SECONDARY TRAUMATIZATION IN THE HELPING PROFESSION:

A CRISIS IN A PANDEMIC THROUGH A PHENOMENOLOGICAL LENS

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ABSTRACT

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Secondary traumatic stress (STS) among helping professionals is a critical issue in times of a global pandemic and mental health crisis. The study delves into the lived experiences of helping professionals with STS due to their involvement with survivors of trauma, using a phenomenological framework. This study focuses on how the participants perceive, internalize, and manage the STS, vicarious trauma, compassion fatigue and burnout, as a result of catastrophic events, especially through the health crisis of COVID-19.

Using Interpretative Phenomenological Analysis (IPA) to develop rich, subjective insights, the research delves deep into secondary traumatization, going beyond surface observations and capturing the underlying experiences of the participants. The research methodology was carried out by having detailed interviews with six licensed clinicians who have worked within the profession for more than five years of active engagement in their fields. This purposeful sampling provided access to participants with different aspects of STS that vary in terms of demographics, practice areas, and personal backgrounds. Emerging from the literature and interviews, I identified four themes: empathic detachment and

depletion, professional self-care practices, emotional and psychological boundaries, and professional support.

My study argues that STS should be better recognized and understood across the helping professions, and comprehensive support is needed to ensure the well—being of integral members of our community. The research underscores the need for ongoing education, appropriate interventions, and preventative measures to address the occupational hazards of secondary trauma, thereby enhancing resilience and effectiveness within the field of helping professionals.

KEY WORDS: Secondary Traumatization, Secondary Traumatic Stress, Compassion Fatigue, Vicarious Traumatization, Burnout.

Image 1: USA Today, Ken Altucker: Huancavelica, Peru, Alessandro Cinque, photographer

DEDICATION

To my beloved wife, Katherine, for your unending love and support. This was a journey of great challenge, with great reward. Because of you, I am.
Christopher, "Our Pride and Joy."

Some things come later in life. "Greater comes later."
Just be ready when they come!

To the memory of the sixty-five family members, friends, and colleagues that I loved
And went away; and the many things that I knew and loved that disappeared.

"He heals the brokenhearted and binds up their wounds."
Psalm 147:3

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PREFACE

My dissertation represents a deep dive into the complex and often overlooked phenomenon of Secondary Traumatic Stress (STS) among professionals in caregiving roles, especially during the extraordinary circumstances of the COVID-19 Pandemic. STS represents a particular challenge and risk of the helping professions that is characterized by the emotional and psychological effect linked to learning about the trauma stories of others. My purpose in this research is to look into the layers of STS—that is, how it manifests, its impacts, and coping mechanisms employed by professionals who find themselves indirectly, yet profoundly, affected by trauma.

I aim to explore at its core the lived experiences of the helping professionals and other allied professionals who come in close contact with trauma survivors. The interviews in this study indeed captured and analyzed their narratives. The participants experience the emotional toll of being close to trauma narratives, highlighting the necessity for effective support systems and coping strategies. The emotional commitment required for this work is, in other words, akin to a double-edged sword. At the same time, it is the setting for vitally important therapeutic relationships but also brings a huge emotional drain when out of control.

The findings in Chapter Four emphasize individual resilience and the importance of systemic support. Here, empathic engagement emerged as both an imperative for good practice and a potential pathway toward personal risk if not coupled with the amount of emotional regulation and professional boundaries required. In that sense, the study highly

recommends coherence in these needs, including support systems within the healthcare setting and organizational support that may ensure sustainable practice.

My dissertation seeks to understand further and more effectively manage Secondary Traumatic Stress for enhanced well–being and quality care among caregivers. This research aims to provide insight into the prevalence and impact of STS and serve as a change agent for policy changes and enhanced practice frameworks. My ultimate goal would be that whoever gives themselves to others is recognized, supported, and protected from the vicarious traumas of their profession. This study opens the discussion for further inquiry into STS to enhance a more sustainable and empathetic approach to caregiving across varied professional landscapes.

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Image 2: Courtesy of the Fire Fighter Leon W. Smith Foundation. Fire Fighter Leon Smith drove the fire engine across the Brooklyn Bridge on September 11, 2001. He ran into Tower One and did not come out.

Chapter One

INTRODUCTION

Secondary Traumatization in the helping professional is the stress of helping traumatized or suffering persons. The prevalence of secondary traumatization, or secondary traumatic stress (STS), among helping professionals underscores the urgent need to understand its multifaceted sources. This includes direct exposure to trauma, media consumption, and technological advancements in order to effectively address the challenges it poses to both the mental well—being of these professionals and their ability to empathize with and support those they serve. This research aims to examine experiences with secondary traumatic stress that may occur through watching television programs, witnessing a traumatic event, reports of violence, mass shootings, and the tragic death of a loved one. Since the invention of mobile phones, laptops, and iPads, our society has become technologically driven; the news is readily accessible through every electronic device imaginable and has become a source of information overload: the constant pinging of news alerts and emails. Social media has facilitated the world's access to graphic depictions of violent events, increasing the risk of STS (Comstock & Platania, 2017). I will focus on how helping professionals who have experienced secondary traumatization can relate to the experiences of those who are sharing them.

STS includes symptoms similar to post—traumatic stress disorder (PTSD) that can occur in helping professionals who frequently listen to trauma histories. The setting event for post—traumatic stress disorder is exposure to a traumatic event during which one feels

fear, helplessness, loss of control, or horror (DSM-V, 2013). Afterward, victims re-experience the event through memories and nightmares (Barlow & Durand, 2005).

Furthermore, the clients of helping professionals who present symptoms consistent with PTSD avoid anything that reminds them of the trauma. The clients display a characteristic restriction or numbing or emotional responsiveness, which may disrupt interpersonal relationships (Barlow & Durand, 2005). They are sometimes unable to remember certain aspects of the events. It is possible that victims unconsciously attempt to voice the experience of emotion itself, like with panic disorder, because intense emotions could bring back memories of the trauma. Finally, victims typically are chronically over-aroused, easily startled, and quick to anger (Barlow & Durand, 2005).

Vicarious trauma, compassion fatigue, and secondary traumatic stress are all conceptualized as reactions to the severe emotional demands on mental health professions. The next chapter discusses these conceptualizations in depth. Compassion fatigue is often used synonymously with STS, as it refers to trauma reactions, specifically in persons who work within a therapeutic context (Ivicic & Motta, 2017). Compassion fatigue is stress from exposure to a traumatized individual (Cocker & Ross, 2016). Compassion fatigue is further explained as "the convergence of secondary traumatic stress and cumulative burnout, a state of physical and mental exhaustion caused by a depleted ability to cope with one's everyday environment" (Cocker & Ross, 2016, p.1). Furthermore, professionals regularly exposed to the traumatic experiences of the people they serve, such as healthcare, emergency, and

community service workers, are particularly susceptible to developing compassion fatigue. The reported changes that occur in mental health professionals working with traumatized persons have also been termed vicarious. McCann and Pearlman (1990) describe vicarious traumatization as a transformation in cognitive schemas and belief systems as a result of empathic engagement with the client's traumatic experiences. This causes significant disruptions in one's sense of meaning, connection identity, and worldview (the world is no longer safe in which to live), as well as in one's affect tolerance, psychologic needs, beliefs about self and other interpersonal relationships, and sensory memory (Pearlman & Saakvitne, 1995, p.151). Mental health clinicians have a distinct susceptibility to vicarious trauma from repeated exposure to aversive details of patients' traumatic experiences.

Description of the Topic

It is a day, twenty-four years ago, that I will not forget. The final few minutes of the Today Show were airing, and the segment was interrupted by Jane Hanson announcing that an airplane had just crashed into one of the Twin Towers. While watching this news alert, I wondered, "What new movie this is?". It was surreal. While the cameras showed the American Airlines Jet penetrating the tower, dangling, I could see smoke coming from the tower. Ashes were falling from the sky. While Ms. Hanson continued to describe the scene, the cameras panned over the scene on the ground, and suddenly, a second jet crashed the second tower. People began to run and scatter, looking for safety, trying to escape from the buildings, fire, smoke, and ash. People were jumping out of windows, engulfed in smoke and dust; it was clear on this day, Tuesday, September 11, 2001, that disaster had hit New York

City. Not since December 7, 1941, the attack on Pearl Harbor, had America experienced an attack on its soil. These were traumatic events, traumatizing, young and old, male and female, children and adults.

Another severe traumatic event impacting the helping professionals and causing secondary traumatization is the recent Coronavirus Disease 2019, COVID-19, with a reach beyond local and national proportions, having a global impact. This virus has disrupted virtually every aspect of daily living, engendering forced isolation and social-physical distancing, economic hardship, fears of contracting a potentially lethal illness, and feelings of helplessness and hopelessness (Polizzi et al., 2020). Past crisis research has revealed an array of responses to crises or disasters, including chronic anxiety and post—traumatic stress, as well as resilience and recovery. COVID-19 is described as the invisible enemy, the angel of death, a relentless and soulless invader that has infected the global psyche with fear and the bodies of our most vulnerable citizens and the broader populace with a potentially lethal illness. This self-mutating virus strikes indiscriminately, with no preference for borders, sex, gender, race, ethnicity, or social class, and poses never—before—seen challenges.

We have been confronted with other traumatic events. In 2019, there have been 38 mass shootings with three or more fatalities (Vigdor, 2019). Vigdor (2019) reports that the Justice Department defines the term mass killings as three or more killings in a single episode, excluding the death of a shooter. There is no legal definition for the term mass shooting, despite its frequent use by gun control groups and the news media.

In recent years, we have heard a great deal about the severe and long—lasting emotional disorders that can occur after a variety of traumatic events. Emotional disorders

also occur after a physical assault, particularly rape, car accidents, natural catastrophes, or the sudden death of a loved one (Barlow & Durand, 2005). Witnessing the murder of George Floyd on television also impacted many Americans, and the Global Community, resulting in vicarious traumatization. Hill (et al. 2020) detailed the arrest and murder of George Floyd, a 46-year-old black man, after a convenience store employee called 911 and told the police that Mr. Floyd had bought cigarettes with a counterfeit $20 bill. They reported that seventeen minutes after the first squad car arrived at the scene, Mr. Floyd was unconscious and pinned beneath three police officers, showing no signs of life. In real-time, witness videos, security cameras, and the officer's body cameras, the world witnessed the series of actions by officers turned fatal. Among those who witnessed this deadly act were the aged in communities of color. In several personal conversations with them in July 2021, they recalled Floyd's death as a triggered memory of their childhood horrors. Many had witnessed family members and neighbors hanging from trees, cross burnings on front yards of homes, beatings, rapes, and abuse. Mary Alice, a friend in her late 80's, a native of Fayetteville, North Carolina, said, "It is modern—day public lynching; it is just not hidden anymore. No one could do anything to stop it. Everyone saw what used to be done in secret and in the dark." Mr. Chauvin, a Minneapolis police officer who is white, kept his knee on Mr. Floyd's neck for at least eight minutes and 15 seconds, according to a New York Times (Hill et al., 2020) analysis of time—stamped video. Dr. Alduan Tartt, a Psychologist from Decatur, Georgia, in an interview with NBC NEWS (nbcnews.com, April 19, 2021), stated, "For many witnessing Floyd's death, it was troubling; black men, in particular, called it 'vicarious traumatization.' These are the same psychological factors that come into play when people see other people

shot," he continued, "It is not happening to us, but it seems like it is happening to us because we are watching it."

In the early days of the pandemic, New York City was in the throes of what would become the deadliest of days to come; a top emergency room doctor at a Manhattan hospital treated many coronavirus patients who died by suicide (Watkins et al., 2020). Dr. Lorna M. Breen, the medical director of the emergency department at New York-Presbyterian Allen Hospital, died in Charlottesville, Va. She succumbed to self-inflicted injuries. She described the devastating scenes of the coronavirus's toll on patients (Watkins et al., 2020). Dr. Breen contracted the coronavirus but returned to work after recuperating for about a week and a half. The hospital sent her home again before her family intervened to bring her to Charlottesville. Her father, Dr. Philip Breen, stated that his daughter had no history of mental illness. However, when he last spoke with her, she seemed detached, and he could tell something was wrong. She described to him the onslaught of patients who were dying before they could even be taken out of the ambulances. "She tried to do her job, and it killed her," says Dr. Philip Breen. She was indeed in the trenches of the front line. She was a casualty just as much as anyone who has died.[1]

While the article details Dr. Breen's sacrifices on the front line, we do not hear what the support was for those in the trenches. For example, Dr. Breen contracted the virus and returned to work after one week away to recover. Doctors are accustomed to responding to

[1] https://www.nytimes.com/2020/04/27/nyregion/new-york-city-doctor-suicide-coronavirus.html

all sorts of grisly tragedies; rarely do they have to worry about getting sick themselves. Was her fitness to return to the trenches questioned? Not just her physical well—being but her mental health. Having witnessed so much devastation, without the opportunity to recover to process her experiences, resulted in her suicide, which is a further indication of the urgency of this topic.

Significance

When a death occurs in traumatic circumstances such as the terrorist attacks of 9-11, Hurricane Katrina, the murder of George Floyd, and the current Pandemic, children and others who witnessed the victims have to deal with their feelings about the terrible manner of the fatality at the same time that they are struggling to come to grips with the actual or probable death of the persons who were lost. Accordingly, traumatic grief differs from "normal" bereavement because preoccupation with aspects of the traumatic event itself may prevent or delay the grieving process and sometimes results in intensified symptoms (Goodnough, 2002, p.1).

In a notable study, Goodnough (2002) revealed concerning results: after the events of 9—11, 75,000 schoolchildren in grades 4 through 12 in New York—equivalent to 10.5% of the children in that age range—exhibited symptoms of post—traumatic stress disorder (PTSD), while 15% experienced agoraphobia. Although children who lived or attended school near Ground Zero were more likely to experience mental health difficulties, they were not as strongly affected as those children who had relatives or acquaintances injured or killed in the attack. Finally, 64% of those students surveyed admitted to having experienced some

previous trauma, ranging from witnessing domestic violence to living in a war—torn country. For these children, their adverse responses to the events of 9—11 were exacerbated (Goodnough, 2002). Galea et al., (2002) and colleagues showed that in the first five to six weeks following the September 11, 2001, terrorist attacks in New York City, 20% of residents living close to the World Trade Center met the criteria for probable PTSD.

Another of the helping professionals experiencing a growing demand to support survivors of various traumatic experiences, including childhood abuse, domestic violence, violent crime, disasters, and war and terrorism are Social Workers (Bride, 2007). It has become increasingly apparent that the psychological effects of traumatic events extend beyond those directly affected. The term "secondary traumatic stress" refers to the observation that people, such as family, friends, and human services personnel, who come into continued, close contact with trauma survivors may also experience emotional disruption, becoming indirect victims of trauma (Figley, 1995, p. 10). Finlay (1999) defined secondary traumatic stress as the natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress of helping or wanting to help a traumatized or suffering person.

Sudden deaths, accidents, illnesses, unexpected job losses, and natural disasters, pandemics often occur with little or no warning. A disaster is a sudden, calamitous event that brings significant damage, loss, destruction, and devastation to life and property (Srivastava, 2010). Additionally, the damage caused by disasters is immeasurable and influences the affected area's mental, socioeconomic, political, and cultural state. Unexpected disasters occur suddenly, causing widespread damage, and are understood to be traumatic and

associated with a high degree of psychological disturbance (Srivastava, 2010). Furthermore, the lives of the survivors are significantly disrupted, which requires lengthy periods of recovery. We cannot prepare for them emotionally or take proactive measures to mitigate their effects (Rudkin, 2003). The attacks on the World Trade Center impacted families and communities across New York City, New York State, and the nation. Hurricane Katrina impacted the communities of New Orleans, destroying homes and separating families. The COVID-19 Pandemic removed the significance of being human, such as embracing, handshaking, when appropriate, greetings with a kiss, sitting and talking face to face, and public gatherings, which were all suspended. People kept their distance from one another, sheltered in place, and live in fear, not knowing what challenges and perils of the day or the following days might bring and if they or a loved one would survive the viral onslaught. Beyond its devastating physical effects, the Pandemic has unleashed a mental health crisis marked by anxiety, depression, post—traumatic stress disorder, and even suicide (Nelson & Kaminsky, 2020). Once social distancing measures started working and the city passed its peak in COVID-19 cases, the adrenaline began to wear off. The floodgates opened, and feelings such as exhaustion, grief, and anger overwhelmed many healthcare workers. There were reports of insomnia, anxiety, depression, and burnout among health professionals. In late April 2020, an emergency room physician and an emergency medical technician stated, "These were collective gut punches to health care workers and emergency physicians and first responders" (Nelson & Kaminsky, 2020, pp. 597-98).

If trauma proves to be contagious (Herman, 1992), and the impact of treating trauma survivors mirrors that of primary trauma, a clinician's interactions with patients could be

negatively influenced. Furthermore, therapists may experience consequences such as disruptions in the therapeutic alliance, conflicts with professional colleagues attempting to rescue or control patients, and breaches of therapeutic boundaries (ibid). COVID-19 has not only caused a global crisis but also resulted in therapists overwhelmed by traumatic material who may begin to avoid or deny their patient's experiences (Figley, 1995). Alternatively, they might push patients too quickly in an effort to mask their own responses. The schematic disruptions associated with vicarious traumatization (Pearlman & Saakvitne, 1995) could also impact clinical work. A clinician whose views of trust and safety have been undermined might be unable to respond effectively to traumatized patients. Recognizing secondary effects requires further investigation of the implications for practitioners because we cannot assume that their responses will not impact the care they provide.

Although trained to cope with traumatic life events, individuals employed in the helping professions are often at risk for developing secondary traumatic stress (Comstock & Platania, 2017). This type of stress appears as a function of not only the constant exposure to traumatic events but also the reliving of traumas through each client's recollection of the specific traumatic life event. These professionals frequently work with individuals and families who have been exposed to trauma in their lives, in some cases, multiple traumas. For example, working with cancer patients, survivors of child abuse, survivors of domestic violence, and torture survivors who may also have experienced community violence and war trauma (Comstock & Platania, 2017).

Mental health professionals and those they serve benefit when they are aware of their reactions to listening and working with those clients who have been traumatized and

understand how these reactions and experiences may either facilitate or impede the therapeutic process and recovery of their clients. Vicarious or secondary trauma involves a transformation of the helper's inner experience, resulting from empathic engagement with clients' stories (Stamm & Figley, 2009). Furthermore, as I will discuss in the next chapter, the Mental Health Professional may develop some symptoms that mirror the post—traumatic stress disorder or depression symptoms experienced by clients who were directly traumatized. Being attentive to survivors' stories also bears a psychological hazard for mental health clinicians, and safe work conditions should demonstrate efforts at mitigating the effects of exposure or how to best cope with vicarious trauma (Quitangon, 2019). In 2013, the American Psychiatric Association revised the PTSD diagnostic criteria DSM-5 and added "repeated or extreme indirect exposure to aversive details of a traumatic event" as a qualifying stressor to meet the criteria for diagnosis of PTSD. This criterion supports the assertion that secondary exposure to trauma is a job-related risk, suggesting that if left unaddressed, vicarious trauma and burnout could progress to PTSD.

The trauma stories told by survivors are personal. They are influenced or colored by many factors, including, in part, the survivor's unique life experiences, cultures, family and psychosocial histories, religious or spiritual orientations, and personalities (Wilson & Thomas, 2004). These same factors influence the therapist or other professionals working with the trauma survivor, along with their particular professional role and orientation — these factors in the survivor and the professional interact with one another during the therapeutic process. The recovery from trauma is promoted when the survivor experiences the therapy environment as a safe and secure place to integrate and work through the trauma

and its effects. One of the critical tasks and challenges of the therapist in this endeavor is to sustain empathy for the client throughout the process. Empathy involves the capacity to understand, be aware of, and vicariously experience the world and perspective of another and feel their distress (Wilson & Thomas, 2004). The clinician's capacity to maintain their empathic stance and stay in tune with the client can become strained as the survivor shares more and more pain and details of their traumatic experiences.

As mentioned, mental health clinicians have a distinct susceptibility to vicarious trauma from repeated exposure to aversive details of patients' traumatic experiences. Understanding trauma has evolved since combat stress was first observed in soldiers returning from war, and the advent of the #MeToo movement heightened awareness of the prevalence of trauma in the general population. The recognition of a wide range of traumatic experiences–physical or sexual assault, motor vehicular accidents, life-threatening illness, unexpected death, or serious injury to significant others, bearing witness to severe human suffering, natural disasters, war, and terrorism—has implications for understanding the vulnerability to vicarious trauma inherent in a clinician's practice (Quitangon, 2019). Unchecked, Secondary Traumatic Stress can be debilitating, like the emotional numbing associated with compassion fatigue. When those in helping professions see a great demand for their services, they may ignore signs of their trauma to serve others (Lipsky & Burke, 2009). Furthermore, the effects of Secondary Traumatic Stress on workers can impede their work, leading to increased absenteeism, impaired judgment, low productivity, poor work quality, high staff turnover, and staff friction (Lipsky & Burke, 2009).

The clinicians specializing in the treatment of trauma hear tales of extreme suffering and observe the emotions of fear, helplessness, and horror registered by survivors consistently. Previous research demonstrates that these occupational duties may cause psychological symptoms in the practitioner who bears witness to the survivors' account of trauma. Secondary trauma among healthcare professionals is a significant concern that has gained attention in scholarly literature and public discourse. A review by Leung et al., (2022) identified 39 studies, revealing a clear indication of growth in this area. In 2003, a search of Psychlit journal articles found only 17 peer—reviewed articles on secondary traumatization. At the time of these, only 12 contained empirical data, most of which were descriptive (qualitative) (Zimering, Munroe, & Gulliver, 2003). More than a decade later, in another review, none of the included studies were qualitative, but the authors did find 40 studies with qualitative data on secondary traumatization that they excluded (Greinacher et al., 2019) Finally, a 2019 qualitative review aimed to synthesize and summarize the current literature on what the authors framed as 'empathy—based stress' at work and contribute to theoretical methodological, and practical improvements. The authors found that qualitative studies exhibit consistent patterns, aiming to uncover insights into individuals' experiences of (secondary) trauma, the occurrence of positive and negative well—being outcomes, and the factors linked to these experiences. However, qualitative methods, such as semi—structured interviews, focus groups and case studies, they concluded are more commonly employed to investigate vicarious traumatization and its contributing factors than secondary traumatic stress (Rouvola et al., 2019). My dissertation is a response to that.

Research Questions

From this concern, this dissertation explores the following research questions. 1) What is known about Secondary Traumatic Stress Disorder in the Helping Professionals? 2) How is Secondary Traumatic Stress experienced, and what is the meaning of these experiences for the Helping Professional? 3) What do these insights mean for the Helping Professionals and for the field of Medical and Health Humanities?

Methodology and Methods

Mixed Methods, Literature Analysis, and Phenomenological Research

This study follows a mixed methods approach, starting with a Narrative Literature Review on Secondary Traumatic Stress (STS) performed using ProQuest, Psychlit, PubMed, and Google Scholar databases to answer the first question. This is followed by a small, qualitative, empirical study to answer the second research question. Qualitative research methods are built around experiential understanding (Stake, 2010, p.20, 62). The third question is answered by combining insights from the literature review and the dialectally understood empirical study: both inform one another and provide insights on secondary traumatization.

For the narrative literature study, keywords such as Secondary Traumatization Stress (STS), vicarious traumatization (VT), post—traumatic stress disorder (PTSD), burnout (BO), and compassion fatigue (CF) were used to find relevant resources. The literature review serves as the foundation for empirical findings of a qualitative, phenomenological study. While existing research primarily concentrates on identifying factors contributing to

secondary traumatization, my primary objective is to delve into the lived experiences of helping professionals who encounter this risk. By exploring their stories and experiences in greater depth, adding vivid detail, and moving beyond theoretical frameworks, I aim to enhance our understanding of secondary traumatization. The qualitative study adopts an Interpretive Phenomenological Analysis design, which will be presented in Chapter Three. Phenomenology acknowledges that humans experience the world in different ways and, therefore, studies the lived experience of phenomena to understand phenomena such as the experience of secondary traumatization. I will follow a particular phenomenological approach: Interpretive Phenomenological Analysis (IPA, cf. Smith & Osborn, 2007, 2009; Creswell, 2013). I chose this approach as it captures the lived experiences of the helping professional, particularly in this Pandemic, instead of primarily focusing on understanding the phenomenon's essence. I gathered and analyzed the in—depth experiences of six Mental Health Professionals in working with traumatized individuals through questionnaires and Zoom interviews. The participants were studied in—depth to provide particularistic insights into their lived worlds (Stake, 2010). The focus is not on the representativeness of these experiences but on what we can learn from a particular case(s). Next, the purpose of the study is not to generalize but to deeply understand the participants' lived experiences. The findings, however, may be transferred to other contexts; we call these "naturalistic generalizations" (Stake, 2010, p. 22). I will elaborate on this methodology in Chapter Three.

Participants were recruited from Treatment Clinics, the Veterans Administration, and Professional Associations. The selection criteria for participants were as follows: working in the field for five (5) years or more; having worked with individuals who have

been victims of trauma; the clients with whom the participants discuss should present with symptoms consistent with Post--traumatic Stress Disorder; and being capable of reflecting on their experiences and sharing these with the researcher in a meaningful manner.

Overview of the Chapters:

This dissertation is organized around three research questions. Chapter two reviews the literature and aims to answer what is currently known about STS in the helping professions (research question 1). Chapter three presents the qualitative research approach, sample, and research methods, including data analysis using interpretive phenomenological analysis. Chapter four showcases the findings of in—depth interviews with clinicians, giving voice to the experiences, highlighting their strategies for working with STS, and discussing their professional support networks (research question 2). Before concluding and providing recommendations in the final chapter, Chapter five critically discusses the findings (research question 3).

Image 3: CDC-Corona Virus, COVID-19; Top Rt: Samaritan Purse, Central Park Medical Tent. Lower Lt Rt: Samaritan Purse, Central Park. www.samaritanpurse.org.

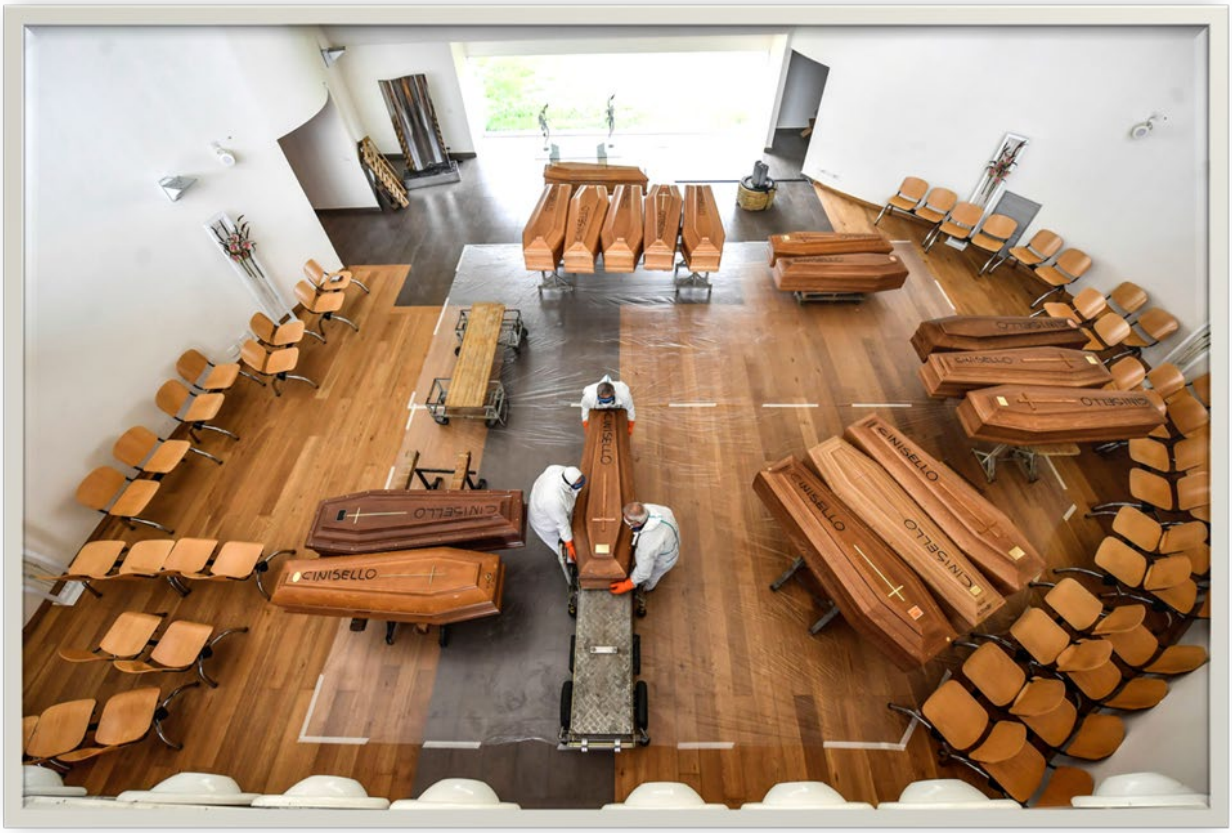

Image 4: ITALY: Coffins arriving from the Bergamo area, where COVID-19 has claimed many lives, are unloaded from a military truck at the cemetery of Cinisello Balsamo, near Milan in northern Italy. (Claudio Furlan/Associated Press)

Chapter Two

LITERATURE REVIEW

Introduction

The phenomenon of secondary trauma among healthcare professionals is a topic that is receiving increasing attention in scholarly literature and public media. This condition, resulting from exposure to other's traumatic experiences, can lead to symptoms mirroring post—traumatic stress disorder. Various toolkits, podcasts, for example, *TEDx Talks, Trauma Rewired, Healing Trauma; Podcasts, Transforming Trauma*, and seminars have been developed to raise awareness and offer coping strategies for STS. This growing body of resources reflects an ongoing effort to address this occupational hazard comprehensively. In a review of the literature, *A Personal History of Trauma and Experience of Secondary Traumatic Stress, in Mental Health Workers*, Leung et al. (2022) highlight the significant association between personal trauma history and the occurrence of STS and vicarious trauma in healthcare professionals. Moreover, personal trauma history is a central feature of STS bearing both practical and theoretical relevance (Leung, et al., 2022). It is important to identify a clear, robust definition of Secondary Traumatic Stress (STS) and its impact on the helping professional.

Some critics of this growing interest argue that diagnosing clinicians with STS medicalizes their response and suggests it should be viewed as a natural reaction rather than a pathological disorder (Molnar et al., 2017; Branson, 2019). They suggest that labeling these

reactions as a disorder could imply that they are abnormal, whereas they may be a normal human response to continuous empathetic engagement with traumatic material (Molnar, et al., 2017; Branson, 2019). This perspective is rooted in the broader debate about the medicalization of normal psychological responses. For instance, McHugh and Treisman (2007) argue that diagnosing PTSD and related conditions too broadly can obscure the context of an individual's overall life experience and personality, potentially leading to over-diagnosis and inappropriate treatment. They emphasize that reactions to trauma can often be part of the normal human experience rather than indicative of a pathological condition.

Moreover, some researchers highlight the potential for such diagnoses to create unnecessary stigma and possibly undermine the resilience and coping mechanisms that many clinicians naturally develop over time (Greinacher, et al., 2019). By framing these reactions as disorders, there is a risk of overlooking the normal adaptive processes and the strengths that clinicians use to manage their work-related stress. This nuanced view encourages supportive measures that enhance resilience and coping without necessarily pathologizing the experience (Figley & Ludick, 2017).

Several seminal studies have significantly shaped the understanding of STS. Figley (1995) is often credited with introducing the concept, describing it as the emotional duress experienced when an individual hears about the firsthand trauma experiences of another. Figley's work laid the groundwork for subsequent research, emphasizing the importance of recognizing the mitigating STS among caregivers. Bride et al. (2004) expanded on this by developing the Secondary Traumatic Stress Scale (STSS), a reliable and valid instrument for

measuring STS symptoms, thus providing a standardized method to assess the condition's prevalence and severity in various professional groups. Figley (1995), McCann and Pearlman (1990), and Stamm (2002) have written extensively on the phenomena of secondary traumatization, the level of corroborative data gathered in the United States of America needs to be commensurate with the sophistication of existing theories. The presence of systemic reviews is usually a good indicator of the state of the art of a field, and as—to—date there are a few systemic reviews on secondary trauma published in the USA. A 2013--study in Auckland, New Zealand, (Nimmo & Huggard, 2013) reported a significant gap in the literature, with only a small number of studies meeting the criteria for inclusion. Using various instruments, including the Professional Quality of Life (ProQOL) scale and the Trauma Stress Institute Belief Scale (TSI-BSL), to assess the levels of these constructs, the findings indicated that these emotional stressors are present among physicians, similar to other healthcare professionals. Furthermore, the authors concluded that while Compassion Fatigue (CF), Vicarious Traumatization (VT) are acknowledged in the literature, STS has received less attention, emphasizing the need for further studies exploring the effectiveness of interventions aimed at mitigating the effects of CF, VT, and STS to support the well—being of physicians. More recent Pellegrini's et al., (2022) in Cork, Ireland, found that psychologists generally do not meet the clinical threshold for STS, although specific prevalence rates could not be determined due to the variability in studies' methodologies and the paucity of research in this area (Pellegrini et al., 2022). Nimmo and Huggard (2013) systematically reviewed the literature on compassion fatigue, vicarious trauma, and secondary traumatic stress among physicians. The study aimed to identify the prevalence and impact of

these conditions, which describe the emotional toll on healthcare professionals who work with traumatized patients.

In this chapter, I expand on this brief overview and report on the current body of literature on secondary traumatization, ultimately to contribute to the well—being of health and mental health professional who work with trauma survivors. This literature review lays the groundwork for the empirical findings presented in Chapter 4. While existing research focuses on identifying factors contributing to secondary traumatization, my primary aim is to explore the lived experiences of helping professionals facing this risk. By delving deeper, seeking detail, giving color to their stories and experiences, I hope to expand our understanding of secondary traumatization beyond theoretical frameworks. Colleagues report working with trauma survivors as a mental health professional is often challenging. Similarly, these experiences of burnout, compassion fatigue and vicarious trauma were reported among the psychotherapists in Ireland (Pellegrini et al., 2022). It frequently places us as professionals at risk for difficult countertransference reactions, vicarious trauma, and, over time, symptoms of burnout. Expanding and deepening our qualitative understanding of the everyday experiences of helping professionals listening to traumatized patients' stories is crucial for developing effective interventions, preventive measures, and support systems for mental health professions.

I will now discuss what is known already, provide an overview of possible definitions and descriptions, including the relationship between post—traumatic stress disorder and

related disorders. Definitions and descriptors are followed by stressors, signs and symptoms, and studies that report on the widespread reach and impact of secondary traumatization.

Secondary Traumatization: definitions and descriptions

Secondary Traumatization in helping professions refers to the stress experienced by professionals who assist traumatized or suffering individuals. This type of trauma can arise in various ways, including viewing traumatic events on television, hearing reports of violence, and mass shootings (Sprang et al., 2018). Secondary Traumatization is closely related to Post—traumatic Stress Disorder. According to the Diagnostic and Statistical Manual of Mental Disorder (DSM-V, 2013), Post--traumatic Stress Disorder (PTSD) is characterized by four criteria:

1. Intrusion, involving recurring distressing memories.
2. Avoidance, marked by efforts to evade trauma-related cues.
3. Negative changes in cognition and mood.
4. Alterations in arousal and reactivity, exemplified by heightened vigilance and startled responses.

PTSD is a mental health condition triggered by experiencing or witnessing a terrifying event. Symptoms may include flashbacks, nightmares, severe anxiety, and uncontrollable thoughts about the event. For a diagnosis of PTSD, a client must have all of the following for at least one month: at least one re-experiencing symptom, one avoidance symptom, two arousal and reactivity symptoms, and two cognition and mood symptoms. The etiology of PTSD is

multifactorial, encompassing biological, psychological, and social factors. Research suggests a genetic predisposition to PTSD, along with neurobiological alterations such as changes in the brain's response to stress (Yehuda, 2002).

Table. 1
Post—traumatic Stress Syndrome Symptomology

Symptoms	Categories
Intrusive Memories:	This includes recurrent, unwanted distressing memories, flashbacks, or dreams related to the traumatic event. There might also be intense emotional distress or physical reactions to reminders of the traumatic event.
Avoidance:	This manifests as avoiding thinking or talking about the traumatic event or avoiding places, activities, or people that remind one of the traumatic event.
Alterations in Cognition and Mood:	This might include negative thoughts about oneself or others, ongoing fear, horror, anger, guilt, or shame. There might be a loss of interest in activities that were once enjoyable and a feeling of detachment or estrangement from others.
Alterations in Arousal and Reactivity:	This includes being easily startled or frightened, always being on guard for danger, self-destructive behavior, trouble sleeping, and trouble concentrating.

Helping professionals, including therapists, social workers, and emergency responders, are particularly vulnerable to developing PTSD due to their regular exposure to their client's traumatic events or stories. Professionals in mental health who specialize in treating individuals with trauma often witness survivors' reactions of fear, helplessness, and horrors. These professionals may develop psychological symptoms from listening to traumatic experiences of STS or vicarious trauma may occur, where symptoms of PTSD manifest from exposure to the trauma of others (Barnett et al., 2007; Figley, 1995). For example, a New

Zealand study studying social workers working with clients with histories of trauma showed these professional experienced Secondary traumatization (Smith & Hanna 2021).

Various terms for secondary traumatization are often used interchangeably (Pellegrini et al., 2022). In general, secondary trauma focuses on cognitive and emotional transformation that happens from the empathic engagement with trauma survivors (e.g., a counselor's previously held belief that the world is relatively safe place has permanently changed to one in which the world is an unsafe place), (Pearlman & Saakvitne, 1995; Leung et al., 2023). Nimmo and Huggard (2013) list the most common constructs of secondary traumatization (ST), Compassion fatigue (CF), Vicarious trauma (VT), Secondary traumatic stress (STS), Post--traumatic Stress Disorder (PTSD), and Burnout (BO). Frequently, ST, VT, STS, PTSD, BO and CF are used interchangeably in the literature (Cieslak et al., 2013; Golab et al., 2016) and are referred to and researched as not conceptually distinct (Bercier & Maynard, 2015). While this creates some confusion for researchers trying to understand by measuring these concepts there is a general consensus regarding the facts that these constructs result from working with traumatized people (Bercier & Maynard; Cieslak et al., 2013; Golab et al., 2016; Greinacher et al., 2019; Huggard et al., 2017; Nimmo & Huggard, 2013; Sodeke-Gregson et al., 2013). Although examination of certain similarities and differences between these terms has found that all concepts share at least one or more of the following symptoms: in direct exposure to traumatic material, symptoms of PTSD, and negative shifts in therapist cognitive schema (Jenkins & Baird, 2002). When studying the literature, I clearly noticed overlaps between these constructs, and I also found additional constructs, such as *shared trauma* (Stahnke & Firestone, 2023) which I will discuss later on in

this chapter. My purpose is not to develop a philosophical conceptual chapter, but I will explore how these constructs are described in the included literature.

Compassion Fatigue

Compassion fatigue is characterized by a spiritual, emotional and physical exhaustion, with little interest by the clinician in being empathic, often due to prolong exposure to the suffering of others (Mento et al., 2019). Secondary traumatization is similar to compassion fatigue with regard to the psychological symptoms of the helping professional linked to an empathic alteration, but it is usually referred to as acute reactions that occur in a short period (Grant et al., 2019; Greinacher et al., 2020; Kolthoff & Hickman, 2017). Compassion fatigue derives more specifically of direct exposure to patient care, while STS mainly originates from traumatic experiences or exposure to traumatic facts in both cases experienced by other people.

Compassion fatigue is characterized by the diminishing capacity of health and mental health professionals in response to the distress caused by their patients' suffering (Mento et al., 2020). Often used interchangeably with Secondary Traumatic Stress (STS), compassion fatigue encapsulates the emotional and behavioral repercussions experienced by health and mental health professionals within therapeutic contexts (Ivicic & Motta, 2017). The literature describes the concept of compassion fatigue as the progression, cumulative, continuous, intense, and stressful contact with patients leading to a compassion discomfort that exceeds healthcare work's endurance levels (Gerard, 2017; Van Mol et al., 2015; Zhang et al., 2018).

Simpson and Starkey's (2006) definition of Compassion Fatigue as a state of exhaustion and dysfunction—biologically, psychologically, and socially—resulting from prolonged exposure to compassion stress aligns it with secondary traumatic stress disorder and equates it to post--traumatic stress disorder. Professional literature utilizes various terms, such as secondary traumatization, secondary traumatic stress disorder, or vicarious traumatization (Figley, 1995; Pearlman & Saakvitne, 1995; Mento et al., 2020; Simpson & Starsky, 2006). Despite differences in nomenclature, a common thread prevails: the delivery of care to those with secondary traumatic stress disorder often involves absorbing information about human suffering (Figley, 1995, Mento et al., 2020).

Burnout

According to the literature, compassion fatigue differs from burnout, even though I found that the two terms may be used interchangeably, and without much conceptual clarity. Burnout, defined by symptoms of personal and organizational stressors, can result in a state of emotional exhaustion, depersonalization, and negative self-worth (Maslach, 1993: Maslach & Leiter, 2017). The concept, initially outlined by Maslach and Jackson (1981), emphasizes an overwhelming exhaustion, feelings of cynicism and detachment from the job, often experienced by individuals involved in people—oriented professions, and a sense of ineffectiveness and lack of accomplishment (Maslach, 1993; Maslach & Leiter, 2017). Burnout, as a consequence, is the experience of a reduced quality of professional and personal life.

Burnout is regarded as an experience rather than a diagnostic entity, and it is better understood dimensionally rather than categorically (Summers et al., 2020). However, it tends to overlook the intricate relationship between the context of trauma work and personal experiences (Pearlman & Saakvitne, 1995). The authors' model further delineates symptom patterns observed in therapists working with traumatized populations, including nightmares, intrusive images, reenactments, amnesia, estrangement, alienation, irritability, and psycho-physiological reactions.

Addressing the challenges arising from exposure to traumatic content, McCann and Pearlman (1990) propose strategies for therapists to transform and integrate clients' trauma, promoting effective service delivery while safeguarding themselves against potential adverse effects. Although burnout commonly results from heightened workloads and institutional stress, its causal factors differ from those of secondary trauma, which typically emerges from exposure to a client's traumatic experiences (Stamm, 2002).

Vicarious Traumatization

Another term that expands on the constructs of Burnout and Secondary Traumatic Stress is vicarious traumatization (VT). Vicarious traumatization describes the cumulative transformative effect of working with trauma victims (Pearlman & Saakvitne, 1995). It encompasses the detrimental alterations in professionals' perspectives of self, others, and the world due to prolonged exposure to graphic and traumatic content from their clients (Greinacher et al., 2016). Examples provided by McCann and Pearlman (1990) illustrate how beliefs in personal invulnerability or the orderly nature of the world may be challenged by

the narratives encountered during counseling or psychotherapy with trauma survivors. This form of trauma can be viewed as a normal response to the continual challenges to a helper's belief values, potentially leading to a decline in motivation, efficacy, and empathy over time.

It is important to identify a clear definition of VT to support an understanding of how it can impact on helping professionals and what this means. Vicarious traumatization is a profound transformation in cognitive schemas and belief systems resulting from empathic engagement with clients' traumatic experiences is integral to understanding STS. As outlined by Pearlman and Saakvitne (1995), vicarious trauma manifests through disruptions in crucial areas of schema—safety, trust, esteem, intimacy, and control—representing fundamental psychological needs experienced in relation to both self and others.

My research accentuates the multifaceted impact of VT in the helping professionals' sense of meaning, connection, identity, worldview, affect, tolerance, psychological needs, beliefs about self and others, interpersonal relationships, and sensory memory (Perlman & Saakvitne, 1995, p151; Nimmo & Huggard, 2013; Leung et al., 2022).

While acknowledged as a normal response to these challenges, VT carries a professional cost, impacting therapists' well—being and potentially compromising their ability to provide effective support.

Secondary Traumatic Stress

Secondary Traumatic Stress (STS) is a natural stress response triggered by witnessing or knowing about the trauma experienced by significant others, resulting in emotional distress akin to post--traumatic stress disorder (Figley, 1995; Mento et al., 2020). STS is

further described as the natural consequences of emotions and behaviors stemming from knowledge about a traumatizing event in a significant other's life, often acquired through helping or wanting to help a traumatized person.

Recognized as an occupational hazard for those providing direct services to traumatized populations, STS shares characteristics with compassion fatigue, vicarious trauma, and burnout, all of which are reactions to the emotional demands faced by mental health professionals dealing with traumatic stress (Figley, 1995; Ivicic & Motta, 2017). Empirical studies, such as those by Ivicic and Motta (2017), have explored the predictors and correlates of STS in mental health professionals, highlighting the risk of experiencing traumatic stress symptoms when working with traumatized populations. The results revealed that between 23 and 27% of the respondents in their study exhibited vicarious traumatization. The key predictors of secondary traumatization included higher caseloads of trauma clients, lack of professional support, and personal trauma history (Ivicic & Motta, 2017).

In a study on social workers, Figley (1995), Newell and MacNeil (2010) investigate the prevalence of STS by examining individual symptoms, the frequency of meeting diagnostic criteria for PTSD, and the severity of STS levels, contributing valuable insights into the lived experiences of those with STS symptoms. By examining individual symptoms, we gained insights into the impact of STS on daily life and how it can adversely affect social workers' professional functioning, reduced job performance, increased absenteeism, and higher turnover rates (Figley, 1995; Newell & MacNeil, 2010).

There have been some attempts to conceptualize better the three constructs of compassion fatigue, vicarious traumatization, and secondary traumatic stress (Figley, 1995; Bride, 2007; Rothschild, 2022). While there appear to be similarities among the constructs individually, they each contribute to understanding the positive and negative aspects of caring. Other common characteristics of these three constructs are that they may be experienced by anyone working in a helping and caring profession, that they are the result of exposure to the suffering of others, and that such experiences may result in long-term adverse effects on one's ability to perform ones' professional roles and maintain safe and effective therapeutic relationships with patients and clients.

Emerging construct: Shared Trauma

A relatively under researched construct is *shared trauma.* A recent study by Stahnke and Firestone, (2023), mentions secondary traumatization has solidified into the concept of *shared trauma* during the last two decades. *Shared trauma* is defined as the affective, behavioral, cognitive, spiritual and multimodal responses that mental health professionals experience as a result of primary and secondary exposure to the same collective trauma as their clients has solidified in the last two decades (Stahnke & Firestone, 2023). The researchers found past trauma as well as being more closely exposed to the trauma of victims were both predictive of one's own trauma symptoms, post—traumatic growth, and stronger therapeutic alliances were also benefits of shared trauma experiences (Stahnke & Firestone, 2023). Most literature

on *shared trauma* exists outside of the United States, indicating a need to seek a deeper understanding of shared trauma among U.S. based health professionals.

Countertransference

Additionally, countertransference is closely related to STS. Countertransference is a well-known phenomenon that, some scholars argue, may be perceived as another form of Secondary Traumatic Stress (Figley, 1995; Pearlman & Saakvitne, 1995). Countertransference traditionally refers to activating the therapist's unresolved or unconscious conflicts or concerns (Hayes, Gelso, & Hummel, 2011). Moreover, within the victimization literature, countertransference has more broadly incorporated the painful feelings, images, and thoughts that can accompany working with trauma survivors (Herman, 1992; Pearlman & Mac Ian, 1995). At first glance, these descriptions show an overlap between countertransference and secondary traumatic stress in which clinicians display an active over-identification stance (Figley, 2002; Rothschild, 2006). Clinicians may be predisposed to developing one type of countertransference reaction over another, but some may experience both during the course of their work. Some countertransference reactions may result in the clinician developing an objective or subjective empathic strain (McCann & Pearlman, 1990).

Traditional views of countertransference specifically refer to activating the counselor's unresolved or unconscious conflicts or concerns (McCann & Pearlman, 1990). Even the broadest definition of countertransference refers to the therapist's emotional and behavioral responses to the client. It is thus restricted to what is taking up the whole of the

caregiver's lives, affecting their relationships with themselves, their social networks, and their work with clients (Stamm, 2002). Countertransference affects not only the professional's work with the client but also interpersonal relationships outside of the professional setting.

Stressors, signs and symptoms

Now that I reported on the various constructs and how they are described in research, I will move toward an overview of what is known about the stressors, trajectories (including signs and symptoms), and the everyday lived experiences of helping professionals who suffer secondary traumatization.

It has become increasingly apparent that the psychological effects of traumatic events extend beyond those directly affected (Bride, 2007). Nowadays, symptoms of secondary traumatization are more common because helping professionals are increasing being called on to assist survivor of childhood abuse, domestic violence, violent crimes, disasters, war, and terrorism. Secondary traumatic stress is becoming viewed as an occupational hazard in providing direct services to traumatized populations.

In cases of secondary traumatization, the majority of individuals are exposed to at least one and often several potentially traumatic events during their lifetime. Bereavement, life-threatening medical events, and other significant stressors are even more common. The links between these events and the development of psychopathology, such as Post—traumatic Stress Disorder or Persistent Complex Bereavement Disorder, are well established. In another review, Galatzer-Levy (et al., 2018) analyzed studies from different types of

disasters, including human-made and technological disasters, natural disasters, and adult civilian traumas or accidents. The four trajectories were consistently identified: Resilience, never showing more than mild distress; Recovery, initially showing above threshold symptoms that decrease gradually to normal levels over time; Chronicity, showing pronounced symptoms from the onset and after that; and Delayed onset, elevations above the diagnostic threshold that emerge following a significant delay. Although the majority of survivors initially exhibit psychological distress and or deterioration in their functional abilities, approximately two-thirds do not require treatment from mental health professionals and show resilience, recovery, or subsyndromal (elevated symptoms below the diagnostic threshold) symptomatology (Galatzer-Levy et al., 2018). Conversely, about one—third of people exposed to the disaster exhibit chronic distress or dysfunction.

When a death occurs in traumatic circumstances such as the terrorist attacks of 9—11, children and others who knew the victims have to deal with their feelings about the terrible manner of the fatality at the same time that they are struggling to come to grips with the actual or probable death of the persons who were lost. According to Goodnough (2002), traumatic grief differs from 'normal' bereavement because preoccupation with aspects of the traumatic event itself may prevent or delay the grieving process and sometimes results in intensified symptoms. Mental health professionals and those they serve benefit when they are aware of their own reactions to listening and working with those clients who have been traumatized and understand how these reactions and experiences may either facilitate or impede the therapeutic process and recovery of their clients.

Helping professionals must recognize the signs and symptoms of secondary traumatic stress, compassion fatigue, and depression in their own lives—not just in the lives of their clients (Hunter, 2016). In *Trauma and the Therapist*, Perlman & Saakvitne (1995) explore the role and experience of the therapist in the therapeutic relationship with adult incest survivors by examining countertransference, the therapist's response to the client, and vicarious traumatization (the therapist's response to the stories of abuse told by the client). Therapists' awareness of attunement to these processes will inform their therapeutic interventions, enrich their work, and protect themselves and their clients.

Feelings of resentment toward specific clients or feeling burdened by certain clients can be warning signs of burnout or fatigue (Shallcross, 2011). Moreover, other warning signs might include becoming sloppy with administrative details, neglecting case notes, starting sessions late and ending late, and missing appointments. This would also include exhaustion, problems at home, and losing your sense of humor. Unfortunately, once these signs and symptoms are recognized and acknowledged, it is probably unrealistic to expect that many helping professionals will get the help they need in a timely fashion (Hunter, 2016). Hence, it is crucial that the helping professionals are members of communities where they can be transparent, receive empathy, and be held accountable to move toward wholeness and healing.

The helping professional may also feel distant, isolated, and disconnected in their relationships at home because they have no emotional energy left to give their significant others in their lives. Figley (2002) states, “It is vital to increase the therapist’s support system in both numbers and variety of relationships so that he or she is viewed apart from the

therapist persona" (p.1439). The helping professionals need assistance from time to time and emotional support—just like everyone else. Therapists empathize as a precious gift; they also need the precious gift of empathy.

Therapists may experience painful images and emotions associated with their clients' traumatic memories and may, over time, incorporate these memories into their own memory systems (McCann & Pearlman, 1990). As a result, therapists may find themselves experiencing PTSD symptoms, including intrusive thoughts or images and painful emotional reactions. The therapist must be able to acknowledge, express, and work through these painful experiences in a supportive environment. This process is essential if therapists are to prevent or ameliorate some of the potentially damaging effects of their work. Suppose these feelings are not openly acknowledged and resolved. In that case, there is the risk that the helper may begin to feel numb or emotionally distant, thus unable to maintain a warm, empathetic, and responsive stance with clients (McCann & Pearlman, 1990). Moreover, helpers must understand how their own schemas are disrupted or altered through the course of their work and also shape the way they respond to clients.

The first category of studies looked at STS as a natural response triggered by trauma narratives. The second category of studies explores secondary traumatization as a function of occupational roles. It examines the variables that correlate with the development of symptoms (Zimering, Munroe, & Gulliver 2003). Jenkins and Baird conducted eight studies focusing on the phenomena of secondary trauma among counselors with diverse training, caseloads, degrees, and socioeconomic status exposed to trauma through their work (Jenkins & Baird, 2002). They report all eight studies described a stable set of symptoms analogous to

PTSD. However, a very low incidence of meeting clinical criteria (range between studies: 0% to 4%) or impairment in occupational roles was reported. This result is difficult to interpret, as the current status of the psychometric utility of available instruments decreases confidence in any conclusion, and each study used a different set of assessments. Trauma counselors are likely to report some negative consequences of their work that map onto a PTSD typology. How often this symptom profile is clinically significant and how symptoms affect patient care remains to be seen.

Widespread reach and impact of Secondary Traumatic Stress

Having explored diverse conceptualizations of STS, stressors, and its effects in previous sections, it's crucial to emphasize the widespread reach and significant impact of these problems. The study "*Well—being, Burnout, and Depression Among North American Psychiatrists: The State of Our Profession"* (Summers et al., 2020) provides a comprehensive exploration of burnout and depressive symptoms among North American psychiatrists. Although the primary focus of the study is on burnout and depression, insights into STS can be gleaned by examining the factors associated with these conditions while understanding the broader implications of mental health strain on psychiatric professionals.

The study's quantitative analysis involved 2,084 North American psychiatrists who participated in an online survey, completing the Oldenburg Burnout Inventory (OLBI) and the Patient Health Questionnaire–9 (PHQ-9). The results revealed a significant prevalence of burnout (78% with OLBI scores ≥35) and depression (16.1% with PHQ-9 scores ≥10)

among participants. These statistics are alarming, highlighting a substantial mental health burden within the psychiatric profession.

While the study directly measures burnout and depression, the high prevalence of these conditions among psychiatrists indirectly points to the potential impact of STS. The exposure to traumatic stories and the emotional labor involved in empathetically engaging with patients can contribute to these outcomes. The quantitative data underscore the magnitude of the problem and the need for targeted interventions to address mental health issues among psychiatrists.

Although the study primarily presents quantitative findings, several qualitative implications for STS can be derived from the analysis of demographic and practice characteristics associated with higher levels of burnout and depression (Summers et al., 2020). Moreover, factors such as the inability to control one's schedule and the work setting were significantly associated with higher OLBI scores. In contrast, female gender, resident or early-career stage, and nonacademic setting practice were associated with higher PHQ-9 scores. These findings suggest that environmental and job—related stressors, combined with the intrinsic challenges of psychiatric practice, contribute to mental health strain, which can be a fertile ground for STS.

The study's findings highlight the importance of addressing workplace conditions and providing support systems to mitigate the effects of STS. Although STS may adversely affect practitioners and the services they deliver, work with trauma survivors can also be immensely rewarding and has the potential to allow practitioners to grow personally and

enhance their compassion, provided responses to this challenging work are used constructively (Zimering, et al., 2003).

Qualitative Perspectives

My research focuses on understanding the lived experience of secondary traumatization among health professionals through a qualitative lens, particularly a phenomenological approach. While psychological studies often utilize scales and psychometrics with roots in phenomenology and qualitative research, they typically aim to establish generalizable findings, by studying larger groups or controlled settings. They also aim to develop theories, identify causal relationships, and create evidence—based interventions. My research doesn't focus on these but aims to understand and communicate the depths and nuances of first-person experiences of a small number of professionals' subjective experiences. One example of a phenomenological study is by Bruce Perry (2021) in his book, *"What Happened to You?"* He delves into the profound effects of trauma on individuals, particularly through the lens of secondary traumatic stress and its impact on both the body and helping professionals. Using a phenomenological perspective, Perry (2021) emphasizes understanding trauma by exploring individuals lived experiences rather than merely their behaviors or diagnoses. This approach highlights the deeply personal and subjective nature of trauma, focusing on how these experiences shapes one's perception of the world and interactions with others.

Further, the author elucidates how trauma, including secondary traumatic stress, manifest in the body. Perry (2021) describes the neurobiological changes that occur as a

result of chronic stress and trauma exposure. The body's stress response system, particularly the hypothermic pituitary adrenal axis becomes dysregulated, leading to physical symptoms such as chronic pain, fatigue, and susceptibility to illness. This somatic dimension of trauma is crucial for helping professionals to understand, as it not only affects their clients but also themselves. The chronic exposure to the traumatic narratives of others can lead to a state of constant physiological arousal and stress, which, over time, can have detrimental effects on their health. By adopting a phenomenological perspective professionals can better appreciate the depth of their own experiences and the necessity of addressing their emotional and physical well—being. By recognizing and addressing the effects of secondary traumatic stress, professionals can foster resilience and maintain their capacity to support those in need effectively.

Another author who acknowledges the meaning of the bodily experience is van der Kolk (2014) in *"The Body Keeps The Score,"* delves into the profound effects of trauma on the body-mind, emphasizing the crucial role of meaning making in the healing process, particularly for helping professionals affected by secondary traumatic stress. Meaning-making refers to the process by which individuals interpret and make sense of traumatic experiences, integrating them into their broader life narratives. This process is essential for mitigating the adverse effects of STS and fostering resilience. Meaning making is not just a cognitive exercise but also involves emotional and somatic dimensions. Helping professionals are encouraged to use body-based therapies, such as mindfulness and yoga, to reconnect with their bodies and emotions. These practices facilitate a deeper understanding of their own reactions to trauma and support the integration of traumatic experiences into a

coherent narrative. By doing so, helping professionals can transform their pain into growth and resilience.

Moreover, van der Kolk (2014) emphasizes the importance of supportive relationships and community in the meaning-making process. Sharing experiences with colleagues, engaging in supervision, and participating in peer support groups can provide validation and different perspectives, aiding in the construction of meaning. These connections offer a buffer against the isolating effects of STS, reinforcing a sense of shared purpose and collective resilience. Finding meaning is a vital component of healing and sustaining the capacity to support others.

While the literature investigates the phenomenon of secondary traumatization stress (STS) among practitioners assisting trauma survivors, much research still focuses on finding explanations and factors that contribute to STS. My review of the literature outlines various trauma—induced stress types, such as vicarious trauma, compassion fatigue, and burnout, noting their detrimental effects on those in mental health professions. After reviewing these sources, I sense a need for a clearer distinction between the various stress types. Also, countertransference is examined both as a potential hazard and a beneficial therapeutic technique. How do mental health professionals experience these theories in their everyday practice? Ultimately, the literature underscores the significance of self-awareness, self-care practices, and support systems in combating STS, suggesting these areas are critical for future research and practice. Enriched by these insights, I will guide my empirical study and interview with mental health professionals. By exploring their lived experiences of secondary traumatization (e.g., emotional reactions, vicarious trauma, compassion fatigue), I aim to

capture the nuanced human dimensions of this issue through close listening and seeking rich anecdotal data.

Image 5: COVID-19's Third Surge Is Breaking Health—Care Workers.

Chapter Three

METHODOLOGY OF THE QUALITATIVE STUDY

Introduction

In order to answer the second Research Question of my study. How is Secondary Traumatic Stress experienced and what is the meaning of these experiences for the Helping Professional, a qualitative, empirical study was carried out. For my empirical research, Creswell's work provides the structure using Phenomenological Design. An American academic, Creswell (2013), is known for his work in mixed methods research, exploring the philosophical underpinnings, history, and key elements of each of various qualitative inquiry traditions such as: narrative research, phenomenology, grounded theory, ethnography, and case study. He has written numerous journal articles and 27 books on mixed methods research, research methods, and qualitative research. In *Qualitative Inquiry and Research,* Creswell (2013) addresses these issues by guiding major design decisions, such as deciding a paradigm, stating a purpose for the study, identifying the research questions and hypotheses, using theory, and defining and stating the significance of the study.

The phenomenological approach in this research proposes to move beyond the surface and explore Secondary Traumatization's underlying, experienced meanings of research participants. Phenomenology is committed to describing, not explaining, how and why meanings arise (Finlay, 1999). Finlay (1999), an Integrative Psychotherapist writes about

the therapeutic relationship and ethics in research and is interested in studying trauma and disability from a phenomenological stance. In previous relational—centered phenomenological research projects, she has explored several topics, including the lived experience of having a cochlear implant, early-stage multiple sclerosis, and the trauma of abortion.

Interest in phenomenological research has been growing steadily over the last decade as researchers have sought to capture the richness of individual experience, which will be a significant part of my study. However, the sheer complexity of ideas embedded within phenomenology is challenging. Confusion abounds as to what phenomenology means, let alone how to apply it as a research method. Misconceptions and contradictions are apparent in the literature. One approach to phenomenology that has been developed and applied rigorously by various psychologist researchers is Interpretative Phenomenological Analysis, developed by Jonathan Smith.

Interpretive Phenomenological Analysis (IPA)focuses on exploring how individuals make sense of their personal and social experiences. This methodology allowed me to delve deeply into the lived experiences of helping professionals who are exposed to trauma through their work (Smith, Flowers & Larkin, 2009). In using this approach, I was able to gather rich, detailed accounts of how the participants perceived their experiences with STS, shedding light on the nuanced ways in which STS affected their professional and personal lives. The participants often experience complex interplay between their personal and professional identities especially when dealing with trauma. IPA allowed me to explore how

the participants navigate this interplay and how their work-related stress influences their sense of self (Brocki & Warren, 2006).

McCann and Pearlman (1990) discuss therapists' reactions to clients' traumatic material. The phenomenon they term 'vicarious traumatization' can be understood as related to the graphic and painful material trauma clients often present and the therapist's unique cognitive schemas or beliefs, expectations, and assumptions about self and others. The authors suggest ways that therapists can transform and integrate clients' traumatic material to provide the best services to clients, as well as to protect themselves against serious harmful effects.

STS involves complexed emotional and psychological responses to the trauma experienced by others. IPA is particularly suited to understanding these responses because it prioritizes the participants subjective interpretations and the meanings they ascribed to their experiences (Smith and Osborne, 2015). This approach aligns with the concept of meaning making which is crucial in understanding how helping professionals process and cope with secondary trauma. Through IPA, I capture the diverse ways individuals construct meaning from their experiences, which can inform more tailored and effective interventions. IPA contributes to the theoretical understanding of STS by providing empirical data grounded in the real—life experiences of the participants. These data can be used to refine existing theories of trauma and stress or to—even though that is not my aim in this dissertation—develop new theoretical frameworks that better capture the complexities of secondary trauma in helping professions (Smith, Flowers, and Larkin 2009).

Research Design

Interpretative Phenomenological Analysis (IPA) has carved out a distinct niche in psychology, thanks largely to the contributions of Jonathan Smith, who pioneered this approach in the mid—1900's. IPA is deeply rooted in the qualitative research tradition, emphasizing the detailed exploration of personal lived experiences. Smith's (et al., 2022) IPA is specifically designed to draw out the nuanced, often complex narratives that people construct around their experiences providing rich, in—depth insights that quantitative methods can miss.

The focus of Interpretative Phenomenological Analysis (IPA) is on investigating how participants make sense of secondary traumatic stress (STS), countertransference (CT), burnout (BO), and compassion fatigue (CF). This study aims to enhance our understanding of how people experience STS as reported by the participants. Specifically, this research seeks to describe what is means to listen to a client's narratives about traumatic experiences and its relationship with STS (Smith, Flowers, & Larkin, 2009).

Smith (et al., 2022) developed IPA to address a gap in how psychological research traditionally approached the study of experiences. He argued that psychological inquiry should not only quantify behavior and cognition but should also qualitatively explore the meaning of experiences as perceived by the individuals themselves. This focus on lived experiences allows the researchers to use IPA to delve into the emotional, cognitive and sensory components of human experience, capturing the essence of how individuals interpret their interactions with the world.

Moreover, the methodological framework of IPA encourages a dynamic engagement between researcher and participant data, promoting a reflective dialogue about the meanings of experiences (Pringle, et al., 2011). This approach aligns well with contemporary psychology's increasing openness to qualitative methods, recognizing the limits of purely statistical approaches to understanding complex human behaviors and mental states (Smith et al., 2009). While initially used in psychology, IPA's applications have grown beyond the field. This approach is particularly valuable in the social science disciplines that seek to understand how people interpret their experiences (Holland, 2011).

In an IPA study, the focus is on the meanings that specific experiences, events, and states hold for participants (Smith & Osborn, 2007, p. 53). Furthermore, the approach is phenomenological, involving a thorough examination of the participant's life world, and it seeks to explore professional and personal experiences, emphasizing an individual's personal perception or account of an object or event. This stand in contrast to an attempt to produce an objective statement about the object itself. IPA also underscores the dynamic nature of research exercise, with an active role for the investigator in the process. The approach defined by Smith et al. (2009) enables the research not just to bear witness to emergent themes but also to become an active participant in discovering these themes (Pringle et al., 2011).

Interpretive Phenomenological Analysis employs double hermeneutic approach, a process that includes both discovery and interpretation of meaning of an experience while remaining intrinsically focused on the individual and the experience itself (Pringle et al.,

2011; Smith et al., 2009). The IPA approach is flexible and responsive and encourages an organic flow of questioning, interpretation, and meaning—making as the process unfolds for both the participant and the researcher (Smith et al., 2009; Willig, 2012); it involves not only examining what is said but also looking beyond the words themselves to being questioning what those words might mean in the larger context of experience. The IPA approach also differs from traditional phenomenological approaches in it ability not only to identify but also to capitalize on both convergent and divergent themes, and as such, often highlights the value of those differences rather than simply focusing on the commonalities; this latter approach of commonalities seeking tends to be prioritized and more traditional phenomenological approaches (Pringle et al., 2011). Accordingly, an IPA approach enabled the interviewer to reflect on the subjective nature of reality and thereby illuminate each participant's view of STS while maintaining the validity and the uniqueness of the individual's experiences. The detailed experiences shared by research participants enhance our understanding STS, allowing for a deeper exploration of the intersubjective nature of experiencing STS (Smith et al., 2009).

Participants

IPA's main concern is fully appreciating each participant's account (Pietkiewicz & Smith, 2012). For this reason, samples in IPA studies are usually small, enabling a detailed and time-consuming case-by-case analysis. This enabled me to give a comprehensive and in-depth analysis of the participants' experiences and to present a more general account of the

helping professional. With IPA, I aimed to produce an in—depth examination of STS and not generate a theory to be generalized over the whole population.

After Institutional Review Board (IRB) approval, the participants were recruited through a flyer posted on social media (Appendix A), contacts at mental health institutions, the Veterans Administration, colleagues, and private practices. Each participant earned a graduate degree, and two had terminal degrees. These participants worked as mental health counselors, marriage and family therapists, Christian counselors, and clinical psychologists. This study has six (6) participants who met the criteria as described above, which allowed for an opportunity to know more about the individual, their response to STS, and consider connections among different aspects of the participants' account (Smith, 2004).

The participants were not offered compensation and could withdraw from the project at any time if they so wished. The selection criteria for participants were as follows: 1) working in the field for five (5) years or more, 2) having worked (or working) with individuals who have been victims of trauma. Clients who are discussed by the participants should exhibit symptoms that align with Post Traumatic Stress Disorder. Additionally, the participants should have the ability to reflect on their experiences and meaningfully share these insights with the researcher.

Data Collection

The researcher conducted an in-depth interview with each helping professional. The interviews were conducted in 50 to 75—minute that were virtually recorded and transcribed via teleconference sessions, email, and virtual conferencing. The interview topics are in the

format (Table 1) related to the health professional's experience working with traumatized individuals and their reactions (lived experiences, feelings, and thinking) in listening to the victim's stories. The interviews were audio-recorded, transcribed, analyzed, and reviewed (member—checked) by the participants for trustworthiness and presented in the results section. In addition, the insights of the interviews were continued and deepened by follow—up exchanges by email and a demographic questionnaire (Table 1).

Table. 2
Topic format for an interview with the Helping Professional(s)

Type	Question
Demographics	Age range Ethnicity? What is your highest level of education? How many years have you worked in the field? How many years have you worked in your present position? What is the population you are working with?
Experience	What is your experience in working with traumatized victims? Can you give an example of a case that was difficult for you? Why was this difficult? What did you do? What was your approach? How did the victim react? How did you feel about the victim's trauma? How did you feel listening to the victims' traumatic experience?
Strategies	What was your approach? Can you give an example of your approach? How many times did you meet with this victim? Were you able to identify progress in the victim, and how would you describe this progress? How did you feel after hearing the victims' experience again?
Support	How and with whom do you process the information from sessions with victims? How often does this occur? How do you feel talking about your victims' trauma? Do you feel you are experiencing the victim's trauma when hearing their stories?

The opening of the interviews was used to get to know the participants and establish trust. Each participant signed an informed consent form detailing the goals of the study's data collection requirements and completed a demographic survey.

Interviews

The interviews were conducted virtually. The questions were open-ended and constructed as follows:

Demographics:	Age range. Ethnicity? What is your highest level of education? How many years have you been working in the field? How many years have you worked in your present position? What is the population you are working with?
Experience:	What is your experience in working with traumatized victims? Can you give an example of a case that was difficult for you? Why was this difficult? What did you do? What was your approach? How did the victim react? How did you feel about the victim's trauma? How did you feel listening to the victims' traumatic experience?
Strategies:	What was your approach? Can you give an example of your approach? How many times did you meet with the victim? Were you able to identify progress in the victim, and how would you describe this progress? How did you feel after hearing about the victims' experience again?
Support:	How and with whom did you process the information from sessions with victims? How often does this occur? How do you feel talking about your victims' trauma? Do you feel you are experiencing the victim's trauma when hearing their stories?

Data Analysis

Interpretive Phenomenological Analysis (IPA)

In analyzing the interviews, the researcher identified themes in line with the IPA approach (Smith & Osborn, 2007). This approach involved the researcher engaging in an interpretative relationship with the transcript. It required reading and rereading the transcript closely to become as familiar as possible with the account and coding. Each

reading had the potential to uncover new insights. Some parts of the interview were richer than others and warranted more coding and commentary. Secondly, connecting the themes, which involved a more analytical or theoretical ordering, attempted to make sense of the connections among themes that were emerging. Lastly, this moved from the final themes to writing the final statements outlining the meanings inherent in the participants' experience. It was expected that the analysis would be expanded during the writing phase.

Quality Criteria

To assess the quality and validity of this study, the researcher used Lucy Yardley's criteria for quality and validity. Yardley (2000) details four principles for assessing the merits of qualitative work: sensitivity to context, commitment and rigor, transparency and coherence, and impact and importance, noting that these principles are flexible in their application but should coincide with qualitative methodologies. Yardley's (2000) criteria were used to ensure that research is indeed credible, both in terms of technique and interpretation, and that the results accurately represent the participants' lived experience with secondary traumatization. The outcomes of the interviews were shared with the participants to conduct a "member check," which is a quality procedure to guarantee the accurate representation of the participants' lived experiences.

Ethical considerations

To comply with ethical guidelines, this study was submitted and approved by Drew University's Institutional Review Board. When recording or publishing data, the interviewer

used a pseudonym or alias (e.g., PN-XY). This was essential to protect the participant if the published data included other identifiers such as age, gender, and clinical or community affiliations.

Participants may experience trauma triggers in recalling and retelling the stories of the clients they have treated. A Well—being and Wellness debriefing sheet with exercises, steps for emotional rebalancing, and contact numbers for immediate help, if needed, were provided (Appendix E). The interviewer monitored the participant's comfort level during the interview. As the informed consent indicates, participants could stop or withdraw from the project if they were experiencing emotional triggers.

Interpretive Phenomenological Analysis is a vital methodology for studying secondary traumatic stress in the helping professional. This emphasis on lived-experiences, subjectivity, and meaning-making provides a comprehensive understanding of how helping professionals experience and cope with secondary trauma, leading to more effective interventions and support mechanisms.

Image 6: The Death of George Floyed Reignited a Movement.

Chapter Four

FINDINGS

Introduction

To answer my second question, this qualitative study utilizes a phenomenological framework, adopting the Interpretive Phenomenological Analysis (IPA) method. The main objectives of the research include gaining insight and a deeper understanding of the experiences of Helping Professionals of secondary traumatic stress (STS). The study also aims to explore participants' understanding of STS and how they make meaning when hearing their patients' stories. The analysis of interview and survey data was conducted through the lens of the researcher's interpretation, following the coding process outlined by Smith et al. (2009). The study employed a qualitative research approach, focusing on exploring and interpreting the lived experiences of the participants, one of the central purposes of Interpretive Phenomenological Analysis.

In this chapter, I utilize data derived from interviews, demographic surveys, and follow-up inquiries conducted with six licensed clinicians who have been actively engaged in the field for five or more years. To enhance the reader's comprehension of each interviewee's perspective, concise profiles of the six participants are incorporated within the chapter. The demographic distribution among the participants includes five females and one male, with varied marital statuses—one single, two widowed, two married, and one divorced (Table 2). Pseudonyms were used to protect participants' identity and privacy.

Table 3.

Profiles of the Study Participants

Participants*	Gender	Ethnicity	Marital Status	Education	Area of Practice
PN-1	Female	Black	S	Doctorate	Marriage and Family Therapy
PN-2	Male	White	M	Masters	Marriage and Family Therapy
PN-3	Female	White	W	Masters	Mental Health Counselor, Marriage and Family Therapy
PN-4	Female	White	W	Masters	Marriage and Family Therapy
PN-5	Female	Black	M	Doctorate	Christian Counselor
PN-6	Female	Black	D	Doctorate	Clinical Psychologist

*Pseudonyms were used for anonymity. PN=Participant

The Participants

Participant PN-1

PN-1, a resident of Connecticut, is an African American female in the 35-44 age range, currently not in a relationship and without children. Professionally, she serves as a clinical program director in Connecticut, managing a program that offers medically assisted treatment for opioid use disorder. This program is specifically tailored for male inmates at the Osborne Correctional Institution in the metropolitan area. In her administrative role, she supervises two clinicians providing treatment, along with overseeing nurses involved in the distribution of medical dosing for clients grappling with opioid addiction. Additionally, PN-1 runs her private practice within the same facility where she delivers treatment services.

With a Ph.D. in Marriage and Family Therapy and over 15 years of experience in the field, PN-1 is also pursuing a J.D. Her professional focus spans diverse populations, including men, women, children, LGBTQIA+, and immigrants.

Participant PN-2

PN-2, a Caucasian male, resides and practices in New York City, falling within the 55-64 age range. Married and with no children, he holds a Master of Science in Marriage and Family Therapy. He has certifications in EMDR (Eye Movement Desensitization Reprocessing) and SOMATIC Therapy, which focuses on the body. With over 15 years of experience in the field, PN-2 has spent more than eight years working in both a group practice setting and private practice.

His professional expertise extends to working with diverse clientele, including couples (married, engaged, and dating), families, individuals, and LGBTQIA+ and transgender populations spanning various cultural and ethnic backgrounds. PN-2's practice particularly addresses individuals dealing with traumatic experiences such as rape, sexual abuse, sexual assault, and violence within relationships.

Participant PN-3

PN-3, a woman of Italian American heritage, is widowed and a mother of two adult children, including a son with special needs. Additionally, she is a grandmother of two. She falls within the 55-64 age range and has an extensive background, having previously served as a

supervisor in an outpatient clinic in Nassau County, New York. Presently, she operates her private practice with over 26 years of experience in the field.

In her private practice, PN-3 specializes in treating individuals aged ten years and older, families, and couples. She has a Master of Science in Mental Health Counseling and Marriage and Family Therapy and holds dual licenses as License Mental Health Counselor and License Marriage and Family Therapy. PN-3 has pursued post-master training focused on working with Veterans and their families dealing with PTSD, as well as individuals facing challenges related to recovery from traumatic experiences and difficulties in maintaining sustained abstinence.

Participant PN-4

PN-4, a Caucasian woman aged 65 and above, resides in Westchester County, New York, and recently experienced widowhood. Engaged in private practice, she specializes in treating adults, both men and women, couples, and immigrants. With 23 years of experience in the field, PN-4's focus includes couples therapy, divorce-related issues, grief work, grief recovery, and addressing traumatic experiences in divorcing couples and their children.

She has a Master of Science in Marriage and Family Therapy, and PN-4 is licensed in New York as a License Marriage and Family Therapist. Initially planning to retire from practice in 2022, her husband's sudden passing led her to reconsider. In the aftermath of this event, PN-4 resumed seeing patients promptly, driven by a commitment to avoid making her clients feel abandoned during a challenging time.

Participant PN-5

PN-5 is an African American woman who is married and a mother of two children. She resides in the Commonwealth of Pennsylvania and commutes to New York City for her role as a Christian Counselor. With a Master of Science and a Doctorate in Counseling, PN-5 operates her private practice with clients aged 45 to 54. She has been in practice since 2015 and specializes in working with adults, both men and women, offering couples counseling and individual sessions.

During a significant portion of her career, PN-5 focused on serving faith-based communities and clientele. However, leading up to and during the Pandemic, she expanded her practice beyond faith-based populations to include individuals in broader communities. PN-5's work during the Pandemic revolved around providing psycho-social education for her clients and communities that were grappling with trauma, loss, and illness due to COVID-19.

Participant PN-6

PN-6, a divorced woman and mother of two identifies as an African American and is a native New Yorker in the 34-44 age bracket. With a Master of Science and a Doctorate in Psychology, PN-6 is a licensed Clinical Psychologist (Psy.D) in the state of New York, with 17 years of professional experience.

Her early career involved working in maximum security prisons, providing psychological services to incarcerated individuals diagnosed with mental illness. PN-6 focused on understanding inmates' traumatic experiences leading to their crimes, sentencing, and

subsequent incarceration. Over the past eight years, her work shifted towards supporting college students in crises within academic environments, including responses to incidents such as shootings, student suicides, and the deaths of teachers or administrators. PN-6 is certified in psychological first aid.

Since 2013, PN-6 has been actively involved in University Mental Health. Her current role involves working with an international student population, acknowledging that they bring more than just textbooks to the classroom. PN-6 recognizes the diverse range of experiences these students bring and emphasizes the need for more than tutoring to help them navigate through the semester successfully.

The Results

The interviews were conducted with the aim of addressing the research questions through the elicitation of comprehensive and authentic responses from the participants. As the investigator, I handled all aspects of data analysis, excluding the transcription of interviews and audio recordings. This included the identification and development of emergent themes. Following my initial and subsequent coding rounds, I imported transcripts into NVivo software to facilitate theme development. Utilizing Smith et al.'s (2007) framework for data analysis, codes were generated through a meticulous and repetitive review of participant transcripts and recorded interviews. This process enabled me to gain profound insights into individual participants' experiences and perspectives, facilitating the interpretation of the meanings inherent in their experiences.

This analytical approach was applied iteratively for each participant's data source. Subsequently, a cross-case analysis was conducted to identify common or similar codes across all participants (refer to Table 3 for code presentation). From the numerous codes derived, four predominant themes emerged, reflecting the participants' experiences consistently across all six cases and directly addressing the research questions.

Themes

The transcripts feature in-depth interviews focusing on the impacts of trauma, specifically secondary traumatic stress, experienced by professionals in the helping fields due to their exposure to the traumatic stories of their clients. The interviews cover a range of themes, including the emotional and psychological effects of dealing with clients' traumas, the importance of setting emotional and psychological boundaries, the role of supervision and support systems in processing traumatic experiences, and the personal experiences and coping strategies of the participants interviewed. The clinicians share insights into their own experiences with secondary traumatic stress, the impact of traumatic stories on their practice, and the importance of self-care and professional support in mitigating the effects of secondary traumatization.

The analysis of data and the subsequent development of themes resulted in the identification of four key themes relevant to the research questions and the focal areas of investigation in this study. These themes, uncovered through interpretative analysis of transcribed interviews and reflections, are outlined below. Additionally, contextual

information, supported by excerpts from participants' data sources, is included to provide further insight into each theme.

1. Empathic Detachment and Depletion

2. Professional Self-care practices

3. Emotional and Psychological boundaries

4. Professional Support

Table 4

Themes and Codes

Theme	Codes	Excerpts
Empathic Detachment and Depletion	Feeling their pain with detachment Overwhelmed by clients' trauma. Struggle to maintain professional composure. Experiencing emotional drain from client's stories. Maintaining a balance between empathy and professional distance.	"Feeling their pain with detachment." "Not taking stories home." "Witnessing stories with compassion." "Releasing absorbed trauma."
Professional Self-care Practices	Seeking personal therapy for coping. Engaging in mindfulness and self-reflection. Using hobbies as an emotional outlet. Prioritizing physical health and wellness activities.	"Utilizing mindfulness and meditation, practicing self-check--ins and self-awareness. Engaging in-person therapy sessions."
Emotional and Psychological Boundaries	Implementing strict personal boundaries to protect mental health. Navigating personal triggers while providing care. Recognizing limits in emotional capacity and adjusting workload.	"Maintaining professional objectivity, managing personal reactions during sessions, referring clients when beyond expertise." "Acknowledging own trauma while supporting others." "Witnessing trauma stories without personalizing."
Professional Support	Relying on supervision for guidance and support. Participating in peer consultation groups. Sharing experiences with colleagues for emotional relief. Seeking specialized training to handle traumatic content effectively.	"Monthly consultations with supervisors, group supervision for skill enhancement, personal therapy for unresolved images." "Engaging in personal therapy sessions." "Utilizing supervision for complex cases." "Maintaining self-care and client balance."

The following presents a detailed description of the thematic findings as determined through an in-depth analysis of the participants' interviews (Smith et al., 2009). Using direct

quotes that represent the general coding, the participants' experiences will be highlighted to support each of the described themes.

Empathic Detachment and Depletion

The theme, *Empathic Detachment and Depletion,* is a result of the participants' recurring expressions of how they experience Secondary Traumatic Stress (STS) when working closely with individuals suffering from trauma, such as incarcerated individuals or students with traumatic experiences. These therapists encounter STS through empathetic engagement with their clients or students, absorbing the emotional and psychological impact of their traumas. "Empathetic Detachment" is a strategy used by these clinicians to protect themselves from becoming overly absorbed in the trauma of others. It involves maintaining a balance between being empathetically engaged with the client's experiences while also keeping a professional distance to avoid becoming emotionally overwhelmed. Participants discuss their approach to empathetic detachment as follows:

> PN-2: I've noticed since the pandemic an increased sense of loneliness. I am always thinking how can I be of most assistance? That's my part in the process. At times I can really feel the unfairness, anger in the stories I hear. And not necessarily just attached but I kinda empathize and feel their lives without getting overwhelmed where I find myself taking patients home with me. I tend to take the more borderline types home with me. When I feel I'm taking these patients home with me I kinda

> have an individual consultant to work through these feelings and process detaching from them (and their stories)."

"I find myself taking patients home with me," illustrates the difficulty with empathetic detachment. Feeling the pain and tears of client's experiences, "the unfairness and anger in their stories," but keeping a detachment to avoid taking on the trauma themselves. Some clients often require intense engagement, and this increases the therapist's risk of experiencing STS. Another participant speaks of meeting the client where they are:

> PN-6: I try to meet the students where they are and being empathic. I work with an international student population. I was working with a student who had experienced a traumatic event. The student was missing classes and I reached out to her for two weeks. When she returned that third week, she disclosed her sister was pregnant and went into preterm labor and gave birth to twins and they both died. And then I wasn't focused on the punitive aspects of the syllabus and content. That wasn't my focus. I wanted to make sure that she was good, because I know if she wasn't good, she would not be able to focus in the classroom. That wasn't important to me at the time to be honest with you, even though I was her professor. She looked at the syllabus and the subject was life science development. She said "I see we are doing life science development this week. And I can't." I said, "so don't." I didn't discuss with her about making up the class. I was just meeting her where she was, I was being empathetic, handling her as a human being who had just dealt with something heavy. I think that was helpful, my heart hurt for her and her family. I was like, wow,

> this is an opportunity to make an impact in this student's life. So you know I was hurting for her, but I also wanted to assist her, advocate for whatever was necessary so that she could get through that difficult time. I think I might have been pregnant with my second child. I may have had a response related to that, like my own mortality of myself and my children. But I don't remember being bogged down by those feelings and thoughts. The student was my chief concern.

While not adhering to syllabus requirements (or consequences), the instructor recounts meeting the student, who experienced a traumatic event, meeting the student where she was, by also allowing the student to bypass the triggering content. Despite the emotional impact, PN-6 maintained a balance between empathy and a level of detachment. PN-3 also maintains a level of detachment with the use of what she describes as the therapeutic wall:

> PN-3: I guess I'm used to putting up the therapeutic wall protecting myself. I have to say that very few experiences of others have really stayed with me. Some go with me to this day, and others just don't. I mean I'm really in the room with the client for the client. So they are sharing what's going on with them, even if they are working in the streets. For example I had a young police officer, it was a big case in the news he told me he was the one who actually discovered where the murder had taken place, as part of his processing he told me everything he saw. Everything! And I asked, "how was that for you?" It was a body in a suitcase, and he described all the details about finding the suitcase and what was in the suitcase, the dismembered body. And then, I let it go. The whole thing was very upsetting. I let it go. I feel it's his story,

> not mine, I just feel empathy for the person. Sometimes I feel sorrow for them. I'm sad for them. I don't have a feeling for myself. Except maybe sometimes I'm grateful, that it happened to them not to me. Because we all have our own versions of trauma, and my role is not for me to share my version of the trauma with the client. My role as a therapist is to be there for them.

PN-6 recalls another experience of Empathetic Detachment:

> "I was working in a maximum-security Correctional Facility specifically for incarcerated diagnosed with a mental illness. I was working with a gentleman whose charges were weighted. His sentence was double life plus 20 years. It wasn't until maybe four weeks before we terminated that he told me what his charges were, his charges were decapitation. And that was the double life because in the state of "*Mainstate"* at the time, decapitation was an automatic double life sentence and then 20 years was tacked on because of his participation in a riot. The bulk of our work was about his relationship with his mother, her turning him in and just the traumatic experiences that he experienced leading up to his crime. At that point, I understood why he waited until four weeks because of the nature of his crime, fear of judgment. Possibly, he might have had to build up rapport and maybe in my eyes, I had developed rapport early on but maybe not in his eyes. I think at that point, my passion for correctional mental health was solidified. Even though people have been charged, tried all of that good stuff, they still deserve mental health care. The experience of being incarcerated can be traumatic. I think remembering in the

> moment, just keep a straight face PN-6 (she said her name), keep a straight face. I didn't want him to see or feel I was judging. I didn't want my facial expression to be misread. So those were some of the experiences I recall having in the moment when he disclosed his charges. My experience of Empathetic Detachment.

Professionals who work with trauma victims must balance empathy with detachment to protect their own mental health.

Empathetic Depletion refers to the emotional and psychological exhaustion that can occur from continuous exposure to the traumatic experiences of others. The clinicians discuss how empathetic engagement, while necessary for providing effective support, can lead to a depletion of their emotional resources. They describe experiencing feelings of being overwhelmed and fatigued and sometimes even experiencing symptoms similar to those of their clients. The impact of empathetic depletion emphasizes the need for self-care strategies, including seeking supervision, personal therapy, and engaging in activities that replenish emotional resources.

> PN-5: When I listen to a client, and because of the intake information, I know what they put down as to what they're coming in for. Sometimes they put down something close to the traumatic event. I'm usually aware of how I'm feeling but as I'm listening and notice little things whether I'm tensing up or not. I usually don't tense up, and I'm not surprised by the traumatic event the patient describes, I do tense up a little bit. I try not to show it if I recognize it in my body and try to relax so that the patient does not feel uncomfortable, sometimes I feel empty.

These experiences illustrate the complexity of empathy depletion. Self-monitoring when listening to trauma stories emphasizes an awareness of the 'somatic' manifestation of empathetic engagement. The clinician works to maintain control expressions, despite the inward tension, in an effort as to not make the client uncomfortable. This at times leads to feelings of emptiness, exhaustion.

> PN-4: In my early years, my experience was mostly with divorcing couples and the reason this is traumatic is because you hear of the behaviors, some violence, which led clients to get orders of protection, and the accusations. One of the challenges was not to respond when someone reached out to me behind their partner's back. It was stressful, I was a newbie and hearing these horror stories. And I carried it, so it actually was very difficult to keep that drama within. Thankfully, at that time I belonged to a group so that I could emotionally vomit what I was feeling. It was stressful, and depleting. Then came the impact (the divorce) on the children's behaviors. What they saw when their parents fought, and the impact on them and how they acted-out in school. I planned to retire Jun 1, 2022; I was tired. I, myself, had a traumatic loss. My husband died right upstairs. I'm doing a lot of grief work, you know. So you can imagine how listening to the stories of clients about their losses made a heck of an impact on me. So what I had to do actually to save my sanity, is recognize I personally have a trauma. I took off a little while, but I never wanted the clients to feel abandoned. I do believe I came back too early. I could detect a difference in myself and secondary trauma. There is this, you know, lack of

> concentration, the sleeplessness. I found myself lacking empathy. If a client became hysterical, I would have a tough time keeping it together for them.

The experiences of Empathetic Depletion, with continuous exposure to client's trauma stories, have an emotional and psychological impact, compounded with personal loss, and can lead to a profound sense of depletion, "I had to save my sanity, and recognize I have trauma." Working with traumatized clients, including divorcing couples and individuals undergoing profound grief, captures the struggle of STS, the efforts to maintain professional detachment for self-preservation, and eventual realization of her empathy being depleted, "I found myself lacking empathy, a lack of concentration, sleeplessness. I would have a tough time keeping it together."

The clinicians spotlighted the complex balance that they must maintain between empathetic engagement with trauma survivors and protecting their own mental health. It underscores the importance of awareness, self-care, and institutional support to mitigate the effects of STS among professionals in trauma-informed fields is described:

> PN-6: So like the concern about triggers or countertransference. That wasn't an issue for me. But there was one student, even though her story, I hadn't experienced it, but it was so heavy, hadn't experienced that exactly how she did. And I think it was the context she had presented in the health center the night prior on a college campus with a panic attack. So she, our crisis counselor was dispatched scheduled her for an intake the following day, intake was scheduled with me for I believe 3:30. We finish, and this is a Friday. We finished at 5:30 So it was two hours. And she had not been in therapy since I think 10 years prior. So she was diagnosed with bipolar

disorder and decided that she did not want to be like the people in her family who were diagnosed with a mental health disorder, so she did not go to therapy. And she literally dumped 10 years of trauma on me in two hours. Wow! And I remember like, when she left, I remember sitting in front of my computer attempting to write the crisis note because it was considered a crisis without hospitalization. So I remember attempting to write the crisis note because it was a crisis follow up. So attempting to write that note, I couldn't. I was staring at the screen really trying and had nothing. So I remember opening up my door and it's almost like I imagined as if I was watching myself, I opened up the door and like smoke billowed out. Like that's what was going on like something was cooking, something was hot in there, I opened the door and all of that came in so like I was emerging from this smoky atmosphere. And I, was kinda like standing there. I heard some voices. So that meant that some of my colleagues had stayed past five I felt like I was going door to door looking for someone to help me debrief, about how I was actually feeling. And I remember my director being there. I said, "Hey, do you have a minute?" And he said he was on his way to an appointment. And I said, "no, don't worry about it." So I carried that home. So then I think I dropped my children off to their father's home and probably went to sleep or whatever. I woke up and I remembered my neighbor, she texted me and asked me to move my car because I was blocking her in and like I saw on my phone that she needed it done (the care moved). I was awake. But I just couldn't get out of the bed. And then yeah, that was that situation and I realized after the fact that because I didn't have the opportunity to decompress and debrief, I was unconsciously forcing it to make sense. So it's just like I

> wasn't given the time or space to decompress. So I'm unconsciously taking it out by not getting up to move my car. And I realized that afterwards. Just empty!

The clinician captures a phenomenal instance of empathy depletion following an intensely emotional session with a student. The description of smoke billowing out as she opened the door expresses the feeling of being engulfed by the student's emotional turmoil, a burden so heavy that it was depleting, rendering her unable to perform basic tasks "I couldn't write the note," or seek the necessary debriefing support from colleagues.

> PN-5: Sometimes I tense up when hearing a client's reveal traumatic events, and trauma stories. I have to be aware of my body language, that's important. I feel exhausted at the end of those sessions, and I have to talk to somebody to decompress my-own-self!

The physical act of tensing up and the listening to client's revealing traumatic events, and feelings of exhaustion further highlight the visceral impact of empathy depletion. "I feel exhausted at the end of those sessions, and I have to talk to somebody to decompress my-own-self," the need to decompress through communication further emphasizes the impact of STS.

Personal Self-care Practices

The theme of *Personal Self-care Practices* emerges as a critical element across the narratives of professionals dealing with emotionally taxing work environments. These individuals, often working in mental health, social work, and healthcare, encounter daily challenges that test their emotional and psychological resilience. The participants reveal a

shared understanding of the necessity of self-care, not only as a means of personal well—being but also as a professional imperative to ensure the quality of care provided to others.

> PN-6: To be completely transparent I'm still figuring that out. I know the importance of it, and I tell students about it and clients about it and all that stuff. But I am now in a place where I mean I'm kind of piecemeal self-care in the past, like when the opportunity comes, like I'll do it. Sometimes my body has forced me to take care of myself because I have burned out. I think when I have these times where like, I'm just blank or like a situation with a student, that's my body's way of telling me . . . . You need to chill. You need to decompress. You need to engage in taking care of yourself. I went for massage here and there, but it felt like any self-care I engaged in wasn't enough because of the trauma and heaviness felt, whatever care I engaged in was just scratching the surface. I need an extended amount of time to just decompress at one of those wellness retreats. I just didn't have, you know, the luxury of doing. I am now rediscovering what self-care looks like, and honestly, I'm just trying to make it a regular part of what I do. One of the things I'm doing, I'll take my lunch hour when I'm in the office. I walked around Long Island City. Fresh air and vitamin D saves lots of lives.

Openly discussing her journey with self-care, PN-6 acknowledges the complexity of effectively implementing self-care practices in her life. She reveals that despite understanding the importance of self-care and advocating it to her students and clients, she has struggled to apply these practices in her own life consistently. "I'm in a phase of rediscovering what self-care looks like for me," she has begun walking spending time outside as part of developing self-care plan.

> PN-3: I have to preserve my own life, and also take care of myself. So I try very hard to balance things. It's been a lot, it's a lot trying to fit people in these days. I have to dial back. I put on the boob--tube, and I disconnect the brain cells that's my relaxation. I read. I play stupid games on my phone. I go through a magazine. My only friend L and I talked about how we don't have many friendships. We talk to people all day long, so to remember to call a friend back, we don't. You don't want to even talk, not even to the friends. I try to remember to call friends, I tried getting together with my very close friends, I see my grandchildren, as much as I can. I sit with the kids, go to the park and watch them on the swings and all, and hold my grand-baby. That's my joy!

The participants collectively underscore the multifaceted nature of self-care, highlighting it as a personalized and dynamic process. The adoption of self-care practices is not a luxury but a necessity for those in emotionally demanding professions. By prioritizing their well—being, professionals not only safeguard their own health but also enhance their ability to provide compassionate and effective care to those they serve. The narratives serve as a reminder of the importance of self-care in sustaining professional longevity and personal happiness. PN-5 explains the need to "pause, take a break, to step back:"

> PN-5: I was giving two to three free sessions to essential workers the pandemic, I thought they might need someone to talk to. I felt they were going through a lot, and so they were coming to see me. I felt like I was helping them. It was a tough time. It was a really tough time. That's when I thought, I need to step back a little bit. People

were dying, it made me want to reevaluate, and do some things differently. I needed a break! I was on pause, I began to meditate, pray, monitor my stress levels, processed my thoughts with other professionals and my husband.

Emotional and Psychological Boundaries

For the participants in this study, *Emotional and Psychological Boundaries* collectively offer rich insights into the complexities of setting and navigating emotional and psychological boundaries in various contexts.

PN-1: Anytime I hear stories regarding clients trauma, there's a part of me that feels for them I, especially since COVID, and meeting my video, and I can feel people's mood more, because it required me to extend myself so to speak so that I would understand their experience which is so very different than when you're sitting in a room with them. So I was grateful that I was able to have a sense of feeling what someone's feeling but then again also which is considered like a Bowenian[2] concept. Particular onset which is different gauge and so how do I maintain that boundary emotionally so that it doesn't overwhelm me? So I usually will hear their stories, and have a sense of compassion for them, but then also I understand that's their story. It's not my story. And so that's why I'm able to maintain boundaries. But then also

[2] The Bowen family systems theory is one of the most comprehensive explanations for the development of psychological problems from a systemic and multigenerational perspective. https://onlinelibrary.wiley.com/doi/abs/10.1002/9781394266470.ch8

> I'll have days or weeks where, if I notice something different happening with regard to how I'm feeling because I always check in with myself like okay, well, these are their stories, not my stories. And this is someone else's emotions and whatever feeling and so if I need to take time off, I will. I also usually will have some form of like a statement, a mantra or prayer. When I'm transitioning from one place to another. It's like, Lord, I release what happened today. You know, it's in your hands. You know, I utilize the work that you've given me and with the guidance of the Holy Spirit. So now it's, you know, I laid at your feet is I'm going to continue on with my life and just you know and live my best life anyway.

Establishing and maintaining emotional and psychological boundaries is a significant challenge for the helping professional. This is important for personal well—being and professional efficacy, particularly in a therapeutic relationship, "There's a part of me that feels for them, I can feel people's mood." This phenomenon is possibly the result of empathy and helping behavior. On one hand, such behaviors are beneficial since they contribute to creating therapeutic relationships, however, STS can occur as a consequence.

> PN-6: How do I make meaning experiencing, or listening to the traumatic experiences or the traumatic stories? What are my emotional and psychological boundaries? A lot of the violence and traumatic stories that I hear in general often happen in the classroom and not always in the therapy room. I use my faith in my training. As far as the training pieces are concerned, I always say that with psychology, it doesn't excuse the behavior, it gives an explanation for the behavior.

So based on all of my ka-jillion years of training I know that the symptoms that the student is presenting with and the experiences they've had like A leads to B, which brings us to C, which is where we are now. That's how I make sense of it because it's okay, you know, these types of experiences can lead to these types of symptoms, interpersonally emotionally, mentally, blah, blah, blah, but sometimes stuff doesn't make sense. Like, why they went through the traumatic experience in the first place, like why would a person be put in that position to even experience it? That's where my faith comes in, that's where my emotional and psychological boundaries are. Like not even, all this was meant to happen, like, I'm not there yet. More so, you know what you might not be able to understand why it happened, why it happened the way it did, but God orchestrating you to be in this person's life. So I think that helps me to make meaning of it like this is part of your purpose. Your here to create a holding environment for people who didn't feel held, your here to listen to people who felt like they don't have a voice anymore. Like the concept of calling sometimes helps me. Stick with it. And not run. So if it's something that I've experienced, then it might have an effect on me in a deeper way. But still, the concept of calling plays in part because like, yes, you can identify, but maybe it is less about you identifying and more about you. Yes, based on your training and your knowledge, but also your personal experience. So you know, maybe not disclosing, creating an environment, a safe environment for the student that maybe I would have appreciated if I had it when I was going through the same thing. So yeah, I think the idea of quality reality,

> like if I've experienced that personally, is just like, okay well maybe this is why you went through what you went through so that you could be a help to someone else.

Connecting personal experiences with professional roles, has it's challenges, and are a foundational for empathy and support: "So yeah, I think the idea of quality reality, I've experienced that personally, maybe this is why you went through what you went through so that you could be a help to someone else." Further underscoring how emotional and psychological boundaries are not just protective but also integrative, allowing the clinician personal history as a means for understanding and aiding their clients.

> PN-3: I have a lot of experience working with Veterans, and Police Officers, listening to their traumatic experiences. You know, police officers use humor a lot of times, so he made a joke. That kid is going to be in therapy for a long time! (speaking of a kid who witnessed his stepfather dismember his wife). And then I made a joke. Don't give him my phone number. I used humor with that police officer. And then he moved on because he's also trained. These officers are trained to deal with the worst of the worst. The worst of the worst! The mundane directions, you know, what they call and EDP (emotionally disturbed person). And when your local police officer, it's the same people over and over again. And I'm going to tell you that anything about being a child is most dramatic. So that's basically how I, you know, listen to him. I asked some questions. Sometimes they don't ask questions at all. It depends on the person joining in his attempt to process it through humor. I wasn't surprised as police officers, they come in with a certain content of trauma. Have I

ever taken anybody home with me in my head or in my heart in my thoughts? I'm sure, sure. But I'm a person of faith and I say a prayer for them, and I had to let it go. Seriously! I think the worst times was when one of my clients (no identifier), came home (thoughts and feelings) and I cried that night. I could cry now thinking about it. But then, I said a prayer for him, and I let it go. Clearly, I remember it. I think one of the worst stories in my mind that I witnessed and listen to was from a Vietnam veteran. And, as with a lot of veterans they don't get the opportunity to tell their story. Particularly the Vietnam veterans. They don't think anybody cared about their stories. So he had PTSD and was receiving benefits from the Veterans Administration. He was retired from; I forget what his job was. He was retired, was in his 60s at the time and he had a lot of physical issues that he would be retired. And he tells a story of being on patrol and a sniper shot his buddy in the head. And he was killed immediately. But the commanding officer said to him go retrieve the body. So he had to go retrieve his buddy's body. Horrible! And this is what he said to me that has stuck with me forever, he says, "you know when you take a shot to the head, your teeth remain embedded in your neck." So that visual is what has stayed with me. And when he had told me that, first of all, I was honored that he told me that because it was really, really hard for any of them to tell that event, that significant event in any way, shape or form. But that minute that he told me that was almost like from a movie you could feel the air in the room change. Very still and very solemn as he told me that and I just listened respectfully. I didn't ask any questions. We took a deep breath and he moved on to something else. But that

> visual stayed with me forever. And it will now stay with you. Little gifts. I've learned and practice maintaining professional objectivity, managing my personal reactions during sessions, practicing being present with the client and not attached to the story. The really hard stuff, I process with my colleague L. I don't take these stories home with me.

STS is not emerging through the listening of trauma stories alone, but the visual—images they create. Which for PN-3 stays with her, "So that visual is what has stayed with me. And when he had told me that, first of all, I was honored that he told me that because it was really, really hard for any of them to tell that event, that significant event in any way, shape or form."

Each of these participants expanded on this theme, exploring the societal and cultural influences on boundary setting, the impact of technology on interpersonal relationships, and the collective journey toward understanding and respecting one's own and other's boundaries. While the act of setting boundaries is deeply personal, it is also universally challenging, necessitating a delicate balance between vulnerability and strength, openness and protection, and individuality and connectivity. Through these diverse perspectives, the importance of boundaries in fostering healthy relationships, personal growth, and emotional resilience is vividly illustrated, offering valuable insights into the complex adaptability between the self and the other in the realm of emotional and psychological well—being.

Professional Support

Centering on the theme of Professional Support, the dialogue offers perspectives for clinicians navigating difficulties in aiding their clients. The discussions capture varied experiences of therapists engaging with clients who have experienced trauma. These stories underscore the importance of empathy, self-care, establishing emotional and psychological boundaries, and the role of peer and professional support.

> PN-5: I was glad to have someone to be able to go to, and honestly, my husband played a big role in helping me with a difficult session. Not clinically, just a listening ear. I have had many talks with him concerning [it] even after having the professional sessions. Because he knows me so well, 36 years is a long time to know an individual. He was able to shed some light and helped me get to where I needed to get to be, not just comfortable but satisfied with the fact that, okay, I can do my job. And I can do this. I can help [her], and I was fine after that. I didn't tense up or anything after those couple of sessions after speaking to my husband numerous times; I don't even know how many. But we got to the point he's saying, you know, you got this. If you didn't, I would tell you that's what he would tell me; you got this."

Professional support here emphasizes the role of personal relationships (not another professional by her husband), "I was glad to have someone to be able to go to, and honestly, my husband played a big role in helping me with a difficult session." This clinician's value of her spouse's support is highlighted following a particularly challenging therapy session. The

support is not clinical but rather emotional and motivational, providing a space to decompress and for reassurance, "You got this."

> PN-6: I see a therapist. Actually, I'll be completely honest with you. Sometimes it depends on the intensity of the situation. . . . So I had a clinical supervisor. I would share those things with her. For the heavy, heavy cases, I would mention in therapy. Most often, I didn't feel like retelling the story; it wasn't re-traumatizing or anything like that. I think it was just a place for me to dump. And in those moments, I felt held and heard, and I was able to be okay, well, besides, it was a deep breath, "I can go back into the world now." I met with my director as needed and my own therapist once a week.
>
> PN-3: I have my friend L. She's a psychologist. She works at a program in the Bronx. We process things together a lot. I go to her, I have like you want to call peer support. That's what we do. So I see her a lot. Most often, she coaches me, saying, well, this happened or how do you handle that, or she'll offer me an insight, and she is the one who just listens and validates. And I do the same for her. I meet with a peer group a couple of times a month.
>
> PN-4: I take myself to therapy, I process all those losses, they can be triggering. I leave them there. I'm learning and practicing letting those stories go.

These clinicians' experiences, collectively and individually as therapists, delves into the challenges of maintaining professional boundaries while personally navigating grief and loss, illustrating the intricate dance between personal trauma and professional relationships.

PN-2: I have an EMDR as a supervisor. For a few years, the EMDR group supervisor met with us every other week. I did individual therapy with a lady and then my initial group supervisor is currently my individual supervisor. And then for somatic work I have a monthly consult with the group and work individually with a woman there it's who kinda consults and also my own work like once a month. I feel supported, I feel heard, I feel understood. I mean, I experienced it mostly with a sense of compassion. The EMDR group supervisor that I met with in regular meetings turned into a personal supervisory relationship: "The first group supervisor who supervised me initially is my supervisor now." demonstrates support, "I feel supported, I feel heard, I feel understood. I mean, I felt mostly with a sense of compassion". This emotional safety and validation serve as support that allows the therapist to understand traumatizing situations together with their clients with confidence and compassion, making the experience a useful exchange for personal growth and well—being.

PN-1: I would contact other fellow therapists who were in private practice. Then I would also meet with my pastor because she's a coach, a relational coach, and so I would meet with her, but usually more so when it had to do with something that had to do with PN-1(client said her name) and PN-1 (client said her name) and also, my profession. And if my profession was having a particular effect because I also want to make sure that I meet with someone who has not only the understanding regarding psychologically, relationally but then also you know, the spiritual and so it was important for me to know that that balance was going to be present. And I've

> worked with other clinicians previously, usually for a short period of time, for just maybe four sessions a month to kind of process things and to continue. Foundation belief (her faith) is important me. So important.

The in-depth analysis of the participants interviews revealed various insights into their experiences and practices of working with traumatized clients. They highlighted the importance of self-care, receiving professional (and non-professional) support, and maintaining clear emotional and psychological boundaries as key insights into managing empathetic detachment and depletion, and preventing burnout.

Summary

This study contains comprehensive summaries of all six interview participants, and it helps readers to get better acquainted with the clinicians who are central to this research and to understand the differences in their perceptions of their roles and experiences as helping professionals.

The findings expand the scope of this study and provide an enriched perspective on secondary traumatic stress, as understood by those who directly experience the phenomenon. Furthermore, the results also gave insights into the four themes that emerged from the analyzed data collection and were formatted and explained in the Methodology chapter. To sum up, the interviewees reflections formed the following four themes: Empathic Detachment and Depletion, Professional Self-care Practices, Emotional and Psychological Boundaries, and Professional Support . Each of the suggested themes is

supported with the excerpt from the interview of a corresponding participant. The presented findings connect theoretical concepts with practical evidence. Therefore, the overall collected findings enhanced the overall understanding of the issue and contributed findings that will help readers to better comprehend and raise more efficient solutions to the issue of helping professionals.

Chapter five will provide a comprehensive discussion by relating these findings to the theoretical review, and additional literature relating to the study at hand. After that in chapter six, I will answer the research questions and provide recommendations and directions for future practices, policies and research.

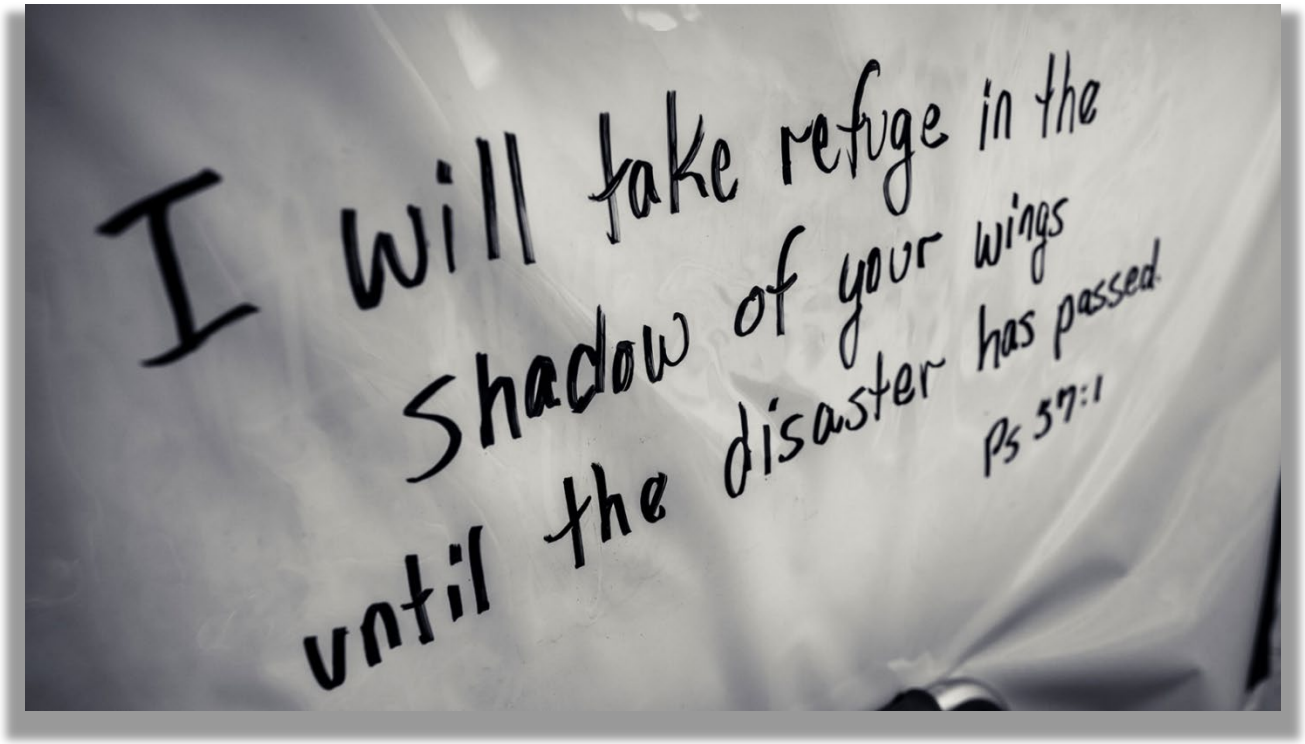

Image 7: David Uttley/©2020 Samaritan's Purse, The New York Times.

Chapter Five

DISCUSSION

Introduction

In the previous chapter I examined the lived experiences of helping professionals with secondary traumatic stress. By capturing the rich details and complexities of their stories, I applied theoretical frameworks to gain a deeper understanding of how secondary traumatization manifests in their lives. The previous chapter presented these manifestations and described the experiences of helping professionals of this study around four key themes of STS: 1) empathetic detachment and depletion, 2) personal self-care practices, 3) emotional and psychological boundaries, and 4) professional support. By examining these themes, we gain a deeper understanding of the emotional and psychological effects of treating trauma, the importance of self-care and boundaries, and the crucial role of professional support. This Discussion chapter critically engages with the study's findings in the context of existing research as discussed in the literature review of Chapter 2, and I also engage with new resources. I will discuss three topics: 1) Rethinking Secondary Traumatization Through a Phenomenological Lens, 2) Examining How to Balance Empathetic Engagement and Emotional Boundaries, 3) Challenging Existing Perspectives on Efficacy of Coping Strategies by Highlighting Support Systems.

Rethinking Secondary Traumatic Stress Through a Phenomenological Lens.

Secondary Traumatic Stress (STS) has traditionally been conceptualized with a framework that emphasizes the pathological consequences for helping professionals exposed to the trauma narratives of their clients. The literature abound with definitions and modes that seek to explain the mechanisms through which STS affects mental health professionals such as compassion fatigue, vicarious traumatization, and burnout. The literature describes STS as a condition where therapists and other helping professionals experience significant stress responses similar to PTSD, triggered not by direct exposure to trauma but through empathetic engagements with trauma survivors. This exposure can lead to changes in the helper's cognitive frames, emotional responses, and professional efficacy. These profound effects raise the question: How can clinicians experiencing STS maintain or recover their well—being and continue their work effectively with their clients?

Next to focusing on the pathological consequences for helping professionals, there is growing recognition in mental health that acknowledging and addressing the lived experiences of trauma work is crucial for developing effective support systems for helping professionals. Rethinking STS through this lens means considering how the constant exposure to trauma reshapes a professional's worldview and emotional landscape. The theory of "vicarious traumatization" is particularly relevant here; it suggests that the helping professional, through empathic engagement undergo changes in their inner experiences that mirror the traumatic alterations experienced by their clients (Pearlman & Saakvitne, 1995). The participants in this study experienced changes in schemas related to safety, trust, esteem, intimacy, and control—fundamental aspects that affect how they perceive the world and

themselves (Figley, 1995). Furthermore, the phenomenon of empathic strain, where clinicians find themselves emotionally overwhelmed by the trauma stories they are exposed to, support the theoretical framework that empathic engagement, while necessary, carries risk of emotional depletion and altered professional efficacy (Bride, Figley, et al, 2004).

Figley's theoretical model of compassion fatigue, while pioneering in the recognition of STS among helping professionals, falls short in addressing the specific and nuanced needs of these professionals. Its emphasis on individual resilience and coping strategies without adequately considering the systemic and organizational factors that contribute to STS. Figley's model predominantly focuses on the personal responsibility of helping professionals to manage their own symptom through self—care and professional support, which can inadvertently shift the burden onto individuals rather than address the broader systemic issues that exacerbate STS. Figley's approach does not sufficiently advocate for workplace interventions such as manageable caseloads, adequate supervision, and institutional policies that promote a healthy work—life balance. This oversight can leave the helping professional feeling unsupported by their organizations, contributing to burnout and exacerbating feelings of isolation and helplessness. While the model's focus on coping mechanisms such as personal therapy and peer support are valuable, they do not replace the need for a supportive and responsive organizational culture that prioritizes the well—being of its employees.

This study consistently highlighted the strong emotional and psychological responses exhibited by participants after working with trauma clients. The participants described emotional and psychological overload, the sense of being burdened from listening to trauma

stories, and a loss of professional composure and personal well—being. For example, clinicians spoke of 'feeling empty, depleted, "exhausted," 'taking home" client's trauma in the form of difficulties with problems such as anxiety, disturbances in sleep, and pervasive sadness.

The participants reported a struggle to balance deep empathetic involvement with their clients and the need to maintain emotional boundaries to protect their mental health. This balancing act is rarely addressed in the depth it deserves in the literature, which often presents theoretical modes that do not fully capture the dynamic and sometimes contradictory nature of real—world practice.

The phenomenological exploration of STS enriches our understanding by viewing these experiences not simply as professional hazards, but as long—term transformative psychological processes. We move beyond viewing them as symptoms to be managed or coped with, and instead recognize them as an integral part of the existential challenges inherent in trauma work. STS would then mean to look at how the relentless exposure of trauma allows forming the worldview and the world of feeling of a helping professional. This shift can influence how training and support systems are designed, emphasizing the need for strategies that address professional competence and personal well—being.

Rethinking how to balance Empathetic Engagement and Emotional Boundaries

My research shows a disconnect between the helping professionals' expectations of client progress and the realities faced by some clients. This misalignment sometimes leads to

frustration and distress when empathy is challenged. My participants describe balancing empathy for clients and emotional self—preservation by setting emotional and psychological boundaries. A participant spoke of "Feeling pain with detachment." Empathetic depletion refers to a state where individuals find it increasingly difficult to engage empathetically due to the cumulative emotional tolls of their work (Figley, 1995). It is characterized by diminished ability to feel or express empathy for others, a critical concern for the helping professional. This condition is characterized by feelings of emotional exhaustion, diminished ability to empathize with clients, burnout, and STS. Another participant in my study expressed: "I feel overwhelmed by my client's stories, sometimes I struggle maintaining professional composure. I feel empty, depleted, I have nothing else to give."

STS presents itself through emotional exhaustion, a reduced capacity for sympathy and empathy, heightened irritability, impaired focus, and feelings of ineffectiveness or reduced achievement. These symptoms not only impact professionals on a personal level but can potentially hinder their ability to deliver care (Bride, Figley et al., 2004). The experiences of STS among helping professionals are deeply personal yet universally understood within these professions, reflecting the profound impact of empathetic engagement with trauma survivors. These experiences often result in emotional exhaustion, reduced sense of personal accomplishment, and, in some cases, significant questions of professional purpose and identity. This raises the question how health professionals could manage their empathic engagement, and whether there are alternatives to empathy, one of the cornerstones of effective mental health care and therapeutic relations involves understanding and sharing the feelings of others, which is paramount to the development of trust and healing. However,

the emotional involvement needed to achieve this can blur the lines of professional engagement with personal emotional boundaries. Is the distinction between empathetic engagement and emotional boundaries realistic? The distinction is realistic and crucial. Empathy entails comprehending and empathizing with someone else's emotions, a crucial aspect in forming connections and offering impactful assistance (Figley, 1995).

Developing empathetic detachment requires practicing self—awareness, emotions, setting healthy boundaries. Empathetic detachment is a psychological concept referring to the ability to care deeply about others and their situations while maintaining a healthy emotional distance (Saakvitne & Pearlman, 1996). This concept is particularly prevalent in the helping professions that involve caring for others who regularly encounter emotionally charged or traumatic situations and listening to trauma stories (Figley, 1995). Empathic detachment can be strengthened through practice and sometimes with professional guidance (Ogden et al, 2006; Saakvitne & Pearlman, 1996). Individuals in the helping professions must nurture empathetic detachment to ensure longevity in assisting others without succumbing to burnout or compassion fatigue (Figley 1995; Gentry et al., 2002).

My research seeks to put into perspective the realism of such boundaries by engaging empathetically and questioning the undiluted goodness of empathy, perhaps, inspired by Nel Noddings (2010) in her commentary on complexities of empathy in *The Ethics of Care and Empathy*. Empathy involves a cognitive recognition of another's feelings, a mental simulation to grasp another's psychological state. Contrarily, sympathy extends beyond understanding to emotional contagion—feeling what another feels without direct personal experience. Accordingly, compassion encompasses a motivational aspect, where the understanding of

suffering prompts a desire to alleviate it. These concepts differ in their levels of engagement: empathy is understanding, sympathy is sharing, and compassion is acting to mitigate distress. Moreover, empathy requires maintaining a delicate balance between deep understanding and emotional detachment to avoid empathic distress or over—identification. Noddings (2010) stresses the importance of distinguishing between one's feelings and those of others to sustain emotional health while engaging empathetically. Maintaining this balance is essential for helping professionals to remain effective without falling prey to Secondary Traumatic Stress (STS). It involves managing the risk of empathetic exhaustion and strategically engaging empathy. Noddings (2010) advocates for a realistic approach to care that recognizes individual limits and supports sustainable practices. This includes acknowledging when to employ empathy and when to conserve emotional energy to prevent burnout.

Paul Bloom (2016) highlighted the emotional toll of empathy, particularly in professions that deal with trauma and suffering, like therapists and social workers. Constant empathetic engagement with suffering can lead to burnout or STS, suggesting that being too emotionally connected can impair one's ability to help effectively. He writes, empathy is too focused on "stepping into the other's shoes," which is impossible. Instead, of empathy, Bloom (2016) advocates for what he calls "rational compassion." Unlike empathy, rational compassion does not involve a shared emotional experience, but rather a more detached concern and desire to see others' welfare improve. This form of compassion allows one to care about and help others without becoming overwhelmed by their emotions or losing sight of the bigger picture. Rational compassion enables a more equitable and sustainable approach to caring for others, as it is not bound by the biases of empathy and is motivated

by reasoned understanding rather than more emotional responses. Furthermore, Bloom (2016) acknowledges the intuitive appeal and some positive aspects of empathy, he ultimately argues for an alternative approach. He suggests that "rational compassion" is a more effective and ethical guide for helping others and shaping social policies. By distinguishing empathy from compassion, we can rethink how emotional responses influence our decisions about who and how to help, advocating for more thoughtful and less partial approach to caring.

Thus, relying on empathy might not be sufficient due to it emotionally taxing nature and the risk of empathy fatigue. Insights from van Dijke et al., (2020) confirm this. Van Dijke et al., propose a relational approach to empathy, emphasizing the back and forth dynamic between the caregiver (empathizer) and the care recipient (empathee). They outline four key aspects of relational empathy: empathy is a collaborative process where both caregiver and care recipient contribute; at its core, empathy involves understanding and responding to the other person's experience; empathy is constantly evolving as caregiver and care recipient influence each other's perspectives; and ultimately, empathy is a quality that strengthens the relationship between caregiver and care recipient. Thus, conceptualizing empathy as one—sided activity suggests that empathy is the sole responsibility of the health professional instead of a reciprocal relationship that depends on the abilities and efforts of the care receiver, the quality of the relationship and even the institutional context.

Aligned with my participants' experiences and these insights from various scholars, empathetic detachment represents a nuanced approach within the helping professions, whereby practitioners consciously balance emotional engagement and disengagement with

their clients' experiences (Neumann et al., 2011). These insights underscore the importance of the therapist being emotionally present and empathetic towards their clients' suffering while safeguarding their own emotional well—being by not becoming overly absorbed in their emotional states. The essence of empathetic detachment lies in the practitioner's ability to navigate the fine line between compassion and emotional self—protection, allowing them to offer effective support without compromising their mental health. While empathic detachment can be a valuable skill, it is not enough. In the next discussion topic, I will argue that health professionals need to practice this skill within the context of a strong social support networks, and as part of a relational process.

Challenging existing view of Efficacy of Coping Strategies by Highlighting Support Systems.

The participants in my study expressed a strong need for processing their experiences working with traumatized clients with peers. They need someone who listens, who validates, who "holds" them. Sometimes to work through complex emotions, other times just to "dump." One of the participants in my study shared, "I have monthly consultations with my supervisor, and group supervision for skill enhancement. I just needed a place to dump, feel held, and heard. I have personal therapy for unresolved images." Another participant emphasized the importance of peer support, stating, "Sharing my experiences with colleagues provides emotional relief and practical advice that helps me navigate my professional challenges." The participants all expressed the desire and need to have a place to 'unload and refuel" to continue their meaningful work with their clients. In general, support systems, encompassing peer groups, supervisions, instructional backing, are

shown to play a pivotal role in the coping process for therapists and other helping professionals dealing with STS. However, the participants' experiences revealed gaps in the availability and efficacy of these systems, for example, "I was looking for someone after that session to debrief. I couldn't find anyone, and my supervisor was leaving for an appointment." The participants described needing more support from their institutions, which contrasts with the more optimistic views presented in some of the theoretical literature.

Various forms of peer support are often considered coping strategies. The traditional view on coping strategies for handling STS in helping professions typically revolves around fostering personal resilience and self—regulation techniques. Resilience frameworks offer opportunities for coping and encompass working with techniques such as mindfulness, meditation, and professional distancing (Smith et al., 2009). These strategies are generally recommended to help professionals manage the emotional toll of their work. However, critics argue that these methods, while beneficial, are insufficient when isolated from systemic or communal support mechanisms (Figley, 1995). Additionally, critics argue there is a misunderstanding of resilience as a "trait" instead of a relational process in the context of the professionals' network (Luther & Zelazo, 2003) However, framing resilience solely as a personal characteristic can be problematic. This approach individualizes what is fundamentally a social issue. It focuses on an individual's ability to bounce back from stress, neglecting the root causes of their disproportionate exposure to trauma (Walls et al., 2024),

(Luther & Zelazo, 2003).[3] This view is supported by my findings, which suggest that while these strategies are crucial, their effectiveness is significantly dependent and amplified by the relationality of support systems that address the multifaceted nature of STS (Figley, 1995; McCann & Pearlman, 1990).

While behavior and cognitive coping strategies have traditionally been emphasized as effective ways to manage stress, it is important to recognize the crucial role of support systems in effectively addressing STS (Zimering, Munroe, & Gulliver, 2003). Social support not only significantly reduced the symptoms of STS in helping professionals but also contributes to their overall psychological well—being (Hunter, 2016). Accordingly, the presence of a supportive work environment, where colleagues and supervisors are understanding and empathetic, has been linked to lower levels of burnout and compassion fatigue.

Reframing coping as a collective responsibility (Noddings, 2010) emphasizes the importance of mutual support and encourages professionals to acknowledge their vulnerability and need for structures, such as supervision (individual, group or clinical consultants) (Folkman & Moskowitz, 2004; Hunter, 2016). Integrating support from various sources such as family, colleagues, supervisors, and professional counseling can offer a holistic framework for mitigating the impact of trauma exposure.

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[3] Another limitation of resilience frameworks is their failure to adequately consider cross-cultural understandings of adversity and well—being. This shortcoming is significant because resilience manifests differently across diverse socio-environmental and cultural contexts (Walls et al, 2024). I will not delve into socio-culture perspectives in my thesis.

Although the importance of support systems is increasingly acknowledged, there is a gap in research specifically detailing how different types of support systems (e.g., formal peer support groups, informal social networks, professional mentorships) connect with coping strategies. The impact of cultural organizational, and individual factors on the effectiveness of those support systems also remains under explored. The literature exhibits tension between the traditional emphasis on individual coping strategies and the emerging focus on communal or support based coping mechanism. Individual strategies like mindfulness and self—care are well—documented, but their integration with communal support is not thoroughly understood. This leads to contradictions in practical guidance, where helping professionals might be advised both to maintain professional boundaries and to engage deeply with peers support groups networks. For example, while the theory suggests that robust support systems can mitigate burnout and compassion fatigue, practical challenges such as lack of time, organizational constraints, and stigma associated with seeking help often hinder the effective deployment of these systems in healthcare settings. Furthermore, the literature reveals inconsistencies and how STS, burnout and coping are defined and measured across different studies. This variability complicates the ability to generalize findings and apply them across different contexts or to develop standardized interventions that are empirically validated.

The role of organizational support cannot be understated. Implementing policies and practices that prioritize the mental health and well—being of helping professionals can create a conducive environment where they feel valued and supported in their roles. This can

lead to a positive ripple effect, ultimately benefiting the individuals they serve and the overall efficacy of their professional practice.

Image 8: David Uttley/©2020 Samaritan's Purse, The New York Times.

Chapter Six

CONCLUSION

Introduction

This chapter will conclude this study by summarizing the research findings in relation to the research questions and discussing the implications of this study for the helping professionals and the field of medical and health humanities (Research questions 3). I will also review research boundaries, implications for the practice and opportunities for future research. The purpose of this research was to contribute to the existing body of knowledge on Secondary Traumatic Stress (STS). Moreover, to understand how STS affects helping professionals by examining their lived experiences. Those they serve benefit when they are aware of their reactions to listening and working with traumatized clients and understand how these reactions and experiences may either facilitate or impede their clients' therapeutic process and recovery. I sought to gain insight into the helping profession and to gain a better understanding of the struggles faced by these professionals.

The participants in this study used their voices to give insight into their lived experiences of working with traumatized and suffering clients, listening to their stories, and managing STS. This research also delved into the helping professional's symptoms, empathetic engagement and depletion, support networks, psychological and emotional boundaries, and practices of self—care.

We begin with my first research question: *What is known about Secondary traumatic stress in helping professionals?*

Understanding STS as an occupational hazard for helping professionals who are exposed to trauma through the experiences of the people, they serve is significant. STS mirrors symptoms similar to Post Traumatic Stress Disorder, such as intrusive memories, avoidance behaviors, negative alterations in cognition and mood, and changes in arousal and reactivity, albeit induced vicariously through their clients' trauma narratives. The pervasive impact of STS can profoundly affect professionals' emotional and psychological health, leading to diminished professional efficacy and personal well—being.

The phenomenological approach in this study explored the lived experiences of helping professionals impacted by STS. It revealed the depth of emotional and psychological effects experienced by those continually exposed to traumatic stories. These findings underscore the complex interplay between professionals' empathy for their clients and the necessity to maintain emotional and psychological boundaries to safeguard their mental health. Theoretical frameworks such as vicarious traumatization articulate how continuous empathetic engagement and trauma survivors lead to significant cognitive and emotional shifts within helping professionals.

Coping strategies play a crucial role in managing the symptoms of STS, but in Chapter 5 I also discussed a need for a transformative approach to coping. Coping isn't just about developing the right skills. Even though effective strategies include fostering sympathetic detachment, where professionals learn to care deeply while maintaining a

necessary emotional distance to prevent feeling of being emotionally overwhelmed, professionals may need to -relearn new approaches to relating with others and themselves. Organizational support, such as training in emotional regulation, developing clear guidelines for boundary setting, and ensuring regular supervision, can reinforce these coping mechanisms, providing helping professionals with the tools they need to manage the emotional demands of their work. What we know about STS in helping professionals is the profound impact on their personal and professional lives, which calls for a multidimensional approach to addressing this issue, combining individual coping strategies with organizational and systemic interventions to support those in this field better.

My second research question explored: *How is secondary traumatic stress experienced, or what is the meaning of these experiences in the helping professionals?*

The experience of Secondary Traumatic Stress (STS) results in significant cognitive and emotional transformations within helping professionals. These transformations involve changes in their belief systems and worldviews, particularly in how they perceive safety, trust, and personal vulnerability. For instance, professionals might begin to view the world as a more threatening place or feel less optimistic about people's recovery from trauma. This shift can impact their interactions with clients, professional relationships, and personal life as they struggle with increased pessimism and emotional exhaustion.

Empathetic strain is a core component of how STS is experienced. Helping professionals are required to engage empathetically with their clients to form effective therapeutic relationships; however, this very empathy can become a source of emotional and

psychological strain. As professionals absorb the emotional content of traumatic stories, they may find themselves over—identifying with clients, which can lead to emotional depletion and reduced professional efficacy. This empathic strain can manifest in compassion fatigue, where the professional feels increasingly less capable of providing care and support.

The meaning of these experiences in the lives of the helping professionals is multifaceted. On the one hand, experiencing STS can lead to a deeper understanding of trauma and its impact, potentially enhancing the helping professional's empathy and therapeutic skills. On the other hand, it poses significant risks to their mental health and professional longevity. The experience of STS can serve as a painful reminder of the costs of deep emotional engagements in trauma work and the need for robust personal and professional boundaries.

Despite the challenges, many professionals find meaning in their experiences with STS through personal and professional growth. Confronting and managing STS can lead to increased self—awareness, better self-care practices, and more effective boundary—setting. These skills not only enhance professionals' ability to cope with the demands of their roles but also deepen their resilience and capacity to treat their clients, contributing to a more sustainable career in helping professions.

My final research question: *What do these insights mean for the field of medical and health humanities?*

The findings of this study on STS among helping professionals carry significant implications for the field of medical health and humanities. This interdisciplinary field, which

integrates humanistic, social science, and arts-based approaches, can greatly benefit from deeper insights into STS, enhancing both theoretical understanding and practical application in mental health settings. Medical health and humanities focus on the human aspects of medicine—empathy, care—ethics, and the therapeutic relationship. The insights from this study highlight the complex emotional and cognitive impacts of trauma work on the helping professionals themselves, expanding the discourse around care to include the well—being of clinicians as well as patients. This can encourage mental healthcare education programs to incorporate training that addresses these aspects, preparing practitioners not only to care for others but also to engage in self—care and emotional regulation.

Subsequently, the phenomenological approach in this research underscores the value of narrative medicine, a core component of medical health and humanities. By documenting and analyzing the personal narratives of helping professionals experiencing STS, this study provides empirical support for the use of storytelling in understanding and learning about traumatic stress. Narrative techniques can be used to teach healthcare professionals about the emotional complexities of their work, enhancing their ability to process and reflect on their experiences.

By integrating insights from the medical and health humanities, particularly ethics, we can enhance our understanding of Secondary Traumatic Stress (STS). For instance, in my study, participants occasionally faced complex moral challenges. This prompts us to consider STS as a form of moral injury (Vermetten et al., 2018). If moral injury and STS are closely intertwined, and if trauma—potentially secondary trauma—has moral underpinnings, how

might this impact coping strategies? A relational approach to coping could extend beyond individual health professionals, encompassing the intricate moral and ethical aspects of caregiving. Rather than placing sole responsibility on health professional to heal through coping, we should explore relational, ethical approaches to understanding moral injury and its implications to understanding moral injury and its implications, including organizational accountability.

Implications for Policy and Practice

The insights of this research could influence policymaking and clinical practice within healthcare settings. By highlighting the prevalence and impact of STS, this study advocates for systemic changes, such as better mental health—professional support systems, mandatory debriefing sessions after traumatic cases, and regular mental health assessments for mental healthcare workers. These policy changes can ensure that STS is recognized and managed effectively, ultimately leading to better patient care and provider well—being.

Furthermore, this study's insights also have implications for developing relational approaches to empathy (Van Dijke et al.), and ethical sensitivity, crucial aspects in the fields of medical health and humanities. Understanding STS can help mental health care professionals recognize the signs of emotional and moral distress in themselves and their colleagues, fostering a more supportive work environment. It also raises ethical questions about the duty care-ethics institutions have towards their employees, encouraging 'care institutions' (Tronto, 2020) by reassessment of workplace practices and policies to ensure they promote mental health and resilience.

Moreover, this study highlights the importance of interdisciplinary collaboration in addressing complex health issues like STS. Medical health and humanities can serve as a bridge between various disciplines—psychology, psychiatry, ethics, and social work—to develop comprehensive strategies that mitigate the impact of STS. This collaborative approach can lead to more holistic care models that consider the emotional and psychological needs of both the helping professional and clients.

Research Boundaries and Recommendations

Most of the existing research is centered on specific demographic groups, often overlooking the unique experiences of diverse populations within the helping professions, such as those from different ethnic backgrounds, gender identities, and those working in varying economic conditions. This underrepresentation can lead to coping strategies that are not universally applicable or effective across all demographic groups. Future studies should focus on developing and testing integrated models of coping that combine personal resilience building with systemic support to provide a comprehensive approach to managing STS in the helping profession by:

Humanizing Healthcare:

These findings focus on the importance of humanizing mental healthcare by acknowledging the emotional well—being of patients and those who care for them. The importance of STS awareness and support in mental health systems aligns with the aim of medical health and the humanities to foster a more empathetic and holistic healthcare environment.

Cross-disciplinary Approaches to Well—being:

Managing STS requires a cross-disciplinary approach, combining psychological support, ethical reflection, professional development, and organizational changes. This reflects the medical health and humanities' emphasis on interdisciplinary strategies to address complex mental health challenges, advocating for integrating psychological insights, social sciences, and arts into healthcare training and practice.

Promoting Resilience and Meaning-making:

These insights into helping professionals create new meanings and maintain resilience in the face of STS highlight the role of narrative and meaning-making in mental health and healthcare. The medical health and humanities, with its focus on narrative medicine, can offer frameworks for helping professionals articulate and process their experiences, fostering resilience and a sense of purpose.

Advancing Research:

Lastly, this study contributes to the call for more research on STS, suggesting areas where the medical health and humanities can further explore the intersections of culture, ethics, and the emotional dimensions of mental and healthcare work.

In conclusion, the implications of this research on experiences with STS for the field of medical health and humanities are profound and diverse. By deepening understanding, fostering relational empathy and ethics, encouraging narrative approaches to healing, promoting interdisciplinary collaboration, and influencing policy that highlights institutional

accountability to care about professionals, this study helps shape a more compassionate, ethical, and humanistically informed helping professional—practice and institution. These insights not only enhance the care provided to patients but also improve the working lives of those who deliver that care, reinforcing the core values of the medical health and humanities field.

Image 9: Ground Zero, photo by Francois Roux

Image 10: The Empty Chair.

EPILOGUE

My motivation for this topic began with the events of 9–11; it was my introduction to Trauma. I was enrolled in a counseling program at the New York Evangelical Seminary in New York City. The counseling students, the chaplaincy program, and students in ministry were invited to Calvary Baptist Church to be briefed on responding to those impacted by the attacks. Dr. Diane Langberg is a Clinical Psychologist whose primary work is in Trauma. She explained this event's emotional and psychological impact on those directly and indirectly impacted by what they witnessed. "Listening to the stories, entering the person's dark places and pain before you can begin to help them," she explained. I was drawn in by her words and to this work in Trauma.

As I reflect upon this dissertation, I am profoundly moved by the resilience and dedication of the helping professionals who shared their experiences with me. Their narratives of navigating the challenging terrain of Secondary Traumatic Stress (STS) have provided invaluable insights into the intricate balance between empathy and self-preservation. This research has deepened my understanding of STS and reinforced the importance of self-care, professional support, and systemic changes within the helping professions.

My four-and-a-half-year journey in conducting this study has been both academically enriching and personally transformative. Engaging with these professionals' lived experiences has illuminated their work's profound emotional and psychological impacts. The themes of empathic detachment, professional self-care practices, emotional and psychological

boundaries, and the necessity of professional support emerged as crucial elements in managing STS.

Ultimately, this dissertation is a testament to the strength and perseverance of helping professionals. It calls for a collective effort to foster environments where their well-being is as valued as the care they provide to others. As we continue to explore and understand STS, I hope this research contributes to developing more effective support systems and interventions, ensuring that those who help others are not left to navigate the impacts of Trauma alone. This work is dedicated to all helping professionals who tirelessly support others, often at great personal cost. Their stories are a powerful reminder of the need for compassion for others and oneself.

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APPENDIX A:

DREW

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February 26, 2022

Dear James Chambers,

The Institutional Review Board has conducted an expedited review of your research for the project entitled "Secondary Traumatization in the Helping Profession: A Crisis in a Pandemic". The IRB has approved your research project. Please note, if you make any modifications to your research, you will need to obtain IRB approval for those changes.

Best of luck with your research!

Sincerely,

Chris Medvecky
IRB Chair

APPENDIX B:

SECONDARY TRAUMATIZATION IN HELPING PROFESSIONALS

INFORMED CONSENT

SUMMARY: The Purpose of this research is to examine Secondary Traumatization in the Helping Professions: the stress resulting from helping traumatized or suffering persons; the means by which secondary trauma can occur (Television programs; witnessing a traumatic event; reports of violence, mass shootings, the tragic death of a loved one).

You are invited to participate in a research study that is carried out by a student of the Doctor of Medical Humanities Program for educational purposes solely. This study is about Secondary Traumatization in Helping Professionals. Your participation is voluntary. You were selected as a possible participant because of your work in the Helping Profession.

The purpose of this study is educational in the study of Secondary Traumatization Stress.

The research will last until **October 2023**. As part of the study, the researcher will conduct interview sessions with participants who are working in the field and may have been exposed to Post Traumatic Stress in the clients/patients they see and treat.

1. The study is being conducted by James R. Chambers, a third-year doctoral student at Drew University, Medical Humanities Department, under the supervision of Dr. Merel Visse, Program Director, and the dissertation readers. We ask that you read this document and ask any questions you may have before agreeing to be in the study.

2. BACKGROUND: The purpose of this study is to focus on how health professionals who have experienced vicarious traumatization are impacted by both of these experiences of those who are sharing them.

3. DURATION: The length of time you will be involved with this study is estimated as a portion of a day at 45 to 60 minutes.

4. PROCEDURES: If you agree to be a participant in this study, we will ask you to do the following things: complete the attached demographic summary. Read and sign this **Informed Consent** and present it to the researcher at the time of the interview. The interview will consist of several questions related to the field in which you work, experiences in the field, the strategies you have used working with your clients/patients, and lastly, your professional support system or network. Participants may end their participation at any time without consequence or penalty. If you do happen to experience strong emotions from retelling your experiences, you can refer to the attached Pause-Reset-Nourish fact sheet and use the hotlines as a resource.

5. RISKS/BENEFITS: This study has no foreseeable risks, for example: to your reputation or physical or mental well—being, including the likelihood of any identified risks in the interview session. There are no foreseeable benefits to your participation.

6. CONFIDENTIALITY: The records of the study are anonymous or confidential. Neither your name nor any other information containing your identity will be used. The interviewer/researcher will preserve your anonymity at all times, which would include how records of your participation and data will be stored, who will have access to them, etc. When the data are published or presented, no information that would directly or indirectly identify you as a participant will be shared.

7. VOLUNTARY NATURE OF THE STUDY: Your decision to participate in this research will not affect your current or future relations with Drew University. If you decide to

participate, you are free to withdraw from the study at any time without affecting those relationships and without penalty.

8. CONTACTS AND QUESTIONS: James R. Chambers is the researcher conducting this study. You may ask any questions you have right now, or later, you may contact the researcher at 917 853 6830 or jchambers1@drew.edu. If you have questions or concerns regarding this study and would like to speak with someone other than the researcher, you may contact Dr. Merel Visse, Program Director, at mvisse@drew.edu.

9. STATEMENT OF CONSENT: Please verify the following: I have had the procedures of this study explained and have had my questions answered. I understand that my participation is voluntary and that I may withdraw at any time without penalty. If I have any concerns about my experience in this study (e.g., that I was treated unfairly or felt unnecessarily threatened), I may contact the Program Director of the Medical Humanities Department at Drew University.

Participant signature_____

Date_____

APPENDIX C:

SECONDARY TRAUMATIZATION IN THE HELPING PROFESSIONS

DEMOGRAPHIC INFORMATION

PLEASE COMPLETE THE INFORMATION REQUESTED BELOW

Gender:	[ ] Male [ ] Female [ ]
Age	[ ] 25-34 [ ] 35-44[ ] 45-54[ ] 55-64[ ] 65-70
Highest Level Education	[ ] Associates [ ] Bachelor[ ] Masters [ ] Doctorate
Profession/Field:	
License/Credentials/Certifications:	
How many years have you worked/practiced in this field?	
Described the population you work with:	

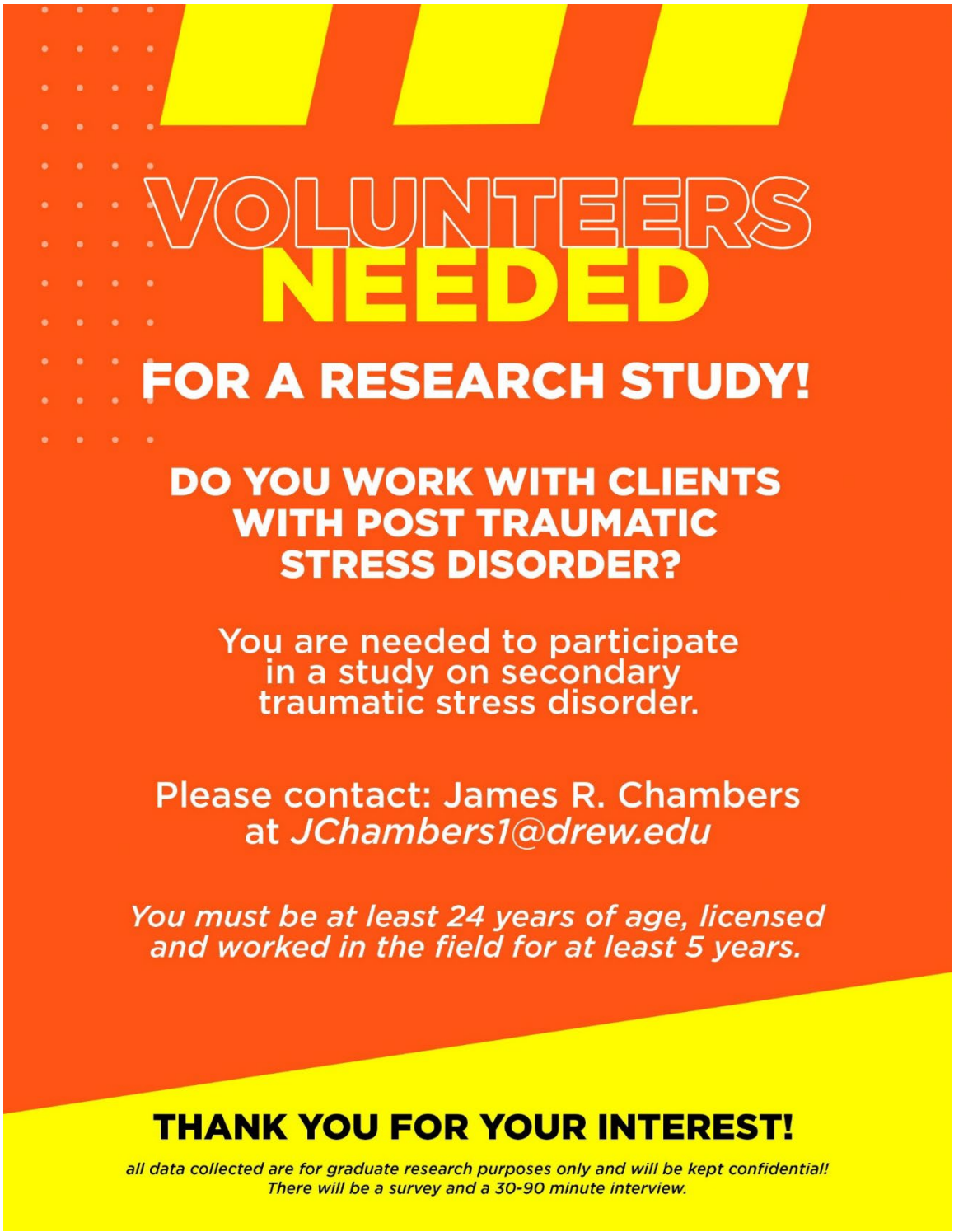
DO NOT WRITE BELOW THIS LINE

Date of Interview: _____

Time in: _____ Time out _____

Index No: _____

APPENDIX D:


VOLUNTEERS NEEDED
FOR A RESEARCH STUDY!
DO YOU WORK WITH CLIENTS WITH POST TRAUMATIC STRESS DISORDER?
You are needed to participate in a study on secondary traumatic stress disorder.
Please contact: James R. Chambers at JChambers1@drew.edu
You must be at least 24 years of age, licensed and worked in the field for at least 5 years.
THANK YOU FOR YOUR INTEREST!
all data collected are for graduate research purposes only and will be kept confidential!
There will be a survey and a 30-90 minute interview.

APPENDIX E:

DEBRIEFING FORM

SECONDARY TRAUMATIZATION IN THE HELPING PROFESSIONAL

PURPOSE OF THE STUDY

The study in which you have participated was designed to examine Secondary Traumatization in the Helping Professional; the stress resulting from helping traumatized or suffering persons. This research will focus on how helping professionals who have experienced vicarious traumatization can relate to the experiences of those who are sharing them. This study may identify professional and organizational needs that would benefit the helping professionals.

METHODOLOGY

The participants will be presented with an informed consent letter, which will be explained by the interviewer (Appendix B). Additionally, a form to gather demographic information from participants for statistical purposes will be explained and then completed by the participants (Appendix C).

The researcher will conduct an in-depth interview with each helping professional. The interview will be conducted by way of teleconference sessions, email, virtual conferencing, when possible, in-person sessions. The interview topics are in the format (Table 1) related to the health professional's experience working with traumatized individuals, as well as their reactions (lived experiences, feelings and thinking) in listening to the victim's stories. The interviews will be audio-recorded, transcribed, analyzed, and reviewed (member-checked) by the participants for trustworthiness and presented in the results section. In addition, the insights of the interviews will be continued and deepened by follow-up exchange by email and a demographic questionnaire (Appendix C).

ADDITIONAL RESOURCES

If you feel a need to speak to a professional concerning any uncomfortable feelings arising as a result of your participation in this research, please contact the Safe Helpline: 877.995.5247; New York Project Hope: 800.273.8255(TALK); Mental Health Mobile Crisis Unit: 888.692.9355. Or go to the nearest Emergency Department. See also the attached Wellness and Well—being Sheet.

CONTACT INFORMATION

If you are interested in learning more about the research being conducted, or the results of the research of which you participated in, please do not hesitate to contact James R. Chambers at jchambers1@drew.edu, or 917 853 6830. If you have questions or concerns regarding this study and would like to speak with someone other than the researcher, you may contact the Chair of the Institutional Review Board (IRB), Chris Medvecky, PhD, at cmedvecky@drew.edu.

Thank you for your help and participation in this study.