their inner selves. It helped them to experience their emotions and be in touch with their feelings rather than be alienated from themselves.

Focus on emotions and venting of emotions. Nearly all participants admitted that repression of their emotions could deny them the fullness of an empathic therapeutic experience. They felt at ease about expressing their emotions during the therapy while maintaining a balance between their personal issues and those of the clients. For example, expressing anger at the perpetrators of violence, becoming compassionate or tearful when listening to clients' painful stories of torture. They viewed their emotional response as a "normal" reaction to hearing about some "abnormal" events.

> I allow myself to feel upset or guilty if I feel that way, because we are human beings and helpful too. I think that the more we accept ourselves the more natural we can be with our responses. **-Kathy**

Mary explained that expressing her sad emotions appropriately conveyed two important and helpful messages to the clients. First, what had happened to clients was unusual and sad. Second, her crying could normalize clients' sad feelings.

> I just let all of my feelings come out, and sometimes I cry when I hear; I don't have a problem with crying with a client, or really expressing my horror. I think that is important to know that someone else is outraged by what has happened. So I think that I am able to work with my feelings at the time **-Mary**

For John, "keeping a journal" was a helpful and safe way of expressing his emotions.

Learning to own and express strong emotions takes courage and willingness. For these participants being in touch with their emotions (identifying and expressing them) was a way of acknowledging how they felt internally rather than walking around in a cloud of emotions and feeling detached from themselves and others. Their coping efforts helped them from becoming overwhelmed and disillusioned.

Emotional distancing. The term emotional distancing seems to convey an unfriendly and "cold" behavior; however, there is nothing implied in participants' statements that suggests repression of emotions; they rather imply a balance between emotions and cognitions.

> I am really good at parceling off my emotion. I would feel it at the time or I'd feel it when I am talking about it, when I go away, I can put that in a separate compartment....I can compartmentalize my emotions quite well. **-Susan**

> To detach myself a little bit from my own personal reaction, because that is not necessarily helpful for the client at the time ....it is more after the fact that I tend to deal with myself. **-Heather**

Participants stroved for the ideal mix of compassion and objectivity. Although they were genuinely concerned about clients' welfare, they kept some psychological distance from clients' difficulties.

Acceptance. In addition to emotional distancing, other ways of cognitively coping with stressful emotions were accepting and/or reappraising the events. For most participants, taking responsibility for their jobs also meant accepting what they could not change.

> It is part of that role as a psychologist, as a human being. It is part of my responsibility. **-John**

> Accept the fact that in this job you have to be flexible, and by this I mean, developing and changing all the time. **-Joan**

Participants discussed how difficult it was to look at their personal and professional limitations and acknowledge the extent to which they could overcome them. However, accepting limitations did not mean avoiding challenges associated with their roles. Rather, it meant finding the grace to learn how to do their jobs as effectively as possible, and attempt to move on the highest level of growth.

Positive reinterpretation. One of the ways that participants coped with their lack of control over their psychological responses was to focus on the positive aspects of an otherwise stressful experience. Participants described how they reappraised the threats of life and instead focused on its empowering aspects. For example, they began to see that the act of organized violence and torture did not solely define the life of the survivors; rather, being survivors of torture was part of their entire life experiences. Such a cognitive reappraisal seemed to be effective in reducing participants' anxiety and pain.

> Reminding myself that there are life-giving empowering things in my life as well, and that the world is not all like that. **-Heather**

> Having a good sense of humor because survivor of torture clients are not always walking around and moping. They have wonderful humor too, wonderful strength of the human spirit....I think sometimes we blow up that torture and forget the person.**-Susan**

Participants took steps to protect and prevent emotional injuries as they entered the emotional world of their clients. One approach to remaining connected with the clients while protecting themselves emotionally was to purposefully remain aware that the person sitting there had survived and he/she now had access to helpful caring other and a hopeful future.

Mental disengagement. Becoming engaged in entertaining cognitive distractions such as watching television, reading books and cooking was another cognitive strategy that participants used in order to mitigate the effects of their stressful situation.

> I shut down my mind, so I'll read trashy novels or watch mindless TV. **-Susan**

> I cook a new dish or go shopping sometimes if I am not able to put that [thoughts] out of my mind. **-Betty**

Behavioral disengagement. Only two participants smoked cigarettes when under extreme stress; however, both clarified that they are not "heavy" smokers.

Summary and Conclusion

All participants described experiencing a variety of intense and uncomfortable emotions. However, through their strength, courage and hope, participants were able to manage, overcome and grow personally and professionally. What they conveyed clearly through sharing their experiences is that they will not allow difficulties of their work interfere with their goals of helping refugee clients who are survivors of torture. Their lives may be touched by their new awareness of pain and suffering, but they will continue to help and enhance the quality of their clients' lives

In the following chapter I integrate the themes identified in the participants' experience with literature on VT and coping. This is followed by the implications of the findings for therapists working with clients who are survivors of trauma, limitations of the findings and directions for future research in the area of vicarious trauma.

CHAPTER FIVE: DISCUSSION

> Those who would be helpful must be willing to be in the presence of sadness and suffering. They must accept that helping does not consist either in making the suffering go away or in bearing the difficult burdens for the one who is suffering. Rather, helping consists of understanding and empathizing with the sufferer and supporting his/her efforts to find the meaning of the suffering and the means to living with it and in its aftermath. (Attig, 1990, p. 54)

Studies of PTSD reveal that many refugees experience severe life threatening traumatic events (e.g., violence, torture) and may require the help of mental health professionals (Bemak & Greenberg, 1994; Jaranson, 1995; Jaranson & Popkin, 1998; Kinzie & Fleck, 1987; Marsella, Friedman, & Spain, 1990; Van Velsen, Gorst-Unsworth & Turner, 1996). The literature on trauma therapy also suggests that mental health caregivers working with survivors of trauma may be affected vicariously and experience distressful reactions similar to those of their clients' PTSD symptoms (Figley, 1995; Kinzie & Boehnlein, 1993; McCann & Pearlman, 1990; Meichenbaum, 1994; Stamm, 1995). This study explored (a) how therapists were impacted by their work when dealing with traumatized refugee clients who are survivors of torture and (b) how they coped with the impact of trauma work.

The general findings of this study indicate that all participants experienced enduring distress related to secondary exposure to trauma as reflected in a variety of emotional, cognitive, behavioral, spiritual, and physiological responses. The findings also show that participants used a variety of emotion- and problem-focused coping strategies to deal with their distressful experiences. Overall, the results of this phenomenological study provide qualitative support for the notion of VT. First, therapists working with traumatized clients who are survivors of torture are themselves vulnerable to the

experience of vicarious effects. Second, empathy appears to play a significant role in the development of VT.

In this chapter the current literature on VT and coping is integrated with identified themes related to the participants' experiences when working with survivor clients. It includes a discussion of precipitating variables that can lead to the development of VT, the impact of VT on the participants, and the various ways of coping. This is followed by a discussion of limitations of the study and directions for future research. Finally, a discussion of the implications of this study for education and training of therapists working with traumatized clients in general and survivors of torture clients in particular is presented.

Motivating Factors for Working with Survivors of Torture

Therapists are expected to be caring, concerned, warm, committed and empathic individuals. Moreover, their job requires them to use interpersonal skills and be understanding, calm and objective while dealing with intimate information (Cormier & Cormier, 1998; Maslach, 1982; Rogers, 1980). However, these characteristics may have important implications for the effects of VT. Although seeing and understanding issues from the clients' perspectives (cognitive and emotional empathy) is expected to enable therapists to provide a better care, the vicarious experience to clients' emotional pain can increase therapists' vulnerability to a variety of emotional responses (Figley, 1995; McCann & Pearlman, 1990; Stamm, 1995). Repeated empathic engagement with clients' traumatic stories during trauma therapy tend to transform therapists' inner experiences and heighten their vigilance and sense of responsibility (Pearlman & Saakvitne, 1995).

It appears that therapists' capacity for caring and the desire to help is one of the most motivating factors leading them to do trauma work. A recurrent theme emphasized by all participants in this study was their sense of compassion and responsibility for clients' welfare and well-being. One participant illustrated this point when she described her

work values as an "extension" of her personal values. This finding supports the view that a combination of the characteristics of the helping role (aspects of the work situation) and the therapist's characteristics such as empathy tends to precipitate VT.

In addition to compassion and empathy, participants in this study were also motivated by many positive and rewarding aspects including personal and professional enrichment.

Rewarding Aspects of Trauma Work

Research has tended to focus on the negative effects of trauma therapy on therapists, giving less attention to the rewarding aspects of trauma therapy (McCann & Pearlman, 1990; Figley, 1995). However, the present study reveals that there are many positive aspects that motivate professionals to work with traumatized clients. The findings show that participants experienced a high degree of personal and professional growth and satisfaction that motivated them to continue working with survivor clients. Participants of this study described their work as "rewarding" and "enlightening". The most frequently mentioned positive aspects of working with survivors were seeing clients change and adapt to their current lives, contributing to the clients healing process, recognizing the human spirit and resiliency to overcome "multiple trauma", and being "trusted" and "appreciated" by the clients. These findings are consistent with the Schauben & Frazier's (1995) study of female counselors working with sexual violence survivors. They also reported positive aspects of working with survivors such as watching clients grow and change, helping clients on their journey of healing, seeing human creativity and strength, and learning more about themselves.

In sum, the rewarding aspects of trauma therapy by participants support the observation of Kassam-Adams (1995) that "undoubtedly, many therapists find that working with survivors of trauma is meaningful and rewarding, and they are truly privileged to witness clients' strength and resilience in the healing process." (p. 38).

The Issue of Countertransference in Vicarious Trauma

Countertransference may contribute to the development of VT through identification with traumatized clients (Figley, 1995). Wilson and Lindy (1994) pointed out that in countertransference, therapists might react by overidentifying with the clients' issues, withdrawing from or avoiding the client. In addition to identification with clients, it seems that countertransference can increase therapists' vulnerability to VT because of their emotional reactions to clients' painful stories (Pearlman & Saakvitne, 1995).

In their discussion of countertransference, Pearlman & Saakvitne (1995) differentiate between traditional definition of countertrnsference and when it is experienced by trauma therapists. Traditionally, countertransference refers to reactions of the therapists to unresolved conflicts through the process of interpersonal involvement with the clients' issues. However, countertransference in VT is considered as a "normal" reaction (e.g., anger, horror, grief, guilt, shame) to the painful feelings, images, and thoughts associated with awareness of the clients' trauma material.

Because counseling clients who are survivors of torture often involves sensitive political and social issues, contertransference feelings can easily lead to ethical issues and dilemmas. For example, participants in this study experienced a broad range of countertransference feelings from horror to admiration for clients' ability and strength to survive. They often questioned their own humaneness and professional role when they experienced hatred or anger at repulsive acts of perpetrators of torture. Although dealing with their emotional responses was frequently difficult in working with survivor clients, participants were particularly aware of their emotional reactions and expressions. Participants' experience with countertransference did not appear to produce any work related difficulties in the therapeutic alliance (e.g., withdrawing from clients, or becoming enmeshed in clients' issues). One explanation of their ability to manage emotional reactions is given by one participant when he stated that "checking the compulsion to help, and the compulsion to confess one's own feelings" is vital in any

therapeutic relationship. Moreover, participants' professional training may have sensitized them to issues of countertransference. They recognized the role of emotional reactions to clients as an important factor in the therapeutic relationship that could have positive or negative effects on therapy's outcome. It is interesting to note that therapists who recognize and deal with countertransference are better able to manage their emotional exhaustion (Pearlman & Saakvitne, 1995).

In sum, the current findings and previous research on empathy and countertransference indicate that it is important for therapists to become aware of and not cross the boundaries between personal involvement and professional caring.

Impact of Working with Survivors of Torture

Counseling refugees who are survivors of torture places special demands on therapists and can create conflicting thoughts and feelings. It is through the therapeutic relationship that therapists face the reality of an "unjust world" and have to acknowledge its existence. According to Saakvitne & Pearlman, (1996) VT is "an occupational hazard and....a human consequence of knowing, caring, and facing the reality of trauma" (p. 25). Following the clients' recounting of traumatic events, therapists may experience a variety of psychological distress and undergo many changes in their cognitive schemas. The descriptive statements provided by participants in this study revealed that the impact of the participants' work is pervasive.

Impact at the Professional Level

Counseling traumatized survivors who are culturally different is especially challenging for therapists and requires a combination of culturally sensitive skills and goals. In a discussion of professional multicultural competence in counseling and therapy, Sue & Sue (1999) suggest that therapists understand the (a) sociopolitical forces that have affected the minority clients; (b) cultural and language barriers that may influence effective therapy; and (c) the importance of clients' world-view and their own belief systems in the helping process. It is clear that counseling refugees who are

survivors of torture is likely be more complex and require high degree of sensitivity and understanding of clients' psychological realities as well as their history of trauma and loss. However, training and supervision in counseling and psychotherapy have seldom addressed multicultural counseling issues that involve refugee experiences (Alpert & Paulson, 1990; Bemak, Chung & Bornemann, 1996; Pope & Feldman-Summers, 1992). Participants in this study who had faced a number of cross-cultural issues for which they were not trained and prepared emphasized this point. For example, one of the most commonly reported difficulties by participants was the lack of assessment tools and intervention techniques that would suit the needs of their culturally different clients. This was followed by boundary issues and clients' difficulty in reestablishing trust in authorities.

The challenges to professional boundaries were experienced by participants as tension, and conflicting thoughts and feelings. For example, overwhelmed by the clients' multiple trauma and immediate need for help (e.g., obtaining medical attention for a client's sick child), participants found themselves stepping out of their supportive roles in order to provide instrumental support to their clients. Consequently, they experienced tension and conflicting feelings because their actions were not in harmony with professional standards. However, when working with culturally different clients, the ability to reconceptualize traditional training is vital for effective therapeutic interventions (Bemak et al.,1996). Many refugees flee from communal societies and their expectations of the therapists' helping role (interdependency and social support) may be in conflict with therapists' North-American values of individuality and independency (Sue & Sue, 1990, 1999). In their discussion of counseling and psychotherapy with refugees, Bemak et al. (1996) suggest a multilevel model (MLM) of counseling and psychotherapy. This model integrates four levels including traditional Western psychotherapy, indigenous healing methods, cultural empowerment, and

psychoeducational training. The MLM offers a holistic approach that allows integration of a variety of strategies to meet the multiple needs of refugee clients.

In sum, working with culturally different survivors placed unique and new demands on both the expertise and the personal resources of participants who had not been trained and prepared to deal with cultural issues. Subsequently, they required coping abilities to manage a wide range of intense emotional reactions, cognitive and spiritual changes as well as behavioral symptoms both at personal and professional levels.

Impact at the Personal Level

Therapists working with traumatized clients may experience symptoms parallel to those of their clients (Allodi, 1990; APA, 1994; Figley, 1995). Vicarious trauma can create symptoms similar to PTSD. In addition, VT can produce changes in belief systems involving loss of a sense of safety and trust, disillusionment and loss of a sense of control (McCann & Pearlman, 1990). The consequence of accumulated VT in the work place can also be feeling of hopelessness and powerlessness (Figley, 1995; Stamm, 1995).

Participants in this study frequently described their feelings of despair and lack of control over clients' pain and suffering. They described their distressing emotions and deep sense of empathy for clients as they listened to graphic descriptions of rape, beating, humiliation, and killing. One participant illustrated this deep sense of empathy when she described that listening to clients' painful stories and empathizing with their suffering hurt her at the very core of her being that is hard to talk about.

As pointed out earlier, participants' deep sense of empathy may have opened them to the experience of a variety of emotional, cognitive, spiritual and behavioral responses. The most commonly described negative emotions among participants were shock, hurt, anger, sadness, guilt and shame resulting in a sense of helplessness and hopelessness. These affective experiences were reflected in participants' (a) cognitive experiences such as flashback of images, diminished concentration, self-doubt and confusion, and (b)

behavioral manifestations such as nightmares, lack of patience with authority and rules as well a physical and emotional exhaustion.

Cognitive impact. According to Saakvitne & Pearlman (1996), a traumatic experience that affects and disrupts individuals' frame of reference or world-view, is experienced as being stressful. McCann & Pearlman's (1990) constructivist self-development theory describes disturbances in therapists' cognitive schema along dimensions of safety, trust, power and vulnerability. The theory suggests that trauma work disrupts individual's cherished beliefs and assumptions about a "just" and "humane" world. It is through the therapeutic contacts with survivors of trauma that therapists come face to face with the reality of existence of horrifying acts committed by one human being against another. This realization can create doubts about previously adaptive assumptions of personal invulnerability and safety in every day life (Janoff-Bullman, 1992).

Consistent with CSDT (McCann & Pearlman, 1990), participants reported experiencing a significant change in their safety schema. They experienced a sense of vulnerability and fear for their own safety and the safety of their children and partners. For female participants (the majority of participants) this sense of vulnerability and fear was exacerbated as they felt vulnerable to harm inflicted by others when they began to internalize their clients' experience of violence. They subsequently became more apprehensive about the safety of their children and partners whenever they engaged in activities away from home. Similarly, Astin (1997), a therapist and researcher working with rape victims in the United States, reports taking extra safety precautions in dealing with men as a result of her work. This sense of vulnerability to violence and harm among women in general, and trauma therapists in particular is associated with victimization and violence against women in our society (Sue & Sue, 1999).

In their discussion on caring for victims of political violence, Witterholt & Jaranson (1998) refer to personal impact and changes in their world-view. They find themselves

altering their lives in order to accommodate such changes. For example, they limited the type of books they read and movies they saw because of their growing sensitivity and inability to tolerate violence. Thus, trauma therapists who repeatedly face the reality of the existence of terrible acts happening to others may experience doubt about their previously adaptive assumptions of personal invulnerability and safety in every day life (Janoff-Bulman, 1992).

It may be observed that the impact of trauma therapy is different from the work of therapy with non-traumatized clients. Although most therapists occasionally hear disgusting and horrific stories from clients, trauma therapists are repeatedly exposed to such stories. Moreover, their world-view may be challenged repeatedly when facing realities of their clients' traumatic experience. Thus, the trauma therapists' beliefs about the world and others as "just" or "good" is defied by interpersonal traumas in which one person or group of persons inflicts pain and suffering on another person (Astin, 1997; McCann & Pearlman, 1990)

Spiritual-religious impact. With respect to spiritual-religious impact, participants' descriptions involved mixed emotions ranging from sadness and anger at God and at the dark side of humanity to a search for meaning and deep appreciation for life's blessings and human resiliency. Their sense of spirituality and religion was strengthened by working with traumatized clients as they strove to find a deeper meaning for pain and suffering in the world (Viktor, 1978). Participants' dual reaction with two contradictory emotions of despair and anger on the one hand, and appreciation of their own safety on the other is consistent with the spiritual transformation in VT (McCann & Pearlman, 1990; Saakvitne & Pearlman, 1996) .

In sum, previous research and current findings indicate that the most important impact associated with the experience of VT involves a sense of terror and helplessness that is perceived to be beyond individuals' "normal" capacity to deal with. Participants in this study reported a sense of helplessness, a sense of anger at self, others, and the

world that allow such inhuman cruelties (cf. Figley, 1995). Therefore, the required exceptional coping strategies to prevent, ameliorate or manage the impacts of working with survivor clients. The use of a healthy balance to cope with the effect of VT on the personal and professional levels is the focus of the following section.

Personal and Professional Coping Strategies

One of the most important aspects of coping with VT is to acknowledge the effects of trauma work on the therapists' psyche. Recognizing that one's vulnerability to intense emotional experiences is a "normal" response to "abnormal" events (trauma), coping with responses to clients' trauma is the next step in addressing VT (Figley, 1995; McCann & Pearlman, 1990; Stamm, 1995). The therapists' acknowledgment of the effects of working with survivors is essential in the development of effective strategies to cope with trauma work.

In her discussion of preventing secondary traumatic stress disorder, Janet Yassen (1995) emphasizes the importance of a holistic multidimensional approach that combines knowledge, wisdom and techniques at the personal and the professional levels. Similarly, participants in this study described a holistic approach to coping including both problem- and emotion-focused strategies in order to cope with distressing thoughts and feelings. Participants' problem-focused strategies involved establishing boundaries, seeking instrumental support from colleagues and becoming involved in proactive behaviors (e.g., volunteering, becoming social activists). Emotion-focused strategies involved self-care and self-nurturing activities, seeking emotional support from family, friends, colleagues and pets, turning to religious and spiritual activities, and venting emotions. Thus, in their attempt to minimize the impact of VT, participants used a variety of coping strategies at both the personal and professional levels. These findings are consistent with studies in the United States which reveal that trauma therapists use both personal and professional strategies to overcome the effects of VT (Dutton & Rubinstien, 1995; Dyregrove & Michell, 1992; Pearlman, 1995).

Problem-Focused Coping Strategies

According to Lazarus & Folkman (1984) people tend to use problem-focused approaches when they believe their resources and demands of the situation are changeable. This was consistent with participants description of a variety of direct actions that aimed at reducing the stressful demands of their work.

Establishing boundaries. Just as important as being empathic in the therapeutic relationships is the need to maintain boundaries. For participants, boundaries meant being aware of their own personal and professional motives, values, biases, resources and limitations. The strategies most often used by participants involved limiting the number of trauma clients seen in a day, alternating between seeing trauma and non-trauma clients, conveying respectfully the limitations of their helping roles, as well as compartmentalizing their personal emotions. Participants also described setting up boundaries within a framework of their personal and professional values/ethics as a very important step in moderating the effects of their work. Establishing boundaries early in their working relationship allowed both participants and clients to have clear guidelines about the limitations of the therapeutic relationship.

A balance between professional and personal life reported by participants is necessary in moderating the effects of VT on therapists: "Time is needed to nourish one's physical needs, personal needs, and professional needs. To maintain the boundaries necessary for good mental and physical health, therapists may have to prioritize their commitments, and even terminate some of them" (Cerney., 1995, P. 141). According to Cerney, being overworked and traumatized may traumatize family and friends through constant unavailability and emotional withdrawal. Indeed, Chestman (1995) found that coping behavior varies with the percentage of trauma clients in the caseload including talking to family and friends about work and attending professional activities. Those therapists with higher ratio of trauma clients talked less to family and friends and attended more professional conferences and activities. Further research with

survivor of torture clients may investigate the relationship between the caseload of participants and the tendency to use professional coping or personal coping (i.e., obtaining emotional support from colleagues or from family and friends).

Seeking instrumental support. Although well trained in counseling and psychotherapy, participants often felt overwhelmed and unprepared when dealing with culturally different survivor clients. Beyond understanding the individual clients, participants found they also needed to understand the larger sociopolitical and cultural relationships of the clients. Participants faced this challenge by actively researching multicultural literature and seeking professional advice from other more experienced colleagues. Seeking information and acquiring knowledge about the stressful situation, which can then be used in planning problem- or emotions-focused coping can be very helpful in managing stress.

Using proactive strategies. Listening to descriptions of the brutal victimization created various psychological reactions in participants, they felt anger and rage at perpetrators of atrocities and the political systems and experienced a great sense of despair and helplessness. However, participants' intense emotions also motivated them to develop a special compassion that grew and eventually turned into a positive quality in approach which can be called generativity (Barnett, 1984; Erikson, 1968). Participants' difficult experience cultivated their ability to understand other individuals at a deeper level and to have compassion for their difficulties. Their generativity involved moving beyond a focus on themselves to a broaden commitment to work, to society, and to future generations. Participants' creative transformation suggests that the same people can use negative experiences to learn and grow, transcending ugliness and pain to gain pleasure from helping.

It seems that participants developed a new awareness that helped them to deal with their sense of helplessness, hopelessness and frustration as they continued to provide guidance and emotional support to their clients. Through becoming advocates for human

rights, they were using an active coping strategy that provided them with some means of control and a feeling that they could bring about some social justice and positive changes in clients' lives (Seligman, 1975). Participants' sense of empowerment was achieved by taking actions, becoming engaged in what they liked to do and holding on to hope and possibilities.

Emotion-Focused Coping Strategies

People tend to use emotion-focused strategies when they perceive they can not change the stressful situation (Lazarus & Folkman, 1984). These coping strategies, however, regulate psychological reactions to stressful situations until such a time that one can deal with the situation objectively. Participants in this study described a variety of behavioral and cognitive approaches that helped them regulate their affective reactions to VT. The most commonly reported strategies were self-care and self-nurturing activities, obtaining emotional support, becoming involved in religious and spiritual activities, focusing on emotions, positive reinterpretation and acceptance. The least reported coping strategy was mental disengagement.

Self-care and self-nurturing behavior. Coping activities such as self-care and self-nurturing provided participants with a sense of control. Personal control is considered an important factor in mediating the negative effects of stressful situations and a component of the hardy personality (Kobasa, 1984; Kobasa & Maddi & Kahns, 1982). According to Kobasa (1984), people who believe to have a greater sense of control, commitment, and challenge will cope more effectively when under stress. Participants' sense of control involved their advocacy efforts to influence outcomes instead of being passively influenced by them, while their sense of commitment motivated them to become actively involved in life problems (e.g., social justice issues) rather than feeling alienated. Finally, continuing to learn from positive and negative experiences helped participants to face the challenges of their works adaptively.

One of the most commonly reported coping strategy by participants was paying attention to signs of stress and taking time to nourish their bodies and minds through rest, play and eating well. For example, participants became engaged in physical and mental exercises during work breaks and after work. They sought peace by taking warm baths, writing poetry, doing gardening, meditating and collecting favorite objects.

Exercise and physical fitness can prevent the harmful effects of stress and provide a wide range of benefits from enhanced intellectual functioning and personal control to decreased anxiety, depression, hostility, and tension. However, these basic and essential activities are often neglected when we experience stress. Self-care issues, like many other ethical dilemmas are complex to deal with and a clear consensus on it is hard to reach. The principle of responsible caring of Canadian Code of Ethics for Psychologists (Canadian Psychological Association, 1991) reminds therapists to become engaged in "self-care activities which help to avoid conditions (e.g., burnout, addictions) which could result in impaired judgment and interfere with their ability to benefit and not harm others" (II. 12, p. 96). Indeed, therapists, like other caregivers, have responsibility to their own physical and mental well-being so that they can continue using their therapeutic skills and creativity effectively.

Seeking emotional support. Obtaining empathy, caring, and concern in times of stress may provide a sense of comfort, reassurance, belongingness and love. Participants sought emotional comfort by turning to family members, friends, colleagues and pets when overwhelmed with conflicting thoughts and feelings. For most participants, being with their children was revitalizing and energizing. One participant summarized this point eloquently by saying that children are a source of life, and in their presence, dreams and hopes can be magically created and reborn again.

Focus on emotions and venting of emotions. Participants in this study viewed emotional responses as a "normal" human state conducive to their emotional growth. They felt comfortable to cry or laugh with the clients and within the established

boundaries. According to Pearlman & Saakvitne (1995), therapists' appropriate expression of emotion strengthens the therapeutic relationship since it validates clients feelings. We generally have feelings about significant experiences. Our emotions such as fear, anger, sadness and anxiety can stimulate our responses and direct our actions. How we express them may have a positive or negative effect on our general well-being. Feelings are a vital part of us and their suitable expression is the balance to sustain our physical, mental and spiritual wellness.

Emotional distancing. Participants described their needs for establishing emotional boundaries that could act as a comfort zone in protecting them from overwhelming thoughts, emotions and hurt. These boundaries, however, were flexible and did not hinder their ability for empathy. Emotional distancing like other types of boundaries allowed them to see themselves as unique human beings with their own feelings and needs.

The emotional demands of the helping relationship can be balanced out when we recognize that both closeness and distancing can help us deal with our intense reactions. When overwhelmed by intense emotions, participants' emotional distancing allowed them to appraise the problem objectively. Emotional distancing is also used to modulate the processing of traumatic events so that therapists would not be overwhelmed by the emotional consequences, and be able to overcome emotional flooding which may threaten their functional capacity (Dyregrov & Mitchell, 1992).

Religious and spiritual activities. Religious coping has been reported by many researchers to be helpful in managing people's experience of stress (Carver et al., 1989; Kliewer, 1999; McCrae & Costa, 1986). In a study, Pargament et al. (1988) suggested three styles of coping involving different relationships with God. In addition to placing the responsibility for the problem on God, the responsibility may be directed toward the individuals themselves or shared by them and God. In their attempt to make sense of the survivor clients' pain and sufferings, participants tended to put the responsibility on God

for clients' misery and horrors. Participants also attempted to make spirituality a part of their every day life in order to restore their sense of meaning, connection and hope (Neumann & Gamble, 1995; Sargent, 1989). For example, they became involved and resorted in activities such as meditation and reflection, creative art and spending time in nature in order to manage the effects of VT.

Participants' expression of anger and sadness as well as their search for meaning may reflect their sense of adaptation to the loss of their cherished beliefs, which is consistent with the stage model of loss and ways to seek resolution (Kubler-Ross, 1975).

Acceptance. A helpful coping strategy in managing VT is simply accepting that trauma work involves dealing with clients' pain and suffering. Moreover, realizing personal and professional limitations in dealing with client's issues. While describing their desire for helping clients, participants talked about the limits of their professional roles. Although difficult to admit, they acknowledged their lack of control over clients' pain and suffering. As one participant pointed out, coming to terms with the limits of our helping role and accepting its limits can help us view our work in a holistic way rather than as a one-sided endeavor. This coping approach was especially appropriate for participants since their works' basic circumstances and source of the stressors could not be changed or controlled (Lazarus & Folkman, 1984).

Positive reinterpretation. Despite experiencing conflicting thoughts and emotions, participants focused on the positive aspects of their experience that became a source of growth and development. They reminded themselves that together (the clients and participants) they were now working in a safe and humane relationship where healing was possible. Helpers usually maintain a positive view about life's possibilities. Though they are aware of the dark side of life, they do not entirely focus on it. Obsession with what is terrible in life can only hinder one's ability to appreciate what is beautiful and good. However, solutions may become more reachable in the light of possibilities.

Participants' attempt to modulate a stressor by changing the meaning of the situation is another coping strategy. According to Lazarus & Folkman (1984) psychological stress occurs when we appraise a situation to be harmful or threatening. Using cognitive appraisal, it appears that participants evaluated the significance of the situation (stressor) as challenging rather than threatening or harmful.

In sum, although coping strategies used by participants are reported separately, they tend to function together as a system on the emotional, cognitive, behavioral, religious and spiritual levels. In general, participants used more than one strategy in dealing with the demands of their work. They tended to use both problem- and emotion-focused strategies together in order to alter the problem or regulate their emotional responses respectively when they experienced stress. Findings indicate that participants used a large number of emotion-focused coping strategies as compared to problem-focused strategies. The powerlessness experienced by the participants, which can be attributed to lack of political resources for intervention may explain the overwhelming predominance of emotion-focused over problem-focused strategies. The present analysis is congruent with suggestions that emotion-focused coping becomes predominant when people perceive that they can not control the situation (Lazarus & Folkman, 1984).

Coping at the Organizational Level

Findings of the present study indicate that there is almost an absence of organizational strategies aiming to provide participants with additional means of coping. All participants provided suggestions and recommendations at the organizational level. Their suggestions include workshops, conferences and training programs, working in a multidisciplinary environment, peer support, and social and professional support. Other researchers have suggested strategies for organizational coping such as reducing the workload, providing supervision and collegial support, and workshops. These strategies have been found to help reduce the PTSD symptoms experienced by trauma therapists (Pearlman & Saakvitne, 1995; Stamm, 1995). More work is needed to increase the

awareness of organizations of the needs of professionals for help when working with traumatized clients (Pearlman & Saakvitne, 1995).

Although participants indicated that therapists affected by VT may require professional help they tended to be reluctant to seek personal therapy for several reasons such as issues of stigmatization and concern about confidentiality (Mahoney, 1991; Neumann & Gamble, 1995). Organizational support may be vital and required in order to encourage therapists to seek help when required. Overall, it is encouraging that despite the limited organizational support, participants became engaged in coping strategies considered to be effective.

Limitations of the Study

Generalization of the findings in the present study is limited by the size of the sample and the individual characteristics of both participants and their clients. Data collected from 10 participants have limited the analysis of the findings and its generalization to all trauma therapists. This is particularly true because of the uniqueness of the clients who are both survivors of torture and culturally different. Moreover, participants did not exclusively work with traumatized clients. Nevertheless, there are similarities between the present findings and those of therapists dealing with other trauma survivors (Figley, 1995; Pearlman and McCann, 1995). Furthermore, despite the small number of participants, the present study may serve as a guide for future research in the area of VT with larger group of participants.

The study did not inquire about the years of work experience participants had with survivor of torture clients. Such information would have allowed the study to explore whether longer years of work experience helped participants to develop more effective case management skills and a larger repertoire of coping resources and strategies. On the other hand, the longer years of work experience may be associated with more cumulative effects of VT.

It is important to point out that participants in this study were not given any formal test to measure their level of stress, or their experience of VT. Therefore, the findings of this study must be interpreted and generalized with great caution. However, the detailed and in-depth descriptions of participants' psychological reactions when working with survivor of torture clients are consistent with those reported in the literature. Participants' reports of various symptoms are consistent with those established for a DMS-IV diagnosis of PTSD. While the intention of this study was not to diagnose pathology, participants' reports of distressing experiences indicate the nature of distress that can accompany trauma therapy.

Directions for Future Research

Because of the exploratory and pioneering nature of studies in the area of VT, more research is needed on the effects of VT and the strategies used to combat such effects. We still have very little information about factors involved in the relative effects of trauma therapy on therapists. Similarly, we need information about factors that can hinder or facilitate the coping process. For example, characteristics of the individual, social support, religious beliefs, learned coping skills and organizational structures may contribute to or prevent the development of VT.

One major area of future research is individual differences in reaction to VT and coping with its effects. Differences in personality, gender, training and previous professional experience may be contributory factors. For example, we need to know about gender differences in both the manifestation of VT and the methods used to cope with it. One question is whether there are gender differences in the manifestation of cognitive, affective, somatic, and subjective symptoms in reaction to VT. Do women experience more negative responses related to safety issues? Other questions are related to gender differences in the use of different kinds of coping strategies and whether the reactions of women and men are consistent with gender role stereotypes. Do women use more emotion-focused strategies as compared to men?

Other needed research is related to the effects of VT on therapists in both their personal and professional roles. For example, in what ways does VT adversely impact social and family relations as well as professional efficiency? Similarly, we still know very little about factors involved in the degree of effectiveness of coping strategies. Professionals seem to select their own coping strategies, and it is important to investigate how effective these strategies are. Factors such as the intensity, frequency and duration of stress experienced in working with trauma survivors, self-perceived ability to cope with that stress and self-perceived helpfulness with clients may affect how therapists perceive themselves as coping successfully (Medeiros & Prochaska, 1988).

There is also a need for the investigation of methods of intervention used to deal with VT. It is now accepted that since VT symptoms are similar to those of clients, the same methods of intervention (e.g., therapy) can be used for both therapists and clients. However, the efficacy of these methods in treating therapists may yet to be empirically validated. More research is also needed to assess the degree of resistance of professionals against personal therapy and the factors associated with it.

Finally, researchers investigating the impact of VT on therapists may also be at risk of becoming vulnerable to experience symptoms similar to those reported by therapists. Researchers' intense and prolonged engagement with the literature on VT and their contact with research participants during research may have a significant effect on their psyche. Questions may be raised whether researchers experience VT, and if they do, it is important to explore how they cope with its impact. Therefore, a new area of research on VT may focus on researchers and their experience of VT.

In sum, I hope that the present study will be replicated in Canadian and international settings so that data could be compared and contrasted to provide a more complete understanding of the experiences of therapists who work with survivors of torture.

General Conclusion

A study by Pearlman & Mac Ian (1995) of trauma therapists and the present research suggest that there is an urgent need for more training in trauma therapy as well as more supervision and support for trauma therapists. In particular, it is essential that therapists who work with refugees who are survivors of torture are trained and prepared to provide culturally sensitive mental health care for this diverse population. While most therapist do not speak the language of many culturally diverse clients, efforts need to be made to understand their sociopolitical culture and their mental health care practices (Sue & Sue, 1990, 1999).

As a researcher and future therapist, I believe that we need to learn more about the impact of trauma work on our general well-being. This dissertation clearly shows that we know enough to acknowledge that burnout and VT are an occupational hazard for therapists. Therefore, educational agencies, teaching supervisors as well as therapists themselves have a moral-ethical responsibility to incorporate occupational hazard topic related to VT into students' curriculum. These topics can also be incorporated into supervision and practicum for preparing future therapists to deal with survivors of trauma more effectively. Moreover, organizations can provide workshops and support programs in order to develop practitioners' competency.

In sum, this study contributes to our understanding of therapists' experiential meaning of VT. The study identified a variety of factors including work aspects and personality characteristics that can contribute to experience of VT. Moreover, it explored and discussed the kind of coping strategies that can help in managing the effects of VT. Furthermore, one significant finding of the study was exploring the positive aspects of work with survivors of trauma. These positive aspects appear to make the trauma work more tolerable and may have acted as a buffering system against stressors. Although participants showed a variety of symptoms, the effects were generally not severe enough to hinder their personal and occupational functioning.

It is interesting to note that most participants pointed out how the interview had positive effects for them. It provided them with the opportunity to gain a more meaningful insight about the impact of their work on both personal and professional levels.

Although this study focused on therapists working with refugees who are survivors of torture, the findings have implications for other workers with trauma survivors. This study suggests that helpers be encouraged to acknowledge and deal with the effects of their work and that organizational strategies be developed for managing VT.

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Appendix A

THE UNIVERSITY OF
CALGARY

Department of Educational Psychology

Dear Host Volunteer/Community Professional,

I am writing to provide information regarding a research project, entitled, ***Providers of Support to Survivors of Torture.*** This project is intended to develop a better understanding of the experiences and needs of people who provide support to survivors of torture. Host volunteers and community professionals are being contacted to inform them about the research project and to ask their participation. I am the main researcher for the project and am contacting you with the approval of Calgary Catholic Immigration Society. In our efforts to provide services to refugees who have survived organized violence, we are attempting to expand a training program for volunteers and community-based professionals. This research project is focused on the experiences of people who work with survivors of torture in order to better understand the ways in which future training programs can be developed.

This letter is a request for your participation in the study. This involves meeting with me and a research assistant for up to 3 interviews regarding your experiences in working with survivors of torture. The interviews will take approximately 1 hour each. You should be aware that participation in the research project is strictly voluntary, and you are free to withdraw at any time for any reason.

The interviews will be audiotaped and transcribed into written form. As soon as the tapes are transcribed, they will be destroyed through erasing the information. Your name will not be placed on the transcribed forms, only a number to identify the interview. The tapes and transcribed forms will be kept in a locked filing cabinet at The University of Calgary only accessible to myself and two research assistants that I supervise. Although Calgary Catholic Immigration Society has provided your name as a possible participant, the agency does not receive a copy of the interview information. All information collected will be destroyed by shredding two years after completion of the study. No members of the community will have access to the tapes or transcribed documents and no identifying information would be reported in any published studies.

Participation in this study involves discussing your reactions and experiences of working with survivors of torture. This reflection process may result in thinking about your experiences in ways that you might not ordinarily experience in daily life.

If you have any questions, please feel free to contact me at 220-6756, the Office of the Chair, Faculty of Joint Education Ethics Committee at 220-5626, or the Office of the Vice-President (Research) at 220-3381. Two copies of the consent form are provided. Please return one signed copy to me and retain the other copy for your records.

Your participation in the study is greatly appreciated.

Sincerely,

Nancy Arthur, Ph.D., C.Psych.
Assistant Professor

Appendix B

Interview protocol for providers of support to survivors of torture

1. Discuss your interest in working with survivors of torture.
2. Describe what is rewarding to you about working with survivors of torture.
3. Describe your reaction of being affected by the survivor's experience of trauma.
4. How has your reaction impacted your relationship with survivors of torture?
5. How has your reaction impacted any other area of your life?
6. What have you found to be helpful coping strategies for working through difficult reactions that you experience in working with survivors of torture?
7. What are the needs of community professionals/host volunteers who provide support to survivors of torture?
8. Describe how you would like to be supported in your work with survivors of torture.
9. What recommendations do you have for a program to provide support for professionals/host volunteers who work with survivors of torture?
10. What else would you like to add about your experience, insights, or expertise in working with survivors of torture?

Appendix C

THE UNIVERSITY OF CALGARY

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

CONSENT FOR PARTICIPATION IN THE RESEARCH PROJECT
PROVIDERS OF SUPPORT TO SURVIVORS OF TORTURE

I, the undersigned, hereby give my consent to participate in a research project entitled Providers of Support to Survivors of Torture. I understand that such consent means that I will participate in up to three interviews during the next year, including audio-taping of the interviews.

I understand that participation in this study may be terminated at any time by my request, or of the investigators. I understand the participation in the study requires discussing experiences working with survivors of torture, which I might not otherwise reflect upon in the course of daily life.

I understand that the responses will be obtained anonymously and kept in strict confidence, that audiotapes will only be kept until they are transcribed, and that my name or other identifying information will not be entered on the transcribed material. No identifying information will be reported in any published reports.

I understand that all raw data will be kept in locked file cabinets and destroyed two years after publication of study results.

I have been given a copy of this consent form from my records. I understand that if at any time and have questions, I can contact the researcher at 220-6756, the Office of the Chair, Faculty of Education Joint Ethics Committee, at 220-5626, of the Office of the Vice-President at 220-3381.

_____
Signature of Participant

_____
Date

Appendix D

DEMOGRAPHIC INFORMATION SHEET

Your participation in completing this survey is appreciated. All information will be treated as anonymous to protect individual identification.

1. Professional specialization (e.g. social work, psychologist, educator):

_____

2. Work setting:

- ☐ community agency
- ☐ private practice
- ☐ hospital setting
- ☐ educational setting
- ☐ public clinic
- ☐ _____ (other – specify)

3. Number of years in professional practice: _____

4. Number of survivor of torture clients you have worked with? Between.

- ☐ 1 – 5
- ☐ 5 – 10
- ☐ 10-15
- ☐ 15 – 20
- ☐ 20 – 25
- ☐ 25 – 30
- ☐ 30 – 35
- ☐ 35 – 40
- ☐ 40 and over

5. Age _____

6. Sex: ☐ F ☐ M

7. Country of Birth _____
(This will be reported as ***continent*** in any public document in order to protect individual identity)

8. Number of years living in Canada? _____