Illuminare:
A Student Journal in
Recreation, Parks, and Leisure Studies

How Much is too Much? Vicarious Trauma and Healthcare Professionals

Michelle T. Shalinsky

Douglas College

Online Publication Date: April 4th, 2014

Publication details, instructions for authors, and subscription information can be found at http://scholarworks.iu.edu/journals/index.php/illuminare/

Articles in this publication of the Illuminare: A Student Journal in Recreation, Parks, and Leisure Studies may be reproduced if 1)Used for research and educational purposes only, 2) Full citation (author, title, Illuminare, Indiana University, Vol. #, Issue #) accompanies each article, 3) No fee or charge is assessed to the user. All articles published in the Illuminare are open-access articles, published and distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs 3.0 United States License.

Illuminare: A Student Journal in Recreation, Parks, and Leisure Studies
Volume 12, Issue 1, pages 16-27, 2014
ISSN: 2158-9070 online
Indiana University, Department of Recreation, Park, and Tourism Studies

How Much is too Much? Vicarious Trauma and Healthcare Professionals

Michelle T. Shalinsky
Faculty of Child, Family and Community Studies
Douglas College
1250 Pinetree Way
Coquitlam, British Columbia, Canada, V3B 7X3

Abstract

When working directly with trauma survivors, healthcare professionals are likely to become attached and involved with clients and their lived experience. Due to the cumulative exposure to clients' traumatic stories, healthcare professionals often experience a phenomenon known as vicarious trauma. Symptoms of vicarious trauma include: depression, anxiety, restlessness, guilt, etc. For this study, I conducted six one-to-one, semi-structured qualitative interviews in Vancouver, Canada. All of the participants were individuals working in the healthcare field. The research findings indicated five major themes: background, experience with vicarious trauma, feelings and emotions, coping techniques and implications for future students. Findings suggest that vicarious trauma is common phenomenon among healthcare practitioners who work with trauma survivors. Unfortunately, there currently is a limited amount of research regarding why vicarious trauma is such an unrepresented aspect of the profession. Results of this study indicate that recreation and leisure activities such as art, music, exercise and mediation were found to be the most common coping techniques when experiencing vicarious trauma. Moreover, findings from this research study suggest a need to add self-care and trauma training to educational programs for healthcare students. Therefore, early prevention and education regarding coping of vicarious trauma will prepare more resilient healthcare professionals. In turn, future professionals will be able to provide better care for clients, and can stay working in the field longer.

Keywords: therapeutic recreation, vicarious trauma, Vancouver, Canada, Douglas College

Address Correspondence to: Michelle T. Shalinsky, Faculty of Child, Family and Community Studies, Douglas College,1250 Pinetree Way, Coquitlam, British Columbia, Canada V3B 7X3, Email: m.shalinsky@gmail.com

Problem, Rationale and Literature Review

Individuals working in the health care profession often work with clients who have lived through stressful or traumatic life events. When working directly with these client groups, it is very likely to become attached and involved to clients and their lived experiences. Therefore, the cumulated exposure to the stress and internalization of lived experiences can put the practitioner at risk for emotional and psychological distress (Shepard, 2013). In fact, "studies demonstrate that working with trauma victims across time does have an impact on caregivers" (Collins & Long, 2003, p.18). There is a large body of research which indicates that the constant exposure to the traumatic stories of the traumatized client over time will eventually influence the healthcare professional's well-being (Baker, 2012, Brockhouse, Mstefi, Cohen & Joseph, 2011, Chouliara, Hutchison & Karztzias, 2009, Collins & Long, 2003, Craig & Sprang, 2010, Devilly, Wright & Varker, 2009, Figley & Stamm, 1995, Goldblatt, 2009, Hernandez, Engstrom & Gangsei, 2010, Shepard, 2013). That being said, it is important to investigate coping techniques that could reduce or diminish the impact of these symptoms. Therefore, this study aims to gain an understanding of the awareness of vicarious trauma among working healthcare professionals, as well as identifying coping techniques and strategies to prevent this phenomenon in the future.

Further research indicates that the healthcare professional's "inner experience can be negatively transformed through empathetic engagement" with the client's traumatic material, which therefore can "have similar symptoms of post-traumatic stress reactions, due to deep sympathy for another's suffering" (Goldblatt, 2009, p.1646). This phenomenon is known as Vicarious Trauma, or VT, introduced by McCann and Pearlman in 1990 (Chouliara, Hutchison & Karatzias, 2009). In fact, the "VT construct emerged primarily from observations of the effects of working with complex trauma survivors who experiences multiple forms of childhood abuse and neglect" (Courtois & Ford, 2009, p.204). McCann and Pearlman stressed the negative changes that take place over time, as relationships with trauma survivors are cumulative transformative negative repercussions (Courtois & Ford, 2009). VT can be experienced in many different ways. These include feelings of anger, sadness, sleeplessness, hopelessness, and irritability as a "result of the caregiver's exposure to patient's experiences combined with their empathy for their patients" (Collins & Long, 2003, p.19). VT is "an experience that parallels that of direct trauma" which, if left untreated, can "escalate in severity until it meets the criteria for a psychiatric diagnosis such as PTSD, other anxiety disorders, mood disorders and substance abuse disorders" (Courtois & Ford, 2009, p.204). However, it is important to note the current research on the existence of traumatic resilience, which is defined as "positive meaning-making, growth, and transformations in the therapist's experience resulting from exposure to clients' resilience" (Hernandez, Engstrom & Gangsei, p.72).

According to McCann and Pearlman, VT is an occupational hazard. In fact, "research findings as well as anecdotal evidence from experienced clinicians suggest that most, if not all helpers, experience transformations of their personal frame of reference" (Courtois & Ford, 2009, p.205). Therefore, in order to be the most effective health care professional, it is important to be aware of one's own emotional state. This includes an awareness of the impact that one's professional life has on their personal life. This needs to be understood, as an awareness of one's emotional state impacts one's sense of self, and therefore, the quality of their practice. As such, there is an "urgent need to include psychological trauma in educational programs for [mental] health professionals" (Baker, 2012, p.2). Moreover, in research on VT and the effects it has on health care professionals, it is "important to continue to integrate overlapping concepts to assist clinicians in addressing the complexities and nuances in this work" (Hernandez et al., 2010, p.80). The same can be said for healthcare professionals, as

they are working with the same client groups. In addition, further research on this topic can generate stress management tools, coping techniques, and educational training to better prepare health care students to become more resilient practitioners (Baker, 2012).

Through this study, I hope that the results will impact future studies by enabling researchers to gain an understanding of VT and the impact it has on health care practitioners' professional and personal lives. As a result, future research could reveal "how we as practitioners can strive to create a culture of wellness and support in the fields of harm reduction, healthcare, and human services" in order to emphasize health, pleasure and sustainability for practitioners (Shepard, 2013; Courtois & Ford, 2009).

Research Topic and Purpose

The literature indicates that "there is a cost to caring. Professionals who listen to client's stories feel similar fear, pain and suffering because they care" (Figley & Stamm, 1995, p.1). Therefore, it is important to understand VT related to healthcare professionals in order to explore coping techniques and strategies to prevent or reduce the effects of VT. That is, "addressing the potential negative impact of trauma work in training and supervision is essential to help therapists become aware of their own vulnerabilities and attend to self-care issues and establish personal and organizational support networks" (Hernandez et al., 2010, p.68). This is equally as important for healthcare professionals working with trauma survivors. The purpose of this research study "How Much is Too Much: Vicarious Trauma and Health Care Professionals" was to gain insight about the current understanding of the experience of VT among working health care professionals. In addition, to identify methods that minimize the effects VT for individuals working with clients who have lived through trauma. Thus, my research question is:

Do healthcare professionals experience vicarious trauma? And what strategies can be put into place to ease the effects of vicarious trauma?

Methods

I began by finding an organization which cared for individuals who have lived through trauma. Once the ethics forms were approved, I conducted six semi-structured one-to-one interviews. This method was the most appropriate, as semi-structured one-to-one interviews allow for a "less ritualized experience", which creates an environment for a guided conversation with more room for organic dialogue (Kirby, Greaves & Reid, 2006, p.134). Through this method of data collection, the researcher's goal is to "elicit from the interviewee rich, detailed materials that can be used for qualitative analysis" (Lofland and Lowland, 1984:12). In addition, "interviewers also can observe the surroundings and give use to non-verbal communication and visual aids" in order to gather rich data (Neuman and Robson, 2012, p.184).

Research Participants

All of the research participants were recruited from a long-term care facility in Vancouver, British Columbia. This organization is a home for Jewish older adults; a majority of whom have been affected by World War II. As a result, traumatic personal accounts of the Holocaust often impact health care professional's daily work with the clients. Due to confidentiality, the organization cannot be named.

I interviewed six participants: two Therapeutic Recreation Practitioners, the Head of Social Work, a Music Therapist, the Director of Care and the Companion Care Supervisor. All participants had worked at the organization for a minimum of three years. Non-probability, purposive and snowball sampling was used to recruit six individuals who met the inclusion criteria for this study. Individuals who met the inclusion criteria: (1) were female, though this was not a mandatory criterion for this study (2) were over

18 years of age (3) have obtained a minimum of a diploma in the health sciences field (4) have a minimum of two years' experience working in the field with clients who have lived through trauma.

Table 1.1: Participant Role and Background

Role at the Organization	Educational Background
Director of Care	Social Work
Companion Care Supervisor	Social Work
Director of Social Work	Social Work; Jewish Communal Services
Music Therapist	Music Therapy; Religious studies
Therapeutic Recreation Practitioner	Therapeutic Recreation
Therapeutic Recreation Practitioner	Therapeutic Recreation

Ethics forms were sent to the Director of Care, and were approved by a board of directors. A letter of recruitment was sent to the organization, as well as verbally promoted internally at the organization by the Director of Care.

Data Collection

For the raw data, I created six verbatim transcripts as primary documents. In addition, notes from interviews, notes with direct quotes, and notes from observations. Moreover, I gathered six sets of field notes and observations as additional secondary documents.

I conducted six semi-structured one-to-one interviews that ranged in length from fifteen to thirty minutes. Some of the questions used to guide the interviews included: How would you define trauma? How did it make you feel to listen to a client's traumatic story? What feelings/emotions were associated with this? What were your personal coping techniques? Do you have any recommendations to better prepare more resilient healthcare practitioners?

While collecting qualitative data, I gathered information pertaining to the participants' experience/behaviours, opinions/values, feelings, sensory, and demographic/background information. Qualitative interviews were the most suitable choice of data collection, as this project aimed to gain insight on personal experience. Having one-to-one, face-to-face conversations allowed for more detailed personal accounts, as well as an opportunity to observe emotional expression. The topic of VT can be very sensitive. Therefore, the one-to-one interview setting allowed for a safe space to share within the organization, and the conversational style facilitated comfort. For the interviews, I wanted to begin the interview with exploring trauma in general. Later, I would dive deeper into personal experiences, coping strategies, and recommendations for the future. For a more detailed list of questions used to guide dialogue, refer to Appendix I.

As anticipated, four out of six participants had never heard of the term vicarious trauma. However, all of the participants described symptoms such as anxiety, restlessness and guilt, which are symptoms of VT. As expected, all participants noted that their client's traumatic stories have an impact on them in general. Asking questions that differentiated between client's traumatic story impact on personal life versus professional life assisted in clarification for the participants.

Data Analysis

Qualitative interviews were conducted for this research study. A majority of the interview questions were open ended, with a few close-ended clarification questions and addressed VT and the impact that it has on healthcare professionals. All interviews were initiated with a script, however each conversational interview resulted in unique questions that pertained to the individual participant. The interviews

were recorded on a recording device, and then transcribed verbatim into a word document.

For first level analysis, the verbatim transcripts were coded descriptively, where the research was broken down into five themes. Once this was completed, the themes and codes were categorized into a code book. A content analysis approach, consistent with ethnographic research methods, was used for data analysis. With content analysis, the researcher examines "patterns of symbolic meaning within written text, audio, visual or other communication mediums" (Neuman and Robson, 2012, p.378). An overarching theoretical or philosophical approach was not used; rather, an open coding approach condensed data into "preliminary analytical categories or codes for analyzing the data" (Neuman and Robson, 2012, p.331). For first level analysis, the verbatim transcripts were coded openly and descriptively and a descriptive code book was generated. In the second level of analysis, 5 themes were identified and codes were grouped into these major themes. The themes and codes were tested through searching for alternative explanations and the examination of negative instances.

Trustworthiness

Trustworthiness of this research project was held to the highest standard throughout the entirety of the research process. The transparency is evident through a log book recording process, as well as working in a partnership to continually assess the proposal, data and findings.

Credibility is an "aspect of trustworthiness, which relates to how much truth value the results of a qualitative study have" (Neuman and Robson, 2012, p.300). In order to maintain internal credibility, systematic steps were taken in order to analyze data and create a codebook. This was done though testing with peer partners, checking to edit and search for alternative explanations, searching for negative instances, and keeping a detailed account of decisions made throughout this study. Triangulation is defined as "using different research protocols or procedures to gather information from the same or similar groups of participants (Kirby, Greaves & Reid, 2006, p.238). In this study, interview and field note data were used to triangulate the development of codes and major themes. Finally, transferability is "the component of establishing trustworthiness in qualitative research that is concerned with how generalizable the findings are" (Neuman and Robson, 2012, p.302). Through the development of credible research findings sufficient detail generated "thick description" and allowed for "certainty of how the findings may be applicable to other settings or situations" (Neuman and Robson, 2012, p.301). In this study, the systematic and rigorous approach to data collection and analysis ensured that a study conducted with a similar group of participants in a similar context would generate the same findings and analysis. I am confident that this research study is internally credible and that participants will see their lived experiences within the research results. In addition, external credibility is evident through sharing the research findings with the course instructor and peer debriefing. I believe that service providers will see these findings as trustworthy, as I have gone through the necessary steps to ensure external credibility.

I anticipate that the findings of the research will hold catalytic credibility. The research findings would be of relevance to supervisors, instructors, and front line workers in the field of healthcare. As a result, these findings could impact further research and help to initiate vicarious trauma prevention strategies for healthcare students. The research results will be shared with the Therapeutic Recreation faculty at Douglas College, as well as the organization.

Ethics

Informed consent forms were reviewed and approved by the organization. The participants read and signed informed consent. Confidentiality was maintained through participant numbers assigned for

the research participants as well as stripping all identifying information from textual data. Throughout and at the conclusion of this study, the information was collected and stored by myself in my secure home on a password-protected laptop. Upon completion of the study, and no later than April. 30th, 2014 the data will be destroyed. In addition, this research study is categorized as "minimal risk". This minimal risk project was conducted as part of a course requirement for an undergraduate research course. The course instructor gained ethical approval through the Douglas College Research and Ethics board. Though the interviewees covered topics that could cause the participant to become emotional, this did not occur. In the event that a participant became emotional, I would have stopped the recording and referred the participant to a counselor or to the Director of Care. However, no unexpected ethical issues occurred during this research study. In terms of ethics, I would not do anything differently for future studies.

Findings

These research findings indicated five major themes: Demographics, Experience with Vicarious Trauma, Feelings and Emotions, Coping Techniques and Implications for Further Students.

Demographics

Participants of this study consisted of various healthcare professionals who work at a long-term care facility for Jewish older adults. The participants' experience ranged from four to twenty five years in the field. Of the six participants, four had past experience with trauma survivors. In addition, only two participants had a direct personal connection to the Holocaust. Only two participants identified specific training in school around burn-out and self-care.

Experience with Vicarious Trauma

All six participants reported that their clients' stories had an impact on them in general. Each participant noted the additional impact that the "re-living" of Holocaust experiences has on the healthcare professionals. For example, one participant stated: "You can never go back from there…you can never un-hear something like that" (Participant 5, 2013). In addition, when asked "do you feel like your client's traumatic stories have an impact on you?" another participant stated:

> *Oh, absolutely! Especially, we work with a lot of Holocaust survivors, and just horrible stories. It is really hard not to think about it when you go home at night. Yeah, it definitely takes a toll…It's like, you are experiencing the trauma with her.* (Participant 2, 2013)

When asked about the direct impact the participant's personal life, four out of the six participants agreed. For example, one participant stated:

> *In my early career, having seen children horribly abused, it really came home with me. Like I couldn't… I really struggled in my own relationships. It just didn't make sense to me that children could be so maltreated.* (Participant 1, 2013)

By contrast, two participants claimed that their client's traumatic stories did not go beyond their work duties and into their personal lives, as one participant declared:

> *The trauma is watching them in their trauma. But, I don't know if I've ever taken it home, so to speak. The Holocaust stories I didn't take home…It's either I have no feelings or I'm really able to deal with it.* (Participant 1, 2013)

Five out of the six participants mentioned that working with trauma survivors has taught them to appreciate their current lives, as well as an understanding of

strength and survivorship through their client's stories. For example, one participant expressed:

> *I think it gave me a great ability to be empathetic, for sure. You know, to enhance those skills and also to gives me a better appreciation for life in general. I have a new appreciation of people and their strengths. What they go through, and how they survive.* (Participant 3, 2013)

and,

> *It taught me a lot about survivorship. And, how people overcome and people carry on even if they have lived through traumatic experiences.* (Participant 4, 2013)

In addition, five of the participants stated that their client's traumatic stories impacted their professional life. Most of the participants indicated that supporting trauma survivors has impacted their ability to be empathetic towards others. These results correlate with current research done on the impact of vicarious resilience on healthcare professionals. That is, trauma work can result in positive changes such as "improved relationships, the recognition of new possibilities for one's life, a greater appreciation of life and personal strength, and spiritual development" (Hernandez et al., 2010, p.71).

However, by contrast, one participant reported that this impacts her practice by having to adapt and modify programming in order to avoid triggers for her clients. She stated that "I try to avoid [triggers] at all costs…I think I've become more careful. Just in modifying my groups so that we don't touch on these topics" (Participant 4, 2013). It is important to note that "practitioners may not be willing to disclose this experience to supervisors and/or colleagues, and may remain in denial that they have experienced VT" (Baker, 2012, p.2). In fact, one participant reported the impact that working with trauma survivors has on her and her colleges as a whole, stating:

> *Because, you know, you don't want to share too much, You don't want to, because you don't want to seem like "Oh, this is affecting me and therefore affecting my work…I'm tough, I've been in this long enough". But I think that we need to address the stigma.* (Participant 2, 2013).

On the other hand, two participants explained how the continuous exposure to traumatic stories has de-sensitized them, and has allowed them to detach from the impact of the traumatic stories. For example, one participant discusses, "I think for me it's more aging and maybe some jadedness just in the job itself. I'm really too tired to be traumatized" (Participant 1, 2013).

Feelings & Emotions

According to Collins & Long, symptoms of VT include feelings of anger, sadness, sleeplessness, hopelessness, and irritability (2003). The most common symptoms reported by participants of this study included: anxiety, helplessness, lack of sleep and feelings of burn-out. For example,

> *I think you feel it physically first. I think I feel it in my chest, I feel it in my gut. It transfers over…you feel emotions for it, but it's more of a body thing. It's a real dreadthat you feel when someone brings you into that experience, the way it happens sometimes. Yeah, it almost takes my breath away when I think about those times, you know?* (Participant 5, 2013).

All of the participants reported that working with trauma survivors has affected them individually. In fact, one participant stated that, "it probably changes who you are" (Participant 6, 2013).

Coping Techniques

A surprising finding was the variability between attachment to clients and their traumatic stories. Coping styles and personality variability had a larger influence on the impact of VT than I had expected. Another aspect that was surprising, was the impact of the aging process on the traumatized client. All participants mentioned the impact of dementia, and how memory impairment often results in clients re-living their traumatic experiences. This adds an entirely new level of trauma for the clients, which therefore impacts the healthcare professional in a different way.

All participants reflected on their personal methods of coping with stress. Though each strategy or method of coping was unique to each participant, there were many overlapping themes such as: debriefing with team members, art, music, exercise and meditation. One participant noted that her coping techniques allowed her to but "try to clean out [her] brain and just shut everything off and relax" (Participant 2, 2013). Moreover, one participant stated:

> *Just trying to do some exercise, or taking a long bath… Releasing the tensions of those emotions. Sometimes it's just talking to other people on the phone, and sometimes it's just being quiet.* (Participant 3, 2013)

All participants noted that participating in activities outside of work has helped them process their client's traumatic stories. This aligns with the current literature, as "research has consistently advocated the use of approach coping and acceptance as effective methods of coping with vicarious trauma" (Day, Bond & Smith, 2013, p. 2).

Implications for Future Students

According to Brockhouse et al., repeated exposure to traumatic stories can weigh down on an individual's well-being (2011). When asked about VT, only two out of the six participants were aware of the term before their interview. Moreover, two participants reported to have received training around burnout and self-care as a health care professional in their education. However, all six participants agreed that there needs to be more research and awareness around vicarious trauma in order to better educate and prepare future healthcare students. One participant proposed that if there is "documentation saying that 'healthcare workers experience this…" then it is relative enough to include and to have an awareness of before going into it" (Participant 6, 2013).

Another recurrent theme among all participants was the emphasis on self-care, as "it's hard work to work with people and be needed all the time. You really need to take care of yourself and have a good life" (Participant 1, 2013). Another participant stressed the importance of being present and labeling one's feelings: "I think that's what we need to do. To identify when things are affecting us" (Participant 2, 2013). Moreover, three participants noted that future students need to accept "being comfortable with the uncomfortable" (Participant 5, 2013), and not holding the burden of trying to fix all of their client's problems. In fact, one participant stated:

> *I'm more aware that I can't [fix my client's problems]. I mean, we all come into these professions because we want to help people, we want to make people happy…We want to make people well, and we want to make people happy but that's not always the point. Sometimes, it's allowing them to take space to even live through it with you, live through it with someone there.* (Participant 5, 2013)

Finally, three participants emphasized the importance of work experience. The more hands-on work and challenging experiences will build on future students' ability and strength, where they can "start to deal with the difficult stuff" (Participant 5, 2013).

Discussion and Implications

The primary goal of this study was to assess the current level of awareness of vicarious trauma among working healthcare professionals. In addition, this study aimed to gain insight regarding how to better prepare future healthcare students. Findings suggest that VT is common among healthcare practitioners who work with trauma survivors. In addition, findings from this study suggest that there is a lack of awareness of the term vicarious trauma, as well as a limited understanding regarding how this term relates to the practitioner. Unfortunately, there is currently a limited amount of research regarding why VT is such an unrepresented aspect of this profession.

This study found that personal coping strategies assist the individual in dealing with their clients' traumatic stories. In fact, the most common coping strategies included recreation and leisure activities such as music, relaxation, meditation, exercise, and having a creative outlet. As cited by Baker, there is an "ethical requirement of not only professionals, but also those who educate and/or employ them, to address the problem of VT" as there is a "need for self-care in the context of helping others that have been traumatized" (Baker, 2012, p.2). Interesting findings from this research study included a prevalent emphasis on adding self-care and trauma training in educational programs for healthcare students. In addition, the results indicate that adding more hands-on experience with trauma survivors will help future healthcare professionals. These results are consistent with research conducted by Hernandez et al. (2010), as "addressing the potential negative impact of trauma work in training and supervision is essential to help therapists become aware of their own vulnerabilities, attend to self-care issues, and establish personal and organizational support networks" (p.68).

Working with trauma survivors is a necessary and integral role in the healthcare system. Therefore, healthcare professionals need to be supported and protected against the risk of VT. If symptoms of VT can be prevented, healthcare professionals may be able to work more effectively with trauma survivors, which can then enable them to work longer in the field, and provide better services.

Recommendations

Upon the completion of this study, I have generated recommendations for working healthcare professionals, as well as healthcare students:

- Pursue additional research on contributing factors and preventative measures of vicarious trauma and the impact on healthcare professionals' lives.
- Investigate the role that personality plays in the experience of vicarious trauma.
- Provide additional training and support for healthcare professionals who work with trauma survivors.
- Provide additional training, support and education for healthcare students going into the field.
- Develop recreation and leisure techniques to promote and prevent the effects of VT.

Limitations and Lessons Learned

The major limitation of this study was the time restriction, as this was required to be started and completed in one semester. For future studies, I would like to interview more healthcare professionals across the spectrum, including nurses, care aids, etc. This would allow for a deeper look into VT from all different roles in the healthcare profession. In addition, I would want to conduct research among various healthcare facilities, as the older adult population added unique barriers that may have interfered with the research results. For example, the role that dementia plays in re-living the traumatic experiences. I would be very interested to compare the results to an organization that works with trauma survivors who have lived through different life experiences.

Furthermore, I would have developed my questions differently prior to the interviews. I had

been so worried about approaching a sensitive topic and setting the tone of the interview, I wish I had consistently asked the participants more detailed questions about their experience.

Upon the completion of this study, I have found that there is limited awareness of the impact that VT has on working healthcare professionals. Findings suggest that while working with trauma survivors, the healthcare professionals' professional life does impact their personal life. Personal coping techniques, such as relaxation, exercise, art and music have been suggested as beneficial to easing the effects of VT. In fact, recreation and leisure activities proved to be the most common coping technique employed by all participants. Moreover, all six participants stressed the importance of early education in order to minimize and/or decrease the effects of VT.

In terms of moving forward, I see research in the field of VT focusing on early prevention through education. That is, creating VT training programs for healthcare students which could include a hands on approach to understanding the signs and symptoms, coping strategies, and protective factors involved in preventing the effects of VT.

References

Baker, A. A. (2012). Training the resilient psycho therapist: What graduate students Need to know about vicarious traumatization. *Journal of Social, Behavioral & Health Sciences*, 6(1), 1-12. doi: 10.5590/JSBHS.2012.06.1.01

Breckenridge, J., & James, K. (2010). Educating social work students in multifaceted interventions for trauma. *Social Work Education*, 29(3), 259-275. doi: 10.1080/02615470902912250

Brockhouse, R., Msetfi, R. M., Cohen, K., & Joseph, S. (2011). Vicarious exposure to trauma and growth in therapists: The moder ating effects of sense of coherence, organizational support, and empathy. *Journal Of Traumatic Stress*, *24*(6), 735-742. doi: 10.1002/jts.20704

Chouliara, Z., Hutchison, C., & Karztzias, T. (2009). Vicarious traumatisation in practitioners who work with adult survivors of sexual violence and child sexual abuse: Literature review and directions for future research. *Counselling & Psychotherapy Research*, 9(1), 47-56. doi: 10.1080/14733140802656479

Collins, S. S., & Long, A. A. (2003). Too tired to care? The psychological effects of working with trauma. *Journal Of Psychiatric & Mental Health Nursing*, 10(1), 17-27. doi: 10.1046/j.1365-2850.2003.00526.x

Courtois, C. & Ford, J. (2009). *Treating complex traumatic stress disorders : an evidence-based guide*. New York: Guilford Press.

Craig, C. D., & Sprang, G. G. (2010). Compassion satisfaction, compassion fatigue, and burnout in a national sample of trauma treat ment therapists. *Anxiety, Stress & Coping*, 23(3), 319-339. doi: 10.1080/10615800903085818

Cunningham, M. (2004). Teaching social workers about trauma: Reducing the risks of vicarious traumatization in the classroom. *Journal Of Social Work Education*, *40*(2), 305-317.

Day, M. C., Bond, K., & Smith, B. (2013). Holding it together: Coping with vicarious trauma in sport. *Psychology Of Sport & Exercise*, *14*(1), 1-11. doi:10.1016/j.psychsport. 2012.06.001

Devilly, G. J., Wright, R., & Varker, T. (2009). Vicarious trauma, secondary traumatic stress or simply burnout? Effect of trauma therapy on mental health professionals. *Australian & New Zealand Journal Of Psy chiatry*, 43(4), 373-385. doi: 10.1080/00048670902721079

Figley, C.R. & Stamm, B.H. (1995). Compassion

fatigue as secondary traumatic stress disorder: An overview. *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized* (ed. Figley, C.R.), pp 1-20. Brunner/Mazel. New York.

Goldblatt, H. (2009). Caring for abused women: impact on nurses' professional and personal life experiences. *Journal Of Advanced Nursing*, 65(8), 1645-1654. doi: 10.1111/j. 1365-2648.2009.05019.x

Hernandez, P., Engstrom, D., & Gangsei, D. (2010). Exploring the impact of trauma on therapists: Vicarious resilience and related concepts in training. *Journal of Systemic Therapies*, 29(1), 67-83.

Kirby, S., Greaves, L. & Reid, C. (2006). *Experience research social change : methods beyond the mainstream*. Peterborough, Ont. Orchard Park, NY: Broadview Press.

Napoli, M., & Bonifas, R. (2011). From theory toward empathic self-care: Creating a mind-ful classroom for social work students. *Social Work Education*, 30(6), 635-649. doi: 10.1080/02615479.2011.586560

Neuman, W. & Robson, K. (2014). *Basics of social research*. Toronto: Pearson Canada.

Pearlman, L. & Saakvitne, K. (1995). *Trauma and the therapist : countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York: Norton.

Shepard, B. C. (2013). Between harm reduction, loss and wellness: on the occupational hazards of work. *Harm Reduction Journal*, 10(1), 1-17. doi: 10.1186/1477-7517-10-5