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# The Lived Experience of Vicarious Trauma for Providers: A Narrative Phenomenological Study

Ambryn D. Melius

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The Lived Experience of Vicarious Trauma for Providers:

A Narrative Phenomenological Study

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## Abstract

This research seeks to gain a greater understanding of the first-hand, lived experience of vicarious trauma for providers who have worked with individuals experiencing trauma. Through the application of phenomenological and participatory action methodologies, the experience of vicarious trauma is illuminated. Narrative exchanges between the co-researchers—the author and eleven providers—further explore the roles of the body and narrative process within this phenomenon. A conceptual evolution of vicarious trauma is presented, along with literature connecting the body and narrative within the trauma field. Data includes co-researcher’s recorded and transcribed interviews, vicarious trauma narratives, and written feedback. Embodied writing selections conducted by the author serve as an additional form of data, capturing the nuanced, embodied data within the narrative process. Using narrative analysis, the major verbal and non-verbal themes of vicarious trauma are identified for the co-researchers involved in this study. Findings offer directions for future research into the phenomenon of vicarious trauma, as well as future suggestions for the development and application of body-based and dance/movement therapy techniques to address the impacts of vicarious trauma for providers working with the trauma field.

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## **Chapter 1: Introduction**

I believe trauma affects us all. Whether we've directly or indirectly experienced a traumatic event, the ripples of this disruption expand outward, weaving in and out of the fabric of daily life, relationships, and communities. Judith Herman (1992) noted the "unspeakable" quality of traumatic violations, while also illuminating their refusal to be buried, forgotten, nor quieted (p. 1). Whether explicitly spoken or left unsaid, the effects of trauma can still communicate loudly, and often do so in surprising, unexpected ways.

Much has been researched and documented about the impact of trauma on individuals and families, including the physical, psychological, cognitive, and emotional repercussions. Generally, trauma is understood to occur when a person experiences, witnesses, or is confronted with a traumatic event(s) involving actual or threatened death and intense fear, horror or helplessness (Herman, 1992; Morrison, 2006; Rothschild, 2000). This can result in disruptions within the individual's ongoing experiences and development, including profound alterations to their brain and psychobiology, as well as loss of identity and sense of self (deVries, 1996; van der Kolk, 1996).

Only within the past few decades, has attention turned toward those who are indirectly exposed to traumatic events and occurrences by watching, hearing about, or bearing witness to the aftermath of trauma for those who have experienced it. Caregivers, clinicians, and human service providers who offer treatment, services, and direct, critical care to individuals who have experienced trauma often play a critical role in recovery. Yet, in this process, providers often become the ones to hear and hold the "unspeakable" details of trauma.

As a result, human service providers can experience their own set of physical, psychological, cognitive, and emotional symptoms, similar to those experienced by the individual who directly experienced trauma. These symptoms often have profound and far-reaching impacts within both professional and personal realms (Figley, 1995; Rothschild, 2000, 2006). Furthermore, the culture of human service work, often fueled by the stigma of admitting one's work is taking a toll, can generate a cumulative effect within provider's already existing symptoms, layering additional feelings of shame, guilt, and denial (van Dernoot Lipsky, 2009). This cycle negatively impacts the treatment and care of the client, while increasing potential for of re-traumatization to occur.

In response to this phenomenon, often referred to as the "cost of caring," many different concepts have developed and evolved in order to more clearly identify this phenomenon. Within this study, I have chosen to focus on the phenomenon of vicarious trauma which is the transmission of traumatic stress through observing, exposing oneself to, and/or hearing stories of traumatic events or suffering of an individual, and the resulting changes that may occur in one's thoughts, feelings, body, relationships and beliefs about yourself, others, the world, and the future (McCann & Pearlman, 1990; Forester, 2007; van Dernoot Lipsky, 2009).

As an emerging mental health counselor and dance/movement therapist, along with my own professional experiences of burnout and vicarious trauma, I've long been compelled by the impacts –on both the body and mind – of working within the trauma field. In my past work with people experiencing chronic homelessness, mental health issues, poverty, violence, and various kinds of trauma, I experienced intense exhaustion



and apathy, isolation and shame, and consistent feelings of being on-guard, along with other significant physical, psychological and somatic symptoms as a result of my work.

However, my personal relationships with dance, yoga, and creative movement, along with a growing relationship with my own somatic experiences, nurtured a personal process of working through vicarious trauma. Therefore, I am drawn to and remain deeply curious about the role of the body and dance/movement therapy in both the experience and potential transformation of vicarious trauma. Dance/movement therapy (DMT) is defined as “the psychotherapeutic use of movement as a process which furthers the emotional, cognitive, social and physical integration of the individual” (Levy, 2005, p. 11).

In this process, I’ve pursued countless forms of information and opinions about the potential for sustainability, wellness, and resiliency within this work. Resilience can be understood as the ongoing ability for a person to self-organize and exist interdependently within their relationships and interactions with others, enabling them to “move toward challenges rather than withdraw from them” (Siegel, 2010, p. 153). In the process of seeking my own relationship to resilience in this work, and as a foundation of this research, I’ve turned toward stories and the process of storytelling as a mode of valuable sharing and exchange.

For many of us, life can be understood through stories. Passed along generation-to-generation, family member-to-family member, friend-to-friend, stories can develop a life of their own. For as long as I can remember, I’ve loved stories. I love telling, hearing stories, and recalling old stories, while soaking up the collective energy that generates between communities who have come to know and re-tell the stories of each other.

In my large, boisterous family of eight, stories –large, drawn-out, dramatic, fully-embodied stories – rule. We gather around, raise our voices, throwing our limbs here and there in tune with the emotions of our topic: a rippling ocean of storytelling ensues. Laughter, pointed pause, sprinkled interruptions, and a consistent flow of body posturing punctuate the space. Eyebrows raise, gazes fix, hand jut to hips. Bodies most often speak louder than words.

By witnessing and holding each other’s stories, in a sense, we witness and hold each other. We become known through stories, both to others and to ourselves. In this way, we construct narratives of the events we have encountered, finding meaning and understanding in this narrative process (Riessman, 2008; Siegel, 1999, 2010). A narrative process is one where a speaker connects events and occurrences in a sequential way that has meaning and implications for future action and for the meanings that speaker wants a listener to take away (Riessman, 2008). Often, this process provides a sense of purpose or belonging that can encourage others to remember, engage and act (Riessman, 2008). Therefore, a narrative is made up of these intentionally selected, organized, and connected events that the speaker deems as meaningful for that audience, and in this way, a narrative can “reveal truths about human experience” (Riessman, 2008, p. 10).

With this in mind, I wanted to know how vicarious trauma is for providers who have worked with individuals experiencing trauma. This desire stemmed from my interest in the wide-reaching effects of trauma, along with my curiosities about the roles of the body and narrative process within vicarious trauma. For this study, providers are defined as any person that provides any variety of professional practice, activities, or methods concerned with direct observation, assessment, treatment, or social services to a client,

patient or participant. These include, but not limited to, mental health counselors, therapists, social workers, psychologists, psychiatrists, medical doctors, case managers, art therapists, music therapists, dance/movement therapists, yoga therapists, direct service workers (overnight and short term shelter staff, emergency food center staff), supportive housing staff, nurses, emergency response team members, or others providing direct care within a professional setting.

The purpose of this research was to provide a more comprehensive, nuanced, and body-based understanding of the lived experience of vicarious trauma for a variety of human service providers as a result of working with people who have experienced trauma. Lived experience is the detailed, nuanced, and subjective experience, including individual perceptions, meanings, understandings, descriptions, and felt somatic sense of an experience from the point of view of a particular person; the essence of an experience for that person (Mertens, 2008). In this process, I sought to explore the roles of the body and the narrative process within the phenomenon of vicarious trauma. What might the body and non-verbal qualities provide in the pursuit of a deeper, more lived understanding of vicarious trauma? Similarly, what might the interactive narrative process offer? And, what might this information mean for the field of dance/movement therapy, and the body-based techniques and methods it could offer to providers living with vicarious trauma?

Further, this research was guided by its attempt to collaborate with providers as co-researchers, with a desire to address the lack of acknowledgement and accountability of vicarious trauma within communities and organizations. Through illuminating first-

hand experiences of providers, this study sought to address the social and professional stigmas of vicarious trauma, including isolation and shame.

As an emerging researcher and therapist, I am informed by my values of human agency and experience. I support values of humanism that use naturalistic approaches in understanding the ways humans make meaning and understand the world around them. In this way, I operate from my foundational belief in the knowledge and wisdom of lived experience, along with the understanding that this experience is always situated within social and cultural contexts.

With this said, both research and the therapeutic process will always be located within complex systems of power and identity. As a researcher, I believe I have the responsibility to explicitly, and consistently, address issues of power to the best of my ability. This includes seeking the collaboration, perspective, and critiques of those participating within the research, as well perspectives from outside the field whom may be affected by this research (Schneider et al., 2004).

Additionally, as a dance/movement therapist, I operate from the understanding that the body and mind are fundamentally connected, believing that shifts within the body will bring about shifts in the mind. Under this belief, I support the inherent wisdom of the body as a valid and invaluable form of knowledge that has historically been silenced and marginalized. As a result, I also support the transformative potential and efficacy of the field of dance/movement therapy. I combine theories of humanism, feminism, oral history and DMT to create my personal theoretical framework.

While the trauma field has steadily been shifting focus and research toward the implications of trauma on the body, only a handful of researchers have focused on the

unique body and somatic themes of vicarious trauma for those who work with individuals experiencing trauma. Siegel (2010) has promoted theories of interpersonal neurobiology to highlight the importance of the therapist's mindful and embodied presence, while van Dernoot Lipksy (2009) draws attention to the wide-range of all trauma exposure responses, issuing a collective call for trauma stewardship. Yet, the body as a place of intersection is often side-lined.

Babette Rothschild (2006) and Cressida Forester (2007) have grounded their research of vicarious trauma, and somatic issues of indirect trauma exposure, within the body, paving the way for similarly focused attention with the trauma field. My research intends to honor and follow this path. However, this research also, very internationally and deliberately, invites the first-hand experiences of providers who have experienced vicarious trauma to lead the way.

Embodied writing served as a mode of data collection, analysis and method of presenting results, as well as a way for me to stay connected to the body and interactive, narrative exchange with each co-researcher (Anderson, 2001, 2002a, 2002b). These embodied writing selections are denoted by a change in color, font and format within the text and are located alongside the words of co-researchers. It is my hope that these selections further encourage the reader to remain present and connected to their own body throughout the process of reading this thesis.

The eleven stories that follow form a collective narrative rippling outward, expanding, and generating in its reach. This narrative has a momentum and energy all its own, breaking silences and in so doing, honoring the stories that came before. In this all,

bodies root, ground, and speak loudly, gently, individually, collectively, with wisdom  
beyond words.

## **Chapter 2: Literature Review**

The effects of traumatic experiences have been documented within trauma research over the last four decades in response to growing acknowledgement and attention to the diversity of trauma itself. Some of these forms of trauma include, combat and war trauma, sexual and domestic violence, childhood abuse and neglect, abduction and hostage situations, physical and psychological torture, political terror, homelessness, substance abuse, natural disasters, exposure to extreme violence or death, witnessing others' suffering and a variety of community tragedies (Herman, 1992; van Dernoot Lipksy, 2009). These experiences may range from a single overwhelming event to a complex set of repeated and prolonged events over time (Herman, 1992). They may occur in private or in public, at home, in the office, or in transit.

A specific focus on the impact of this traumatic material on the clinicians, service providers and caregivers that work with those who have experienced these traumas has only emerged as its own field of research within the last two decades (Figley, 1995, 1999; McCann & Pearlman, 1990). Research has noted the cognitive, affective, psychological, and behavioral reactions many providers have to working with traumatic client material, along with the resulting impacts on their personal and professional lives (Figley, 1995; Gentry, 2002; Maslach, 1982; McCann & Pearlman, 1990). Only recently have somatic and body-related responses been included in this literature, such as experiences of body disassociation, increased heart rate, sensation numbing, freezing responses or muscular tensing patterns in the body (Rothschild, 2006; Forester, 2007). This work has drawn attention to the body as a unique and notable tool within the therapeutic process, as well as a key component in the transmission of trauma between the provider and the individual

who experiences trauma (Eckberg, 2000; Forester, 2007; Lengerich, 2001; Munnell Trif, 2010; Rothschild, 2000, 2006).

In this emerging field of traumatology, a multitude of concepts continuously emerge and intersect (Figley, 1995). Some of these concepts include, burnout (Figley, 1995, 1999; Gentry, 2002; Lengerich, 2001; Maslach, 1982; McCann & Pearlman, 1990; Rothschild, 2006), countertransference (Figley, 1995, 1999; Herman, 1992; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Rothschild, 2006), compassion fatigue (Figley, 1995, 1999; Gentry, 2002; Joinson, 1993; Rothschild, 2006), secondary trauma/secondary traumatic stress/secondary traumatic stress disorder (Eckberg, 2000; Figley, 1995, 1999; Stamm, 1995) and vicarious trauma (Forester, 2007; Herman, 2006; McCann & Pearlman, 1990; Munnell Trif, 2010; Pearlman & Saakvitne, 1995; Rothschild, 2006; Trippany, Kress, & Wilcoxon, 2004). Though many other related terms appear throughout the literature and research, such as secondary catastrophic stress reactions, (Figley, 1995), acute and chronic secondary trauma (Eckberg, 2000), complex post-traumatic stress disorder (Herman, 1992), and intrafamilial trauma (Figley, 1995), it is not in the scope of this review to address them all. Instead, this review will focus on the most referenced and researched concepts within the field as they relate to this study.

This literature review will focus on defining key concepts, while tracking their emergence and evolution within the trauma field. Within this evolution, each concept offered a base of knowledge that informed the development of the next, often resulting in overlaps of language and research. In this way, as awareness and momentum grew, conceptual boundaries blurred making it difficult to always know where one concept ended and another began. This review will track the nature of this evolution based on the



progression of literature. In so doing, it will provide a more comprehensive understanding of the language, history and evolving nature of the concepts that have lead to the phenomenon of vicarious trauma for those who work with individuals who have experienced trauma. In addition, this review will present literature related to the role of the body within trauma exposure, introducing concepts and research related to modes of somatic trauma transmission and treatment. It will present literature from the field of narrative theory, defining a narrative, while offering a framework from which to understand the role of the narrative process within this study.

This literature review is not an exhaustive listing of each subject, but instead seeks to offer clarity and understanding to the topics that most directly relate to my thesis. I have limited the scope of this review to provide the basic and foundational elements of each topic. This delimited review scope serves the smaller scale of this study, while offering a scaffold from which the reader might understand the intersections between topics and fields.

## **Trauma**

When a person experiences, witnesses, or is confronted with a traumatic event(s) involving actual or threatened death and intense fear, horror or helplessness, their experiences and development thereafter can be greatly disrupted (Herman, 1992; Morrison, 2006; Rothschild, 2000). They may experience a traumatic loss of cultural identity and sense of self (deVries, 1996), in addition to experiencing profound alterations in their brain and psychobiology (van der Kolk, 1996).

Bessel van der Kolk (1996), a leading researcher on the psychobiology of trauma and traumatic stress, highlighted the variety of self-regulatory functions carried out by

parts of the brain. These include, functions of growth and production of the body, interacting with others and the world around us, assessment of new information, engaging in routine tasks, learning from experience and following social rules (p. 215). As a result, van der Kolk noted that an alteration to one part of the brain will intimately affect other parts, linking the brain and body via mental processes. Systems of processing information combine “both innate and acquired knowledge about the body, the brain itself, and the environment” (p. 216). When people experience trauma, this relationship between the body, brain, and environment can result in a set of psychobiological symptoms that can involve loss of stimulus discrimination, loss of emotions as signals, hypersensitivity or hyperactivity in response to stimuli, and trauma re-experiencing (van der Kolk, 1996).

When a person has experienced trauma over and over, in many different ways and settings, their symptoms grow in complexity and can develop into a more chronic-based disorder that is, “qualitatively different from a simple exaggeration of the normal stress response” (van der Kolk, 1996, p. 218). With this in mind, Judith Herman (1992), a clinician focused on the complexity of trauma within recovery, illuminated the need for more accurate accountability of the complexity of prolonged and repeated trauma. Herman proposed more of a spectrum of traumatic disorder conditions in effort to promote accurate acknowledgement of the complexity in symptoms and expand effective care for survivors. After years of research and advocating, a formal diagnosis emerged in response to the increasing prevalence of these psychobiological symptoms experienced by a growing diversity of people who had experienced a variety of traumatic events (Figley, 1995). This move brought validation to the symptoms experienced by a wide set

of people living with the effects of trauma, along with organizing more effective future treatment and research to address this phenomenon.

### **Post Traumatic Stress Disorder**

The diagnosis of post traumatic stress disorder (PTSD) first entered the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1980 (Figley, 1995; Herman, 1992). This diagnosis brought increased awareness and understanding to the treatment of individuals who had experienced trauma, highlighting the variety of traumatic events possible in a person's life (Figley, 1995; Herman, 1992). PTSD refers to the persistent and profound alterations to stress hormone secretion, resulting in a collection of biopsychosocial symptoms, including, rapid heartbeat, elevated blood pressure, insomnia, anger and irritability, poor concentration, excessive vigilance, increased startle response, mental distress, intrusive and distressing recollections, repeatedly distressing dreams, and anxious/fearful flashbacks of the traumatic event (APA, 1994; Morrison, 2006). These symptoms result in responsiveness numbing, feelings of detachment and isolation, restrictions in an ability to love or feel strong emotions, and a general sense that life will be unfulfilling (APA, 1994; Morrison, 2006).

In addition, the PTSD diagnosis brought valuable research attention to the neurobiological changes that can also occur within a person who has experienced trauma. This includes the nervous system reflex to "fight, flight, or freeze" in response to perceived threats to safety (Levine, 1997, p. 95). Within many traumatic experiences, this fight or flight response is interrupted or overridden by various parts of the brain. As a result, an individual can become stuck in the ongoing nervous system reflex, often

producing a chronic immobility response that can profoundly disrupt many aspects of life (Levine, 1997). Increased awareness and research about these neurobiological changes have contributed greatly to understanding the various implications of trauma on individuals and within families. The formal PTSD diagnosis also added organization and credibility to the trauma field, as well as increased recognition of those who had experienced and were living with trauma.

In this process, attention began to shift to a sector of the population who were reporting similarly intrusive and negatively impactful symptoms; those who experienced indirect or secondary exposure to trauma (Figley, 1995, 1999; Rothschild, 2006). Research began to show that a person could be traumatized just from witnessing or learning about a traumatic event in the life of someone close to them, even without experiencing direct physical harm or threats of harm oneself (Figley, 1995). To support this emerging dynamic, researchers highlighted the specific criterion of what constituted a traumatic event within the PTSD diagnosis. The following excerpt comes from the PTSD diagnostic description in DSM-IV:

The essential feature of posttraumatic stress disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves threatened death, actual or threatened serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury or a threat to the personal integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associates. (APA, 1994, criterion A1, p. 424)

This DSM inclusion formally recognized that the process of witnessing or gaining knowledge about another person's traumatic experiences could be traumatizing in and of itself (Figley, 1995, 2009). This paved the way for new understandings and conceptualizations of indirect or secondary experiences of trauma. Yet, the literature lacked clear indications of how this indirect trauma occurred, as well as clear language from which to expand its research on this phenomenon (Figley, 1995, 1999; Stamm 1995).

As the trauma field grappled with the implications of people's indirect exposure to traumatic events in both public and private spaces, the realm of therapy and the therapeutic relationship began to be re-examined. The therapeutic exchange between the clinician and the client was traditionally founded upon the process of transference (Turner, McFarlane & van der Kolk, 1994; Figley, 1995, 1999). In this exchange, the potential for issues of countertransference was a clinical topic already noted within literature, but was newly being re-examined within the context of the emerging research regarding indirect and secondary exposures to trauma.

### **Countertransference**

Many sources point toward studies of countertransference as the first writings about the effects of psychotherapy on the therapist (Figley, 1995; Gentry, 2002; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). Freud (1959) first mentioned countertransference within the context of psychotherapy. He noted it to be the unconscious reactions that can occur to a therapist, also influenced by that therapist's life experiences, when working with a client. As attention to this interplay of transference between therapist and client grew, clinicians and researchers called for a broader

understanding of countertransference. Researchers sought to consider all of the therapist's conscious and unconscious emotions or attitudes about a client, along with the influence of that therapist's personal events and history within the therapeutic process (Figley, 1995, 1999; Herman, 1992).

Previously, countertransference was considered to be a negative product of the therapeutic interaction, in need of prevention or elimination (Eckberg, 2000; Figley, 2005). Later clinicians acknowledged it was not only a normal component of the therapeutic interaction, but also held important potential for the therapeutic process. Knowledge and increased awareness of this phenomenon could also offer a way for therapists to manage their own countertransference (Eckberg, 2000; Forester, 2007; Figley, 2005; Gentry, 2002; Rothschild, 2000, 2006).

In her work with the *Healing Center for Victims of Political Torture*, Maryanna Eckberg (2000) noted the three categories of countertransference: 1) withdrawal, 2) over-involvement, 3) disequilibrium (p. 72). She understood these categories as distinct ways a therapist's reactions from their work with clients might influence their professional and personal realms. The more a therapist noticed and understood their own countertransference symptoms, Eckberg believed, the more they could remain personally balanced and professionally effective.

Babette Rothschild (2006), involved in the *International Society for Traumatic Stress Studies* and a prominent writer in the field of vicarious trauma and self care, defined countertransference as, "the practitioner's reactions to his client that have roots in his own past" (p. 18). She noted times when countertransference provided new and valuable information for the therapist in understanding what might be going on for the

client (Rothschild, 2006). Thus, she believed countertransference was a tool that could enhance the therapeutic relationship.

The emergence of countertransference as an acknowledged and understood phenomenon of the therapeutic interaction opened up important dialogue and research within the trauma field. As clinicians considered both the risks and the potential of their own reactions to the material of their clients, the road was laid for new concepts and understandings to develop. The phenomenon of countertransference offers a base foundation for understanding the cycle of how a provider might progress into more disruptive and all-encompassing experiences of indirect trauma exposure, such as burnout, secondary trauma, and vicarious trauma.

### **Burnout**

Christina Maslach (1982) was one of the first psychologists to label and research the burnout phenomenon. Maslach offered the term burnout to address feelings and patterns of emotional overload that resulted from working extensively with people who have troubles, issues and problems. A unique and distinguishing aspect of burnout response was its rise from the social interaction between a helper and the receiver, as opposed to the specific therapeutic process between clinician and client (Maslach, 1982). As research emerged, it came to be understood that burnout was also greatly influenced by the nature of the situation, job expectation, or workplace setting within which the helper was operating, often contributing to an inability to meet the growing needs around them (McCann & Pearlman, 1990; Figley, 1999; Lengerich, 2001; Gentry, 2002). Burnout is noted to follow a drawn out and gradual progression that incrementally layers negative and harmful symptoms on the helper (Maslach, 1982).

Three key symptom categories of burnout included, 1) emotional exhaustion, 2) depersonalization, 3) reduced sense of personal accomplishment (Maslach, 1982). These categories made way for creation of the Maslach Burnout Inventory (MBI), a standardized scale measure developed to address people's experience of burnout according to their experienced symptoms (Maslach, 1982; Figley, 1999). In addition to these key symptoms, research revealed how burnout eventually impairs the therapist's ability to provide competent and effective care and services (Gentry, 2002).

Lengerich (2001) utilized the MBI in her dance/movement therapy graduate thesis research to determine the existence of burnout for staff on an outpatient psychiatric unit. She used this data to create a program based on dance/movement therapy principles and aimed at addressing the greatest reported staff needs. Findings of the MBI revealed varying levels of burnout among staff, while other portions of data collection illuminated need for strategies to improve staff communication and teamwork (Lengerich, 2001).

Munnell Trif's (2010) thesis work explored her own experience of burnout and subsequent vicarious trauma from her therapeutic relationship with a child who had experience trauma during her graduate internship. In the process of assessing her own symptoms, Munnell Trif drew from the research of Norcross and Guy (2007) whose research identified three stages of warning signs on the road to a clinician's fully experienced effects of traumatic material. These stages included 1) wear-out, 2) brownout, and 3) burnout (Norcross & Guy, 2007). Both Lengerich (2001) and Munnell Trif's research identified burnout as a key measure of traumatic material transmission, with important implications for the ongoing wellbeing and care of clinicians, therapists and caregivers.



Literature noted the most significant factors of burnout were often connected to problems of the client, when client need far outweighed the capacity of the provider (Maslach, 1982; Figley, 1999). Research findings confirmed this external nature of burnout, turning an inquisitive lens toward situations and expectations of the job setting where people experience burnout, as opposed to a focus on the person experiencing burnout (Maslach, 1982; McCann & Pearlman, 1990; Figley, 1999; Lengerich, 2001; Gentry, 2002). In this way, burnout began to be understood as a product of the nature of a situation or setting, as opposed to the nature of the person (Figley, 1995). As burnout began to be understood as a step or stage in the direction of more fully experienced effects of traumatic material for providers of human services, the ongoing research revealed the need to look beyond the workplace in order to more fully address the full impact of indirect exposure to trauma for the individual (Norcross & Guy, 2007; Pearlman & Saakvitne, 1995).

### **Secondary Trauma**

Attention shifted toward the affects of indirect trauma exposure on personal and domestic realms, including personal relationships and community settings. The concept of secondary trauma was originally described as trauma symptoms that could be caught or passed on like flu symptoms between family members and within close relationships (Figley, 2005, 2009; Rothschild, 2006). It was also understood that secondary trauma could include the effects of witnessing a traumatic event or incident. Eyewitnesses to these kinds of events were considered to have had a “direct experience of witnessing” and as a result, often experienced overwhelming feelings from what they saw or heard (Rothschild, p.14).

Secondary traumatization was believed to occur in those who witnessed the September 11, 2001 attacks on the World Trade Center in New York City. Though not actually in the buildings at the time of attack, they watched, heard and experienced the attacks from afar and thus, were vulnerable to secondary traumatization (Gentry, 2002; Rothschild, 2006). In these kinds of situations, Figley (1995) noted the phenomenon of traumatic stress appearing to “infect” an entire system after it first appeared in just one person. This process could produce, what he referred to as, secondary traumatic stress (STS) and secondary traumatic stress disorder (STSD) (Figley, 1995).

### **Secondary Traumatic Stress**

Figley (1995) defined secondary traumatic stress (STS) as, “the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other-the stress resulting from helping or wanting to help a traumatized or suffering person” (p. 7). In contrast to the gradually emerging symptoms of burnout, symptoms of secondary traumatic stress emerged quickly and suddenly, coming on without much warning. These symptoms brought about a sense of helplessness, confusion, and isolation, as the person experiencing them would become compelled by a search for the way to help alleviate the original trauma (Figley, 1995).

In this way, symptoms often remained disconnected from their original sources, and thus more elusive, becoming extremely debilitating to the person experiencing them within a short period of time (Figley, 1995; Gentry, 2002). Stamm (1997) further noted the specific and immediate way that secondary traumatic stress permeated throughout the entirety of a person’s life. It not only affected their professional work, but also infused into their fabric of personal social networks, relationships, and sense of self.

In their work with military veteran clinicians and caregivers, Bride and Figley (2009) reported common symptoms of secondarily traumatized caregivers. These symptoms included physical and physiological stress, along with changes to ways the caregivers understood who they were in the world. This research laid the groundwork for an established model of secondary traumatic stress, helping to clarify its course of development (Bride & Figley, 2009). This model was based on elements of the interaction between caregivers and traumatized individual, taking into account details of the actual trauma exposure (i.e. sharing emotional burdens, witnessing damaging events, facing the reality of terrible acts), reactions of empathy (creating trust, comfort and a sense of alliance), compassion satisfaction (the positive aspects of doing trauma work), risk factors (length of professional experience, how much time spent with client, personal trauma history), and support structures (reaching out to friends and family, humor, outside activities) (Bride & Figley, 2009).

Much like countertransference, researchers and clinicians agreed that it was important to understand the emergence of secondary traumatic stress as a naturally occurring phenomenon within trauma work. As a result, research in this area was deemed vital and quickly pursued (Figley, 1999). This shift of mindset was believed to offer hope toward the prevention of future traumatic stress for trauma workers and supporters, while also increasing the quality of care for those who have experienced trauma (Figley, 1999; Eckberg, 2000). With these goals in mind, researchers sought a more formally organized conceptualization that could describe, in greater detail, the effects of repeated exposure to secondary traumatic stress (Figley, 1995, 1999; Gentry 2002). And thus, the concept of secondary traumatic stress disorder (STSD) emerged.

## **Secondary Traumatic Stress Disorder**

Though not formally recognized with the DSM, secondary traumatic stress disorder (STSD) is defined as a “syndrome of symptoms nearly identical to PTSD, except that exposure to a traumatizing event experienced by one person becomes a traumatizing event for the second person (Figley, 1999, p. 11). In this way, symptoms of STSD are experienced in direct relation to the person experiencing PTSD (Figley, 1999). Figley presented a comprehensive table comparing the symptoms of PTSD with the symptoms of STSD. The major distinguishing stressors within STSD include a person experiencing: 1) a serious threat to the traumatized person, and/or, 2) sudden destruction of traumatized person’s environment (Figley, 1995, p. 8).

Within his work, Figley strongly advocated for the inclusion of STSD as a recognized disorder within future versions of the DSM. He believed this recognition would contribute to more research related to the effects of secondary traumatic stress. At the time of this writing, though STSD is still not recognized as a diagnosis in the most recently released DSM version (5<sup>th</sup> edition; DSM-5), changes have been made within the PTSD diagnosis (Grohol, 2013). These changes offer more explicit details as to what constitutes a traumatic event and the potential of reoccurring indirect trauma exposure to some kinds of first responders (APA, 2013; Grohol, 2013).

## **Compassion Fatigue**

Within the literature, the concept of compassion fatigue is referenced and utilized quite interchangeably with secondary trauma, STS and STSD, but is most often used as an overarching umbrella term for the entire range of symptoms already discussed and considered to be a part of the “cost of caring” (Figley, 1999, p. 10). Having originally

emerged from the field of nursing (Joinson, 1992), compassion fatigue referred to the stress and fatigue that comes from working with compassion for others (Figley, 1995). Figley (1999) noted that use of the term compassion appeared to resonate more with nurses, emergency workers and other professionals who might experience STS and STSD in their work, but might also feel those terms were too harsh, derogatory or did not fully represent their experiences in the field.

Compassion fatigue has easily been correlated with burnout. While burnout refers to the affects on a provider of a client's needs far outweighing the capacity of the provider within that provider's current workplace or setting, compassion fatigue focuses on the overarching and potentially cumulative symptoms that come from working compassionately with others in need, regardless of the setting or workplace (Maslach, 1982; Figley 1995, 1999). At the same time, compassion fatigue also grew out of the foundational knowledge, research, and education that emerged from understandings of burnout.

Gentry (2002) utilized the term compassion fatigue in his work with emergency responders during the events of September 11, 2001. He divided compassion fatigue symptoms into three categories: 1) intrusive symptoms, 2) avoidance symptoms, and 3) arousal symptoms (p. 42). These categorizations supported Figley's proposition that the effects of caregiver's "continuous visualizing of clients' traumatic images," in addition to symptoms of burnout, manifest the larger, more overarching experience of compassion fatigue (1995, p. 42).

The Compassion Fatigue Self-Test was developed to help distinguish between burnout and secondary traumatic stress symptoms, and in effort to account for why some

people develop compassion fatigue and others do not (Figley, 1995, 1999). Figley noted that elements of empathy and exposure were at the heart of the experience of compassion fatigue. He articulated four reasons why those working with trauma might be vulnerable to compassion fatigue: 1) empathy as a major resource for trauma workers to help the traumatized, 2) most trauma workers have experienced some traumatic event in their own lives, 3) unresolved trauma of the work will be activated by reports of similar trauma in clients, 4) children's trauma is provocative for therapists (Figley, 1995, pp. 15-16). Following these efforts, other researchers began to theorize why and how the larger umbrella of compassion fatigue might occur in hopes of identifying methods of future prevention (Eckberg, 2000, Figley, 1995; Forester, 2007; Rothschild, 2006).

In his development and implementation of the Accelerated Recovery Program for Compassion Fatigue, Gentry (2002) noted the traumatic experiences, or primary traumas, that many caregivers brought from their own developmental past into their work with others. To this effect, Gentry's literature added the element of "pre-existing and/or concomitant primary posttraumatic stress and its symptoms" to Figley's previous definitions (p. 42). Gentry also hypothesized about an "interactive or synergistic" effect that occurred between primary traumatic stress, secondary traumatic stress and burnout symptoms for caregivers (p. 42). This theory, labeled the Compassion Fatigue Model highlighted the possibility that a symptom from any one of these three sources could "diminish resiliency and lower thresholds for the adverse impact of the other two" (Gentry & Baranowsky, 1997, p. 42).

The concept of compassion fatigue provided an overarching lens from which researchers and clinicians could view the wide range of collective symptoms of all the

different kinds of indirect trauma exposure, including countertransference, burnout, and secondary traumatic stress. This development illuminated the additional cumulative affect that appeared to result from intersecting symptoms that a provider experienced within their career. And yet, even in its illumination, the wide reach and all encompassing nature of the concept of compassion fatigue also brought increased confusion that muddled efforts directed at addressing and mitigating its effects.

### **Vicarious Trauma**

McCann and Pearlman (1990), clinicians and researchers with years of leadership with the *Traumatic Stress Institute*, proposed the concept of vicarious trauma to offer increased clarity about the negative effects of trauma work. This term sought to distinguish itself from the other concepts within the field by bringing attention to the understanding that, “much of the therapist’s cognitive world will be altered by hearing traumatic client material” (McCann & Pearlman, p. 136). Vicarious traumatization referred to the transmission of traumatic stress through observation and/or hearing stories of traumatic events, and the resulting alterations, shifts, and/or distortions that occur in the therapist’s cognitive schemas, feelings, relationships, perceptual and meaning systems, and life (McCann & Pearlman, 1990).

In addition, the trauma field was starting to observe and note the impact of trauma material on the body of the therapist. Cressida Forester (2007), a psychologist focused on the role of somatic countertransference and body awareness of the therapist within psychotherapy, defined vicarious traumatization as, “the traumatizing effect of work with traumatized patients on the clinician’s ‘mind’ and ‘body’ ” (p. 124). Attention to the body

as an important element within the experience of vicarious trauma would continue to grow.

The constructivist self-development theory (CSDT) helped researchers further distinguish vicarious trauma by focusing on its cognitive and thought-based components (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Trippany, Kress & Wilcoxon, 2004). The CSDT offered a framework through which to understand the therapist's responses to client material as a product of not only the individual situation, but also the psychological needs and cognitive schemas of that therapist (McCann & Pearlman, 1990). Through this lens, the effects of traumatic client material on a therapist is seen as pervasive, cumulative and possibly permanent, with the potential to infiltrate all realms of a therapist's life (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Trippany et al., 2004).

Symptoms of vicarious trauma can echo those of direct trauma including, nightmares, disrupted sleep patterns, fearful thoughts, intrusive images, suspicion of others' motives, depression, despair, sense of futility, hypervigilance and reactivity (Figley, 1995; Forester, 2007; McCann & Pearlman, 1990). These symptoms can occur in short-term reactions or persist long term as alterations to therapists' thoughts, beliefs, and ideas regarding self, others, the world and the future (Forester, 2007; Gentry, 2002; Munnell Trif, 2010; McCann & Pearlman 1990; Trippany et al., 2004). Forester (2007) and Munnell Trif (2010) noted somatic symptoms of vicarious trauma to include, shortness of breath, palpitations, numbness and experiences of being frozen or unable to move, along with various pains, sensitivities and postures that might reflect those of the client.



As is also true of secondary traumatic stress, the resulting symptoms of vicarious trauma were understood as a “normal consequence,” an almost expected by-product of working with the traumatic material of those who have experienced trauma (Figley, 1995, 1999; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). This normalization spurred new discussions and research about the negative impacts of a therapist’s vicarious traumatization on the therapeutic process itself (Forester, 2007; McCann & Pearlman, 1990; Munnell Trif, 2010; Trippany et al., 2004). Additional literature and research has expounded on methods and modes of adapting to negative implications of vicarious trauma in therapy, but are beyond the scope of this literature review (Trippany et al., 2004).

### **Trauma Exposure Response and Trauma Stewardship**

Many researchers have agreed that rapidly growing access and wide-spread exposure to traumatic events, incidents and experiences has been increasing on local, national and international levels (van Dernoot Lipksy, 2009). In response, research and literature within the trauma field has continued to seek new models and understandings of the ways trauma continues to ripple throughout individual and collective life. Laura van Dernoot Lipsky (2009), a trauma social worker, educator and author of *Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others*, developed the concepts of trauma exposure response and trauma stewardship in order to address this ever-expanding phenomenon. After working within the trauma field for more than a decade, van Dernoot Lipksy realized her work’s cumulative toll on her life: she was exhausted, drained of internal resources, arrogant and angry, rigid in her beliefs, and emotionally, spiritually, and physically numb (van Dernoot Lipsky, 2009).

In her process of reconnecting to her self, she came to understand and define the concept of trauma exposure response as, “the transformation that takes place within us as a result of exposure to the suffering of other living beings or the planet” (van Dernoot Lipsky, 2009, p. 41). Trauma exposure responses can result from exposure that is formal or informal, paid or volunteer, intentional or unintended, but occurs when “external trauma becomes internal reality” (p. 42). While the exact details are different for everyone, an underlying belief is that people are both deeply affected and changed by the suffering around them.

The concept of trauma exposure response recognized the wide spectrum of trauma exposure possibilities, while specifically drawing attention to the ways that people begin to see and experience the world differently as a result of their work within the trauma field (van Dernoot Lipsky, 2009). Van Dernoot Lipsky (2009) issued a collective call for increased accountability and responsibility for the growing intersections between individual and community trauma exposure. Thus, the concept of trauma stewardship emerged.

Trauma stewardship refers to “the entire conversation about how we come to do this work, how we are affected by it, and how we make sense of and learn from our experiences” (van Dernoot Lipsky, 2009, p. 6). Trauma stewardship is seen as a daily, ongoing practice taken on by individuals, organizations, and societies tending to the collective impact of trauma (van Dernoot Lipsky, 2009). This includes caregivers, therapists, teachers, military personnel, environmentalists, animal welfare workers, activists, parents, and children.

The three levels of trauma stewardship focus on, 1) exploring individual personal dynamics (i.e. examining our history, suffering, resources and why we do the work we do), 2) examining organizational tendencies (learning how organizations shape culture and either harm or support workers), and 3) understanding societal forces (acting to change systems of oppression and violence) (van Dernoot Lipksy, 2009). Within this process, it is acknowledged that when organizations and agencies, “[lack] the resources and means to realize their goals, they can actually increase their clients distress and create hardship for workers” (p. 17). In effect, individual causes and organizational missions are often thwarted when they don’t tend to the reality of trauma exposure. The process of trauma stewardship challenges a collective response to the affects of trauma exposure for individuals, communities, and organizations.

Amidst this momentum for a more systemic community response to the rippling affects of trauma exposure, research continued to highlight the body as a location of trauma transmission, as well as a protective resource. Clinicians and researchers began to note and document specific ways a provider’s body reacted and interacted to the somatic and body-based responses of the client. In this way, somatic concepts became more prominently utilized within research as well as within trauma treatment.

### **Somatic Modes of Trauma Transmission and Treatment**

Only recently has traumatology literature reflected and acknowledged the additional effects of client traumatic material on the therapist’s body (Forester, 2007). Cressida Forester’s (2007) work with the treatment of trauma and disassociation within the body brought attention to the importance of the body as a lens when working with those who have experienced trauma. She highlighted body-based methods and

techniques, including body awareness skills, somatic countertransference, and kinesthetic empathy, as valuable psychotherapy tools, as well as potential modes of vicarious trauma transmission from the client to the therapist.

Within the field of dance/movement therapy, much literature exists on the work of dance/movement therapy informed interventions and techniques for various populations that have experienced trauma. This work has included those who live with the impacts of physical, sexual and emotional abuse (Bernstein, 1995; Chang & Leventhal, 1995), disassociate identity disorder (Levy, 1995) and veterans (Winters, 2010). While the unique nature of body-based modes of countertransference are briefly touched upon within some of this work, such as attention to the therapist's unconscious movement impulses and body awarenesses informed from client material (Chang & Leventhal, 1995), little of this literature has specifically focused of somatic modes of trauma transmission as they relate to the therapeutic process between client and therapist. Though some literature has brought attention to the importance of clear distinctions between various dance/movement therapy techniques in order to mitigate somatic trauma transmission (Tortora, 2006), the intersections of dance/movement therapy, somatic modes of trauma transmission, and vicarious trauma remain rich for future research and application.

### **Somatic Countertransference and Kinesthetic/Somatic Empathy**

Within the literature, somatic countertransference is one of the most commonly referenced modes of somatic transmission between provider and client, and is defined as, “the effect on the therapist's body of the patient and the patient's material” (Forester, 2007, p. 129). Forester's research pointed out that while the therapist engages with the

thoughts, feelings, stories, and experiences of the client, so does her body, through the process of kinesthetic empathy. Kinesthetic or somatic empathy are related terms believed to have the, “same relationship to somatic countertransference as empathy has to cognitive and affective countertransference” (p. 124).

Babette Rothschild (2006) also pointed out the role of the body in expressing empathy. She understood empathy to be an, “integrated process involving cognitive and somatic, brain and body,” noting the lack of research and literature regarding the role of body empathy and its importance within the therapeutic process (p. 47). Somatic empathy can be expressed through body based expressions and muscular shifts, such as smiling, yawning, eye contact, postural shifting, along with culturally shared somatic expressions of frowning, crying, and opening the mouth in surprise (Rothschild, 2006).

When processes of kinesthetic/somatic empathy are acknowledged and utilized, these methods have been reported to have the potential to enhance the therapeutic process, as well as inhibit it (Eckberg, 2000; Forester, 2007; Rothschild, 2006). This potential can offer protective factors to the therapist and client, or put them both at risk for vicarious trauma.

After her dance/movement therapy work with a child who had experienced severe trauma, Munnell Trif (2010) identified the roles of somatic attunement and kinesthetic empathy within her own vicarious trauma. After focusing her DMT thesis research on her own experience of vicarious trauma during her internship year, she came to understand that her symptoms of hyper-arousal, immobility, burnout, and unexplained emotions were partly influenced by over-identifying somatically with her client (Munnell Trif, 2010).

On the other hand, research has also pointed out the protective factors that can exist when a therapist can utilize their somatic cues within the therapeutic process as tools to help remain aware of their own feelings and reactions to client material (Eckberg, 2000). In her work with individuals who have survived natural disasters and political torture, Eckberg (2000) reported ways that she remained aware the role of her body, including “awareness of her own breath, presence of her feet on the ground, and attention to the organization of her body” (pp. 71-2). These moments of body awareness helped her identify points of countertransference with her clients, and then implement strategies to maintain her boundaries (Eckberg, 2000).

This research encourages treatment providers to engage in their own somatic psychotherapy or bodywork on a regular basis as a way to practice kinesthetic empathy and notice moments of somatic countertransference, under the guidance of another clinician. Eckberg (2000) believed these body-based modes of therapy can be a way for the provider to “discharge excess energy in the body” in order to help manage the effects of working with individuals who have experienced trauma (p. 77). As researchers and providers grew more aware of the role of their body within their work, new research regarding somatic skills and techniques emerged.

### **Somatic Attunement**

Peter Levine (1997) describes attunement as a method of relying on the “felt-sense,” in order to remain aware and present to the multi-sensory details of our internal and external information (p. 91). He highlighted the ways animals utilize this primal skill of attunement for hunting and survival by tapping into the finely tuned senses of their body, instinct, and environment (Levine, 1997). When a person connects to their “felt-

sense,” Levine found that a flow begins to develop between alertness and a relaxed sense of wellbeing. This flow promotes a way of orienting to the world that can increase a person’s sense of security, confidence, connection, and vitality (Levine, 1997).

Within the field of movement observation and assessment, Carol-Lynne Moore (1988), a movement analysis scholar and educator, discussed attunement as the second phase in the process of movement observation. The act of attuning can be compared to focusing a camera to bring the point of focus into sharper, clearer view (Moore, 1988). Moore wrote, “attuning allows one to sense the movement process....use our sense of sight, hearing, touch, and kinesthesia to establish a contact with what we see...” (p. 212).

The technique of somatic attunement within dance/movement therapy has served as a valuable mode of therapeutic intervention and treatment, as well as a way to build the therapeutic relationship (Tortora, 2006; Levy, 1995; Bernstein, 1995; Chang & Leventhal, 1995). Janet Kestenberg Amighi (1999), who developed the Kestenberg Movement Profile as way to link movement patterns within the context of development, understood attunement as the “process of translating movement qualities observed in another person’s into one’s own body (Kestenberg Amighi, Loman, Lewis, & Sossin, p. 13). This process involves one person matching the qualities of another person’s movements, though not entirely replicating them, seeking instead to portray a characteristic of the movement as a way to engage the therapeutic process (Tortora, 2006).

Within her work to implementing movement and dance within mental health programs, dance/movement therapist Suzi Tortora (2006) differentiates between techniques of somatic attunement and somatic mirroring. She notes that while somatic

attunement only seeks to represent a characteristic of the other person's movement, somatic mirroring is a way of replicating the exact ways another's body is moving, following the literal shapes, forms, qualities and tone of movement (Tortora, 2006). This difference is important when considering the potential trauma transmission that can occur between the client and dance/movement therapist amidst methods of somatic empathy and somatic countertransference. By utilizing somatic attunement as a way to tap into an overall felt-sense within the therapeutic process, instead of mirroring the exact body patterns and qualities of an individual who has experienced trauma, providers may find ways to avoid the transmission of trauma (Tortora, 2006).

Babette Rothschild (2006) has written extensively on the role of the body as a factor underlying risk for vicarious trauma, as well as a resource in preventing vicarious trauma. To this end, she has developed a variety of exercises that can help reduce the risks of somatic empathy and somatic countertransference to the therapist (Rothschild, 2006). These include practices to increase facial and postural awareness, conscious postural mirroring and un-mirroring, using patterns of muscle tensing as sensation arousal brakes, developing sensory anchors, establishing spatial comfort zones, and controlling empathic imagery (Rothschild, 2006). Designed for practice in the workplace, these exercises offer providers practical and applicable skill building that promote somatic empathy awareness, arousal awareness, imagery control, and self-care (Rothschild, 2006).

The development of concepts identifying somatic modes of trauma transmission and treatment has helped to further recognize the body as a valuable tool within the trauma field. However, clinical awareness and therapeutic application of somatic



countertransference, somatic/kinesthetic empathy, and somatic attunement within the therapeutic process is still slowly growing, in need of ongoing research.

Dance/movement therapists and other body-based clinicians are poised to continue fueling this research, offering new somatic and dance/movement therapy techniques that can more fully integrate the body into existing treatment, as well as offer techniques to address trauma exposure risks for providers along the way.

### **Narratives and Trauma**

In this section, I will present literature on narratives, introducing the narrative function and its role, while noting the emergence of the narrative process as a story-telling exchange. I will then position the narrative within the trauma field, noting its use within trauma treatment, as well as ideas about its future potential in this field.

#### **The Narrative Function**

The emergence of the ‘narrative’ function is believed to appear in children by the age of three (Siegel, 1999). This function provides children a way to create stories about all the interactions and events they encounter throughout their lives. In turn, these stories help a person make sense out of these events and their own resulting mental experiences by creating a “sense of coherent comprehension of the individual in the world across time” (Siegel, 1999, p. 323). Creating stories about what we have encountered or experienced is a way to organize and make sense of oneself within the world. The narrative function allows us to engage in a collaborative and interactive narrative process with others, sharing our storied accounts of who we are in the world.

## **Narrative Process**

The term narrative holds many different meanings and can be used in a variety of ways. Though often synonymous with the word “story,” a narrative’s distinguishing element is the linking of events or ideas into a meaningful pattern (Riessman, 2008). The emergence of the narrative form links to Aristotle’s application of *mimesis*, conveying the idea that “action is imitated” (Riessman, 2008, p. 4). In this way, by constructing a narrative, an individual, “...creates a representation of events, experiences, and emotions” (p. 4).

Catherine Riessman (2008), a clinician and scholar who specializing in narrative inquiry, describes the connection between the process of oral storytelling and the narrative. She explained, “...in everyday oral storytelling, a speaker connects events into a sequence that is consequential for later action and for the meanings that the speaker wants listeners to take away from the story (p. 3). Here, the narrative emerges from the events and elements of the story that were “selected, organized, connected, and evaluated as meaningful...” (p. 3).

As a person creates narratives about the meaningful events and occurrences in their life, along with forming a correlated understanding of who they are in relation to these experiences, these narratives grow in power and significance. In this way, narratives have the ability to orient a person across time, providing a sense of stability, belonging and coherence (Siegel, 1999). Yet, in the same way that traumatic events, or cycles of repeated traumatic occurrences can result in profound physical, emotional, cognitive, psychological, and somatic disruptions, so too does trauma disrupt a person’s ability to form complete and coherent narratives (Siegel, 1999, 2010). Research and

literature within the trauma field has noted the role of narratives within trauma treatment, understanding it as a tool to assist a client journey toward recovery (Herman, 1992).

### **The Narrative within Trauma**

As the field of trauma developed, many clinicians and researchers came to understand the “unspeakable” quality of many traumatic events and occurrences within various cultures and communities (Herman, 1992). Within the lives and inner circles of the individuals who experienced trauma, great pressure often exists to maintain the secrecy and deceit of a traumatic act. This often brings shame, denial, and buries the pain and harm that occurred.

And yet, the work of the feminist movement, alongside survivors of traumatic acts and events, drew attention to the power of telling their stories and reclaiming their power (Herman, 1992). After two decades of research and work with victims of sexual and domestic violence, Judith Herman discovered “remembering and telling the truth about terrible events are pre-requisites both for the restoration of the social order and for the healing of individual victims” (p. 1). In this way, for many individuals who have experienced trauma as well as the clinicians and providers who work alongside them, narratives have come to play a vital and transformational role in the work of the trauma field.

Judith Herman (1992) has written extensively about the journey between trauma and recovery, noting the value of the narrative within the process of recovery. In her work, she noted the emergence of three general stages of recovery: 1) the establishment of safety, 2) remembrance and mourning, and 3) reconnection with ordinary life (p. 155). Within these stages, she noted the vital role of story telling within the second stage of

remembrance and mourning. She wrote, "...this work of reconstruction actually transforms the traumatic memory, so that it can be integrated into the survivor's life (p. 175).

In this process, Herman noted the role of nonverbal modes of communication as a part of reconstructing the traumatic story. Understanding the involvement of bodily sensations and visceral qualities as keys to moving into the final stage of reconnection, she wrote, "a narrative that does not include the traumatic imagery and bodily sensations is barren and incomplete" (1992, p. 177). Just as Siegel (1999) noted the way narrative function helps a person make sense of the events in their lives, leading toward coherent understandings, so too Herman understood the role of narrative reconstruction of a traumatic experience as a key component toward recovery.

"In the process of reconstruction, the trauma story does undergo a transformation, but only in the sense of becoming more present and more real. The fundamental premise of the psychotherapeutic work is a belief in the restorative power of truth-telling. In the telling, the trauma story becomes a testimony" (Herman, 1992, p. 181).

### **Conclusion**

As I reflect on the power of truth-telling, I return to my research questions: How is the lived experience of vicarious trauma for providers who have worked with individuals experiencing trauma? What are the roles of the body and narrative process within vicarious trauma?

My motivation for this study is fueled by a curiosity about "how" providers have experienced the impact of their work with those who have experienced trauma, but it is also bolstered by a desire to offer a space for the truths of these experiences to be told.

What I will find, I don't know. Will I be able to safely offer this space for providers? Will providers want to share their intimate stories, and if so, will it offer anything for them in return? And how will I invite the bodies involved in this study—each provider's body as well as my own—actively, safely and authentically into this exploration?

This literature review reveals a lack of clear, decisive boundaries within the concepts and understandings related to the wide range of ways that providers might experience indirect trauma exposure from their work with others who have experienced trauma. As a result, these descriptions blend in and out, consistently informing each other, but also muddling together. Clarity for real-life application can be hard to find.

What has been revealed is that any future work and research in this area will need to acknowledge and honor these porous boundaries, adhering to an understanding of trauma exposure that allows for more of a spectrum, continuum, or life cycle model that can shift, turn around, recycle and jump ahead depending on the stories and people involved. However, it also seems true that the ability to note and ground within historical developments of concepts and symptoms will stabilize the ever mobile, expanding nature of vicarious trauma.

With this new understanding, how might this limited, yet informed literature review, tracking the intersecting evolutions of concepts and understandings within the trauma field inform my own research implementation? When I first began my dive into the vast sea of research related to the intersections between trauma, indirect or secondary trauma exposure, the therapeutic process, and the body, I hoped to emerge with greater clarity. And yet, this literature review reminded me of the inherent interconnectedness of

these topics, offering a foundational resource base from which to proceed forward, adjusting any expectations of exactness and certainty.

Within this process, I return to my initial wonderings about the experience of vicarious trauma for providers, and what might be revealed about the roles of the body and narrative process within these experiences. In addition to seeking conceptual clarity and history related to vicarious trauma, I also sought literature about the ways the body is understood to be involved in trauma and trauma transmission between provider and client. Here I discovered emerging terms and methods, such as somatic countertransference, somatic empathy, somatic attunement and somatic mirroring, all pointing toward the body as a key component within this exchange. Yet, within the field of trauma, a lack of wide spread understanding, application and integration about the role of the body remains.

However, as I explored the literature regarding the role of narratives within trauma and trauma treatment, I found theories and research that located the body and visceral, somatic awareness as a key ingredient within trauma treatment. It appears these intersections between the body and the narrative process may offer an inroad into increasing understandings of how vicarious trauma is for providers who experience it, in addition to ways this phenomenon could be addressed through body-based techniques and methods. Could the narrative structure, involving the process of a provider recounting and re-constructing the details, sensations, visceral awarenences and meanings of their experiences of vicarious trauma, offer a valuable bridge between the body and vicarious trauma?

The purpose of this study is to provide a more comprehensive understanding of the lived experience of vicarious trauma for providers who have worked with people who have experienced trauma. It seeks to illuminate the subjective experience of vicarious trauma, by seeking knowledge from first-hand experiences, wondering how this information might enhance understandings of vicarious trauma and other trauma exposure responses. Within this process, this work strives to challenge the lack of acknowledgement, understanding, and accountability of vicarious trauma within individuals, communities and organizations. It also aims to address the social and professional stigmas of vicarious trauma, including symptoms of isolation, shame and guilt.

In addition, this study intends to explore the roles of the body and narrative process within the phenomenon of vicarious trauma. This literature presents emerging research about somatic modes of trauma transmission, along with growing use of the body within trauma treatment. In response, as providers share their experiences of vicarious trauma, I wonder how attention to their non-verbal/body-based narrative might present unique body-based themes, patterns, sensations and material? How might this somatic information contribute to greater understandings of vicarious trauma, along with offering a new knowledge base from which to address symptoms of vicarious trauma, and other forms of indirect trauma exposure? Furthermore, how might dance/movement therapy principles, theories and methods contribute to the existing literature and ongoing evolution of vicarious trauma?

This literature offers a foundation as I proceed ahead, eager to engage with the providers in this study as they share their experiences of vicarious trauma. Ongoing

research may explore the experiences of vicarious trauma within one specific set of providers, or within one particular organizational setting. Future research may also choose to focus on an already existing somatic method of therapeutic intervention as a way to address this phenomenon for providers. May all of this future research utilize and hopefully benefit from the conceptual and theoretical groundwork laid out in this review.

For now, I hope this research will continue building bridges between understandings of vicarious trauma, the role of the body and somatic modes of trauma transmission, and the narrative process, as well as within the trauma field, itself. Even more so, I sincerely hope this research can open more truth-telling space for those who remain committed and engaged in working alongside individuals who have experienced trauma.



### **Chapter 3: Methods**

The methods and procedures for this research developed from my overarching drive to understand and be with the topic of vicarious trauma. I hoped to engage with this topic through the first hand-experiences of others, while trusting the body as a source of information. As I sought to follow my natural curiosity for an intangible concept, I chose methods that I hoped would keep me grounded, connected to my body, and in consistent engagement with my co-researchers. I hoped these methods would create space for authenticity, safety, and trust, alongside in-depth exploration.

In the following section, I will describe the variety of qualitative research methods I utilized to create the framework for this thesis. The choice to include my participants as co-researchers will be explained, along with a description of what this choice meant for my research process. My research procedures will be presented, along with the tools used to collect data. I will explain my choice to use embodied writing as a key method for data collection, analysis, and reporting portions of my findings. And finally, I will lay out the ethical considerations of this study.

#### **Methodology**

**Phenomenology.** As I explored my choices of qualitative research methods, key characteristics of phenomenological research grabbed my attention. With the aim of understanding how humans make sense of their own experiences and situations in the world, phenomenology seeks to illuminate "...how individuals create and understand their own life spaces" (Mertens, 2005, p. 240). As an emerging therapist and researcher, I deeply value understanding experience from direct engagement with those who actually live it. In fact, I believe this lens is imperative when working with people in the social

and cultural contexts within which we are always enmeshed. Phenomenology offered me a lens from which to invite human experience to be revealed and then examined.

Another underlying belief of phenomenology is that knowledge can generate from a person's perceptions, sensations, and moment-to-moment awareness of their experiences (Moustakas, 1994). This ability to understand human experience as multi-sensory and deeply nuanced provided a place from which I could examine the body as a mode of human experience. This aligned well with my identity as a dance/movement therapist, founded on the intersections between body and mind, non-verbal and verbal, believing the body to have its own inherent wisdom. Here, I could explore the embodied and interactive narrative process between two people as a structure through which experience might be illuminated.

As a type of qualitative research, phenomenology offered a way for me to illuminate the point of view of providers and place a high value on the whole of an experience or phenomena (Moustakas, 1994). Qualitative research emphasizes an examination of "things in their natural settings" (Mertens, 2005, p. 229). Supporting a naturalistic and humanistic approach to the world, process is honored within qualitative research (Mertens, 2005). This humanistic approach further aligned with my own theoretical orientations as an emerging clinician and researcher. Therefore, as soon as I began learning about qualitative research, I knew on a visceral level it was the right approach for me. The components and values of qualitative research not only mirrored how I understood and made sense of the world around me, but also how I believed I could best understand the experience of vicarious trauma. Qualitative research provided a way to ask "how" vicarious trauma was for those who experienced it.

**Participatory action research.** As I settled into my choice to work from a phenomenological research approach, I also yearned for way to be in shared partnership with the providers who were going to be involved in my study. I sought a way to acknowledge and address the often reported disempowering impacts of vicarious trauma, including shame, guilt, isolation, and fear (McCann & Pearlman, 1990). In this pursuit, I discovered participatory action research as an additional qualitative research strategy.

Participatory action research encourages those involved in a study to take an active role in the research, assuming those who live an experience are the experts of that experience (Schneider, et al, 2004). This approach promotes the potential of the research experience, along with any knowledge gained, to lead to transformation (Schneider, et al., 2004, pp. 564-5). Ideally, this transformative potential could lead to social change and an improved quality of life for those involved in the study. By inviting co-researchers into active participation with the research, participatory action research also seeks to recognize power dynamics and potential power issues between co-researcher and main researcher. A focus on the “cultural knowledge of the people” serves as a means from which to generate potential change for the future (Mertens, 2005, pp. 243-244).

In effort to promote the side-by-side collaboration and value of “sense-making coming from the community,” participatory action research chooses to identify participants as “co-researchers” (Schneider, et al., 2004, p. 564; Mertens, 2005, p. 243-244). For these reasons, I also chose to utilize co-researcher as the title for each provider involved in my study, and will continue to refer to them as such. The recognition that co-researchers were the experts of vicarious trauma, and thus the vital component of making sense of vicarious trauma, was at the core of my research (Schneider, et al., 2004).

## **Co-researchers**

My study involved 11 co-researchers who identified as having experienced vicarious trauma as a result of working with individuals who have experienced trauma. Co-researchers included seven women and four men, between the ages of 30-56 years old. Two co-researchers self-identified as White, two as White-Caucasian, one as Caucasian, one as Caucasian-non Hispanic, one as White Euro-American, one as White-Jewish, with two choosing to remain unidentified. At the time of the interviews, co-researchers held the following professional job titles, mental health counselor, licensed mental health counselor, licensed social worker, yoga therapist, mental health case manager, critical care nurse, dance/movement therapist, licensed psychologist, executive director and workshop facilitator, art therapist, youth case manager. It is important to add that I also served as a participant in this study.

As I began co-researcher recruitment, I intentionally reached out to as wide of a net of human service providers as possible. This strategy recognized the variety of ways human service work is done, along with the diversity of positions that exist within the field. In particular, I wanted to be sure to invite the experiences of front-line, direct-service workers who often connect people to the basic, vital needs of food and shelter. With this rationale in mind, it seemed valuable to capture co-researcher's current job titles, as well as the job titles they held throughout their vicarious trauma experiences. I felt this information would contribute to my understanding of "how" vicarious trauma was for co-researchers spanning time, agency, and professional title. Co-researcher's past job titles, held during vicarious trauma experiences, included, legal/medical advocate, mental health case manager, group home worker, acute residential psych milieu,

classroom counselor, shelter counselor, shelter supervisor, program manager, critical care nurse, dance/movement therapist, volunteer, residential counselor, mental health art therapy intern, family case manager, peace corps volunteer, wildlife center program manager, and clinical support specialist/housing case manager.

Co-researchers were recruited and data were collected in Chicago, Illinois and Seattle, Washington, drawing upon my professional connections in both locations. Co-researchers were recruited through email (Appendix B). Each co-researcher self-identified as having experienced vicarious trauma based on the specified definition of vicarious trauma generated from my literature review and operationalized for this study (included in Appendix A).

## **Procedures**

Individual interviews were carried out in a location mutually agreed upon by the co-researcher and main researcher ahead of time, maintaining as much privacy as possible. These locations included: co-researcher's home, main researcher's home, or the co-researcher's private office setting. Interviews were conducted from August-December 2012, scheduled to fit within a 60-90 minute time period. Variations in interview timing accounted for a natural narrative flow, and/or co-researcher workday time limits, or a combination of both. Though my approach and execution of each session varied according to a variety of factors, a general outline of the co-researcher interview session is as follows.

Each interview session began with a verbal welcome/greeting, followed by shared review and signing of the informed consent form (Appendix C). Here co-researchers were provided the choice to either be identified with their real name, or a pseudonym,

along with a chance to review the study's operational definition of vicarious trauma. Safety was addressed as co-researchers were reminded of their ability to end the session or take a break at any time, as well as self-direct the flow of topics, including making the choice to decline answering or addressing any question or topic. The co-researcher and I discussed our timing needs, mutually agreeing upon a time parameter for the session. I agreed to be responsible for this shared time boundary.

Next, the co-researcher was offered the choice to review a written list of eight, semi-structured interview questions (Appendix D). As interviews progressed, I began to experiment with the timing of when I offered this interview question list, allowing co-researchers the choice of reviewing written questions before the opening grounding, after opening grounding, or not at all, with different choice from each co-researcher. Overall, offering this option seemed to support a sense of co-researcher agency and control throughout the interview, displayed by the variety of choices made by each co-researcher and the shift in power between co-researcher and myself, as main researcher. All of these choices align with the values and structure of participatory action research (Mertens, 2005).

From here, I verbally guided the co-researcher through a brief body/mind grounding experience, often including some of the following cues; grounding through feet, noticing inhales and exhales, becoming aware of body parts in contact with the chair or floor, and cycling through awareness of the five senses (sight, smell, taste, sound, touch). This grounding exercise was intended to serve as a transition into the interview, along with promoting mindfulness, awareness of present moment, and an embodied presence for the both the co-researcher and myself.

At this point, I encouraged the co-researcher to begin sharing their experiences with vicarious trauma in any way they were naturally inclined. In order to encourage and support the emergence of the ‘narrative function’ of each co-researcher, I sought to remain present, open, and embodied within the interview (Siegel, 1999). Throughout each interview, I followed the co-researchers choice to either begin with one of the prepared questions or to follow their own story-telling impulses, honoring their natural narrative flow (Riessman, 2008). Some co-researchers requested I begin by re-reading the first question listed the interview question list out-loud. In some sessions, the co-researcher continued to request additional questions to be verbally read as a guide to their sharing. Other co-researchers shared freely without questions, jumping around between various topics and interview questions. I concluded each verbal interview by reading the following two questions out-loud: “What is most important to you about your telling of this experience?” and “What about your experience do you most want to be heard?”

Organically, I used techniques of somatic attunement throughout the interviews. The act of attuning brings a point of focus into sharper, clearer view by calling upon all senses in order to be in contact with the multi-sensory details of both internal and external information (Moore, 1988; Levine, 1997). I responded to co-researcher’s movements through shifts in my own body. I mirrored particular gestures, positions, or qualities that I observed or sensed from each co-researcher. As I drew upon my own experience of “felt sense” within interviews, I also hoped to support each co-researcher’s connection to their “felt sense” and embodied self throughout their narrative (Levine, 1997). Throughout the interviews, I invited co-researchers to share any emerging body sensations or awarenesses. These attuning techniques helped to develop and deepen my

own embodied presence within the interviews, thus sharpening my collection of the details within co-researchers stories.

Each interview was audio taped, with co-researcher permission, in order to collect verbal and audible data for later analysis. Throughout each in-person interview I took informal written notes, as I was inclined, most often informed from my observations and embodied presence within each interview. These notes served as another way I could capture intersections of key words and phrases, along with noting non-verbal actions and qualities of each co-researcher.

The session concluded with a closing body/mind grounding, again verbally guided by myself, but also non-verbally cued by the co-researcher's body, breath, and/or images mentioned throughout the interview. These closing groundings intended to bring both the co-researcher and myself back to the present moment, reorient the co-researcher to time and space, resource each co-researcher in order to safely transition them back into the rest of the day. By choosing to conduct individual interviews, I was allowed greater capacity in my role, with space to focus on the individual, subjective details of how each co-researcher understood their vicarious trauma experiences. I was also able to fine-tune my focus on the narrative and body within each interview, and in this way, hone in on the answers to my research questions in the most effective way.

Following each co-researcher interview, I conducted an embodied writing session in a personal journal. In these sessions, I wrote about my own internal sensations, questions, phrases, recollections, emotions, and impulses that arose both within and from the interview. My embodied writing would often evolve from words, into informal



drawings or abstract images, informed from my embodied experience with each co-researcher's narrative.

In most cases I traveled from the initial interview location to a different setting where I could conduct embodied writing in privacy. I sought a location that might allow me the freedom to situate or move my body in any way that naturally emerged. In cases where the interview occurred in my home, I made sure to intentionally transition from interview to embodied writing. Sometimes I did this by moving around the space, stretching, engaging in household tasks, and/or taking a brief walk around the block before settling back into the apartment to begin embodied writing.

The next steps included transcribing, typing, and editing each co-researcher's audio taped interview into a written, storied account. These accounts included each co-researcher's stories of the interactions and events they encountered throughout their vicarious trauma, along with the ways they made sense of these events and understood their own involvement across time (Siegel, 1999). This storied version became each co-researcher's vicarious trauma narrative. Differing from the full interview transcription, narratives were comprised to the most significant segments of each in-person interview, guided by my study's unit of analysis: intersections of verbal content, audible cues, and non-verbal/body observations. The narratives also highlighted the story-telling format of each interview and served as another mode of data collection.

Each vicarious trauma narrative was sent back to the co-researcher from which it originated, accompanied by a letter sharing how I created the narratives and a request for feedback. This letter included optional questions and requests, including: "What came up for you as you read your narrative? Thoughts? Emotions? Body sensations?"; "Share any

specific feedback about your narrative, including any or all of the following: additions or subtractions to the written content, additional contextual information about any section, anything new that has surfaced for you, in the time between our interview and now, regarding your vicarious trauma experiences” (Appendix E). After reading their vicarious trauma narrative, co-researchers returned their written feedback to me through email.

### **Data Collection**

In effort to capture the nuances of body and narrative exchange between the co-researcher and myself, I chose to utilize several different modes of data collection. These included: individual interviews, observation, embodied writing, narrative, and co-researcher feedback. I will discuss each method in further detail below.

**Interviews.** Initially, I was drawn to consider a focus group format for data collection. However, as I took time to consider the vulnerability of my research topic, the depth of group dynamics, and my identity as novice researcher, I quickly sensed I was expanding outside my research questions and the capacity of my role. With these considerations in mind, I turned toward individual interviews as one of my main modes of data collection.

Janesick (1998) defined interviewing as, “a meeting of two persons to exchange information and ideas through questions and responses, resulting in communication and joint construction of meaning about a particular topic” (p. 30). Within qualitative research, interview questions often remain minimally structured or unstructured in order to prioritize what naturally emerges as meaningful from each co-researcher as the interview unfolds (Mertens, 2005).

I chose to provide semi-structured, open-ended interview questions to co-researchers at the beginning of each interview. Co-researchers were encouraged to make use of these questions as they desired, with no expectation for how they would inform the interview process. As much as possible, I attempted to follow the verbal and non-verbal guidance of each co-researcher regarding interview flow, timing, topic, and structure. I believed this process encouraged increased rapport in my relationship with co-researchers, leading to richer nuance and depth within our interview exchange.

Adler and Adler (1994) noted that an active and mutual rapport between those involved in an interview had the potential to challenge traditional hierarchical research roles and decrease differences in status. In this way, researchers are encouraged to explicitly turn over control within an interview to the person being interviewed or those whom might not have as much power as the main researcher (Mertens, 2005). Throughout each interview, I sought to turn over control to co-researchers as much as possible, a process that aligned with participatory action research and accounted for the variety of ways each interview played out.

**Narrative.** Riessman (2008) noted that, “many kinds of texts can be viewed narratively, including spoken, written, and visual materials” (p. 4). As I typed each co-researcher’s vicarious trauma narrative, informed from the full interview transcriptions, I recalled Riessman’s idea that, “just as interview participants tell stories, investigators construct stories from their data” (p. 4). The narrative served as a mode to capture not only the storied form of each interview, but also the storied interaction between co-researchers and myself.

The emergence of the narrative form links to Aristotle's application of *mimesis*, conveying the idea that "action is imitated" (Riessman, 2004, p. 4). In this way an individual "...creates a representation of events, experiences, and emotions" (p. 4). Instead of merely answering a line-up of mechanical questions, I hoped the interviews might be a place where a more interactive and embodied storytelling, narrative form, could prevail. In this way, I provided opportunity for co-researchers to tell their story of vicarious trauma in an interactive, emotive, and narratively-driven way (Riessman, 2008).

I hoped the influence of narrative structure might allow space for ideas and storylines to link and meaning to emerge from co-researchers accounts of their vicarious trauma experiences. Phil Salmon (2008) stated, "...a fundamental criterion of narratives is surely contingency. Whatever the content, stories demand the consequential linking of events or ideas. Narrative shaping entails imposing a meaningful pattern in what would otherwise be random and disconnected" (p. 80). Narratives offered a way to organize and present the uniquely meaningful patterns that emerged within each co-researcher's interviews about their experiences with vicarious trauma.

**Co-researcher feedback.** Co-researcher narratives were delivered back into their own hands for input and feedback. This feedback served as another mode of data collection, as well as a method of establishing research credibility and validity known as member-checking (Mertens, 2005). As a validation strategy in qualitative research, member-checking is a way to "verify within the respondent groups the constructions that are developing as a result of the data collected and analyzed" (p. 255).

Each co-researcher was allowed the opportunity to review their vicarious trauma narrative and then provide feedback. Feedback was requested to address accuracy and

contextual clarification, along with sharing any other new information that may have emerged since the interview related to their experiences with vicarious trauma. This method of validation aligned with my study's participatory action methodology, by placing a value on co-researchers active participation in the research and recognizing issues of power between those involved in the study.

**Embodied writing.** As I settled into my choice to utilize individual interviews as a main data collection mode, I knew another piece of the puzzle was still missing. I needed a way to capture and make sense of the somatic information I would be observing and absorbing from co-researchers throughout their interviews. I also desired consistent ways to stay connected to my own body, my own embodied presence as a researcher, throughout my study of vicarious trauma. I hoped I could encourage this same embodied inquiry from co-researchers as a way to help gather a more holistic and multi-faceted experience of their experiences.

Early in my graduate school journey a professor noted my natural tendency toward writing in an embodied way. She encouraged me to research embodied writing, and when I read the definition, I felt immediate resonance. Embodied writing is concerned with conveying the lived experience of the body through written word.

Anderson (2001) shared:

Embodied writing brings the finely textured experience of the body to the art of writing. Relaying human experience from the inside out and entwining in words our senses with the senses of the world, embodied writing affirms human life as embedded in the sensual world in which we live our lives (p. 83).

I had found a label for a process that emerged very naturally and kept me connected to my own moment-to-moment experience of the world. From here, I continued to learn about embodied writing, utilizing it as a way to merge the creative and academic. As I wondered how to find balance within my research methods, I reached toward embodied writing as an additional mode of data collection.

By “giv[ing] the body voice” embodied writing tunes the writer and reader inward in effort to relay human experience as if the reader were having the experience within their own skin (Anderson, 2002a, p. 41). The writer seeks to engage readers’ kinesthetic, visceral, perceptual, somatic, and imaginal senses, and in so doing, relies on fostering a quality of resonance between the senses and the written word (Anderson, 2001). Within the realm of research, Anderson noted that, “the researcher collects, analyzes, and reports findings, fully intending to invite readers to encounter the narrative accounts for themselves and from within their own bodies through a form of sympathetic resonance” (2002a, p. 40). When I engaged in my embodied writing sessions, I called upon this concept of sympathetic resonance to document not only my own experience of each interview, but also capture non-verbal and somatic information that might have otherwise been missed.

Within research, sympathetic resonance can offer a form of validity, summoning the recognition or felt sense of a particular phenomenon through the embodied word. Anderson (2002b) wrote, “in responding through resonance...we deepen our understanding one body to another body” (p. 44). This process of sympathetic resonance informed many stages throughout my research, including the development of my unit of analysis.

The seven characteristics of embodied writing include:

1. Embodied writing contains true to life, vivid depictions intended to invite sympathetic resonance in the readers or audience.
2. Embodied writing is inclusive of internal and external data as essential to relaying the experience.
3. Embodied writing is written specifically from the inside out.
4. Embodied writing is richly concrete and specific, descriptive of all sensory modalities, and often slowed down to capture nuance.
5. Embodied writing is attuned to the living body.
6. Embodied writing includes narratives embedded in experience, often first-person narratives.
7. In embodied writing, poetic images, literary styles, and cadence serve embodied depictions and not the other way around. (Anderson, 2001, p. 87-88)

The more I used embodied writing, the more I understood how embedded it was within my research questions and methodologies. Phenomenological inquiry, the “how?” of my research question, seeks to understand the lived experience of a person about a particular phenomenon, searching for the essence of that experience (Moustakas, 1994, p. 13).

Embodied writing honors and conveys experience from the point of view of the lived body. It allows the researcher to “collect and analyze data close the raw lived experience itself,” and as a result can allow a researcher to “know more fully what he or she is studying” (Anderson, 2001 p. 92). Both phenomenology and embodied writing seek a lived and embodied understanding of human experience.

**Observation.** The process of observation played an important role within data collection, especially during interviews and embodied writing. Cruz and Berrol (2004) believe the heart of observing is, “to look so fully and deeply that one has a felt sense of what one is seeing” (p. 133). Even though observation was not a formal part of my original research plan, it naturally emerged as a bridge between interviews and embodied writing sessions.

As the study progressed, I found that my observations naturally occurred in stages. I drew upon a phrasing model developed by Carol-Lynne Moore (2010) including, relaxation, attunement, point of concentration, and recuperation. These phrasing stages allowed for my increased “observational stamina” throughout the 60-90 minute interviews (p. 31).

In this process, it was important to consistently assess my own personal body knowledge and body prejudice (Moore, 2010). Moore (2010) understands body knowledge as the knowledge a person has about the meaning of movement based upon their own embodied experiences in the world. She further distinguishes body prejudice as the kind of positive or negative meaning one might place on different kinds of movement based on how they’ve learned to make sense movement from their own movement experiences (Moore, 2010). My embodied writing sessions were a place for me to document and explore observations of the co-researcher, the interactive narrative space between the two of us, as well as the role of my own body knowledge and body prejudice.



## **Data Analysis**

Narrative analysis brings attention to the “storied form” of the interview, with a focus on how the co-researcher assembled or sequenced events, utilized language or visual images, and communicated nonverbally via gesture or body movement (Riessman, 2008, p. 12). Within narrative analysis, the intention and particularities of language are found by asking “how?” and “why?” (Riessman, 2008). This attention to the story within the interview, with consideration of non-verbal, body-based story-telling methods, immediately compelled me.

Embedded in an appreciation for the way that narratives can illuminate and make sense of everyday human experiences, narrative analysis flowed naturally from my original research questions. Narrative analysis aligned with my phenomenological methodology through a shared focus on broader commentary and inquiry into a social process (Riessman, 2008). Furthermore, narrative analysis partnered with participatory action research through mutual desires to highlight the socially significant and potentially transformative act of storytelling (Riessman, 2008). I planned for narrative analysis to be conducted after each individual interview, during the interview transcription process.

**Dialogic/performance narrative analysis.** As I began recruiting co-researchers, I needed to decide if I was willing to conduct some interviews long-distance via Skype or stick to my original, intuitive desire to conduct interviews in-person. As I revisited my research questions, I was reminded of my foundational value of sharing tangible, in-the-flesh story-telling exchanges with co-researchers. Guided by this value, I discovered dialogic/performance analysis.

This form of narrative analysis draws attention to interaction between speakers. It recognizes that we are always creating, producing, and performing narratives interactively (Riessman, 2008). Utilizing dialogic/performance analysis allowed me to honor and hone in on the rich data that was emerging between co-researchers and myself, especially informed from each of our bodies, during vicarious trauma interviews (Riessman, 2008).

**Thematic narrative analysis.** A second mode of narrative analysis, thematic narrative analysis, helped to round out the examination of my mounting data. Riessman (2008) noted that a main focus of thematic narrative analysis is on the process of, “generalizing thematic categories across individuals, even as individual stories are preserved and grouped...” (p. 62). By focusing on what was spoken within the narrative, that which was told to me by the co-researcher, while also keeping the essence and identity of each vicarious trauma story intact as a whole, thematic narrative analysis gave me a way to identify broad patterns across all co-researcher’s vicarious trauma narratives (Riessman, 2008). This process allowed me to focus in on the “how” of my main research question. After initial feelings of being swallowed by data, uncertain of how to hold words and body side-by-side, the combination of dialogic/performance and thematic narrative analysis created a scaffolding upon which I could stabilize and broaden my analysis gaze.

Though my initial intention was to separate my data collection and analysis, in reality, these two phases intersected as a part of my organic research process. Looking back, my analysis really began through my embodied presence in each interview and my intention to use embodied writing as a research tool. This analysis continued during my

post-interview embodied writing sessions, as I honed in on felt sense, images, and resonating elements of the storied exchange between myself and the co-researcher. Analysis continued to unfold as I sat down to transcribe each audio taped interview. Without consciously realizing it at first, I began to mark certain phrases, words, and sections of the written transcription that evoked significant kinesthetic, audible, imagistic, or somatic resonance in my own body, as supported by embodied writing (Anderson, 2001).

I soon realized my body responses, along with the evoked memories from the original, in-person interviews, were guiding my analysis. From here, a coding system organically emerged as I marked those sections that evoked embodied response from verbal content, audible quality, and my own kinesthetic resonance. Here again, though it was not a part of my initial plan, I organically began calling upon on my knowledge and experience of Laban Movement Analysis (LMA) as I began this coding process (Laban, 1974; Laban, 2011).

Developed by Rudolph Laban, Laban Movement Analysis is a system of understanding and describing the range of movement possibilities for a mover, involving factors of Body, Effort, Shape, and Space (Laban, 2011; Hackney, 2002). Effort elements are identified through the motion factors of flow, weight, time and space (Laban 2011: Bartenieff, 1988). I coded those interview sections evoking my embodied response with a corresponding Effort quality: strong or light weight, direct or indirect approach to space, acceleration or deceleration in time, and moments of free or bound flow (Laban, 2011, Bartenieff, 1988). I also organically coded sections that involved any explicit verbal mention of the body from the co-researcher, including body parts, body sensations, or

postural shifts (Laban, 1974). These coded and most significantly experienced sections became each co-researcher's vicarious trauma narrative.

In this process, I quickly became overwhelmed with my mounting data, revisiting my research methods for guidance. I turned toward the method of triangulation to increase research credibility, but also as an organizing structure in which to cross check my mounting sources of data (Mertens, 1994). Mertens describes triangulation as a process of “checking information that has been collected from different sources or methods for consistency of evidence across sources of data” (1994, p. 255). Moustakas (1994) also writes about the importance of validating data in this way. He encouraged the process of sending copies of the main researcher's “synthesis of the textual-structural description of [co-researcher's] experiences” back to each co-researcher so they can “carefully examine the unified description...” (pp.110-111).

As I searched for ways to organize my growing data and make sense of the diversity of data sources, I developed cover sheets for each co-researcher (Appendix F). These cover sheets served as a way to line up my different sources of data and enhance research credibility through triangulation. Each cover sheet was divided into four columns separated into the following headings: audio interview, embodied writing, interview notes, co-researcher feedback. In these cover sheets, I found a place to organize all my coded data sets, literally placing verbal and non-verbal data side-by-side. From here, the patterns and themes of vicarious trauma across eleven co-researcher narratives, along with the “how?” of my research question, began to surface.

Moustakas' method of “horizontalizing the data” echoed the method of triangulation, providing further support for the creation of cover sheets as organizational

and analytical tools (1994, p. 118). He encouraged viewing “horizons or statements relevant to the topic and question as having equal value” and literally laying these data sets side-by-side (p. 118). From here, he believed “meaning units” could emerge and be used to create “textual descriptions of the experience” (p. 118). As I organized my data sources into cover sheets, indeed, I began to find the integration of my research questions.

### **Ethical Considerations**

A handful of ethical concerns arose both in the planning and implementation of this study. To address these unfolding concerns, I sought review and feedback from my Departmental thesis coordinator, Departmental Thesis Committee (DTC) and college International Review Board (IRB). One concern related to the safety and wellbeing of each co-researcher, as they re-counted and re-shared their experiences with vicarious trauma. This process asked co-researchers to open up a potentially intimate and vulnerable subject carrying the possibility of re-experiencing their vicarious trauma material.

To address this concern, I made certain my informed consent form, recruitment communication, and discussions with each co-researcher clearly addressed these potential risks or discomforts. I also clarified my role as researcher distinct from that of clinician, offering a listing of local therapy and supportive service contacts for co-researchers, if the need arose at any time throughout the study. If a co-researcher identified as currently experiencing symptoms of vicarious trauma, it was agreed they had an established outside of study therapist. Throughout the implementation on this study, the closing grounding exercise following each interview became increasingly valuable. It served as

not only a transitional tool, but as way to resource each co-researcher, re-orienting to time, space, and the external world before returning to the rest of their day.

Another ethical concern included the safety and wellbeing of myself, as I embarked on a process of hearing, witnessing, reviewing, and holding space for the vicarious trauma stories of eleven co-researchers. This concern was compounded by the existence of my own past, personal experiences with vicarious trauma. Initially, I considered a focus group format for this study, but with the guidance of my thesis coordinator, decided to shift to individual interviews. This shift allowed me to maintain clearer boundaries in my researcher role, while paying more attention to my own self-care throughout the study.

My post-interview embodied writing sessions, already built into my study, along with my ongoing yoga and movement practices, served as important self-care practices. Between interviews with co-researcher two and three, I discovered a post-interview phrasing that was naturally emerging from my recuperation needs. This phrase often included the following progression: walk/travel from interview setting, immerse in outside external sensory information, find new location (my home, art museum, coffee-shop), embodied writing session, directed physical tasks (commute, dishes, cleaning, dinner prep), physical movement (run, yoga, creative movement).

Sometimes I desired more space to actively move my body during embodied writing sessions. Other times at the end of my physical movement I found myself emotional, sometimes crying. But, all in all, I allowed these natural impulses, trusting the function they served. I quickly discovered by tending to my ongoing wellness, body and senses throughout the interviews, and thus, tending to my own vicarious trauma history, I

was more fully engaged and attentive to the wellness, safety, and data of the co-researchers.

### **Conclusion**

With the spirit of my recuperative phrasing discovery in mind, I invite the reader to pause. Inhale. Exhale. Shift your gaze away from the page or screen. Scan the space around you, taking in what is surrounding you. Find an object upon which to re-focus your gaze. Notice the shape, colors, and qualities of this object. Inhale. Exhale. Take a moment to shift your position in some way, perhaps standing or walking around the room, before you settle back into a newly revived position.

## Chapter 4: Results

I began this study with a deep curiosity about the impacts of working with people who have experienced trauma. This curiosity was spurred by my own work experiences, fueled by ongoing research and dialogue with others who shared this work, often resulting in confusion about the vague and nebulous concepts attempting to pinpoint this very real and complex human phenomenon. Shame and secrecy surrounding these conversations further fueled my desire to illuminate, explore, and gather material about real-life, first-hand experiences of vicarious trauma from a variety of human-service providers.

I was particularly interested in framing my exploration of vicarious trauma within storytelling exchanges between the provider and myself. I wondered what this narrative space might provide for the re-counting and re-telling of how vicarious trauma had been experienced. I wanted to attempt to engage providers as co-researchers, involved in the research process alongside my role as main researcher. As a dance/movement therapist, I was also specifically interested in what the bodies and non-verbal communication within each story might reveal about vicarious trauma as a human phenomenon.

In 11 semi-structured interviews and 11 embodied writing sessions, I attempted to collect stories, sensations, memories, reflections, and non-verbal body-based material, such as gestures, postural shifts, effort and energetic qualities, related to experiences of vicarious trauma for 11 co-researchers. Data were collected in hopes of understanding and describing how these lived experiences were for human service providers. In this pursuit, it was important to return to my guiding research questions on a regular basis: How is the lived experience of vicarious trauma for providers who have worked with



individuals experiencing trauma? What are the roles of the body and narrative process within vicarious trauma?

Throughout narrative interviews, embodied writing sessions, and co-researcher narrative feedback, I do believe distinctive verbal and non-verbal/body themes and qualities of vicarious trauma emerged. These themes and qualities emerged throughout the interview and transcription process, but most clearly presented within the points of integration between the verbal and non-verbal of each narrative. These points of integration, my study's unit of analysis, occurred when a co-researcher's spoken words and their body/effort qualities merged during the in-person interviews, further supported by additional data sources. Because my beliefs about my research findings may be biased by my own involvement and body knowledge/body prejudice, I will present and describe evidence of verbal/nonverbal intersections from co-researcher narratives that helped to illuminate the salient themes of vicarious trauma (Moore & Yamamoto, 1988).

From 11 co-researcher interviews and embodied writing sessions, eight main verbal themes emerged including difficulties with relationships and social life/isolation, powerlessness/helplessness, hypervigilance/fear of future, physical symptoms/sleep disturbances, overarching sense of responsibility, head-body disconnect/numbing, primary trauma within vicarious trauma, gifts/resiliencies. Within themes of primary trauma within vicarious trauma and gifts/resiliencies, I discovered nuanced sub-themes, listed and expanded upon below.

In addition, I captured shared non-verbal/body themes of vicarious trauma for co-researchers. These non-verbal/body themes contributed a somatic lens to my phenomenological inquiry into vicarious trauma, as well as directly addressing my

second research question: What are the roles of the body and narrative process within vicarious trauma? Also, as is examined through dialogic/performance narrative analysis, these non-verbal/body themes further illuminate the narrative, story-telling space created within the interview between each co-researcher and myself.

I will list each main themes followed by supporting evidence, as well as any existing sub-themes. This supporting evidence was collected from the triangulation of four different data sources, co-researcher interview, main researcher interview notes, main researcher embodied writing session (occurring post-interview), and co-researcher narrative feedback (Mertens, 2005). Throughout data collection and analysis, additional thematic categories emerged including coping/self-care, systemic/administrative issues, relationships/social realm, and vicarious trauma as a label/term.

However, as my analysis continued I discovered these additional findings took me away from my main research question of “how” vicarious trauma is for co-researchers, instead focusing more on external and contributing factors to vicarious trauma. As a result, these additional themes, while potentially valuable for other future research, fell outside of the scope of my research and are not included in this chapter. For more details about additional thematic categories, see Appendix G.

### **Difficulties with Relationships and Social Life/Isolation**

The majority of co-researchers noted significant difficulties within their relationships and in social interaction with others as a major component of their vicarious trauma experiences, along with consistent experiences of isolation and feeling alone. Four co-researchers shared the discovery that they, “couldn’t connect with others...” and as a result, experiencing growing tension with friends, partners, and family members that

hadn't previously existed. Other co-researchers spoke of the changes they noticed in how they related to those around them, including numerous attempts to re-adjust to these changes, as one co-researcher shared, "I needed distance...and needed to retool how to interact with others...it was overwhelming."

Within these narratives, friendships and relationships suffered due to feelings of disconnect, anger and judgment towards others. One co-researcher realized she "couldn't validate anybody's concerns that weren't big..." instead finding herself caught up in making judgments and projections about the "stupid...self-serving" nature of others who weren't able to understand or relate to her work. Another co-researcher who worked as a rape-crisis advocate admitted, "It became kind of hard to connect with people that weren't doing [rape crisis] work, I would go to parties and all I could talk about was rape, you know...[I thought] people don't get it, but I know, you know?"

In some cases, co-researchers experienced a need to pare down and sometimes cut out certain relationships within their social lives as a result of feeling "relationally exhausted" from their work. One co-researcher, who spent her work days listening to stories of how mental health issues impacted client's daily lives, finally had to ask herself, "Who are my relationships where...there's enough mutual reciprocity that it feels worth holding onto and who are the friends that I can't do right now?" This co-researcher admitted by the end of her workday, she just wanted to "go home and be alone."

In one of my post-interview embodied writing sessions, non-verbal and body-based information emerged in relationship to one co-researcher's stories of experiencing isolation and feelings of being alone during her work with kids experiencing trauma. As she spoke of this time of isolation, I sensed a shift within the shared story-telling space

between the co-researcher and myself, as a sense of solidarity, familiarity and normalcy entered our interview:

“she rubs, rubs, rubs her thighs, pressing down hips, pelvis with her hands....she just wanted solidarity, normalcy, she wants that solidarity now...she and I and we soften as we mention this wish, this desire to not feel alone...we circled the story back together in a shared body space, with shared understanding...rubbing, rubbing, rubbing...her journey pressing her hands up the body to down...we sink into solidarity together. Familiarity, nodding, nodding, rubbing, rubbing...in it together...”

The majority of co-researchers experienced difficulties within relationships and social interaction with others, resulting in an overall sense of isolation, as a major component of their vicarious trauma experiences.

### **Powerlessness/Helplessness**

The majority of co-researchers shared distinct feelings, sensations, thoughts, and experiences of powerlessness and helplessness as a part of their vicarious trauma. This theme included feelings of minimization, shame, and in one case, an overwhelming sense of feeling “damaged....invalidated and not being good enough...invisible and not seen...” For these co-researchers, their feelings and experiences of powerlessness enforced beliefs about what they were or were not capable of, along with what was or was not possible for those with whom they worked.

One co-researcher, who worked with immigrant children living in poverty and experiencing abuse, came to the realization that “folks...are dealing with all kinds of poverty and all kinds of issues, tons of trauma, so sometimes you just can’t help and people are suffering and they’re gonna suffer, no matter what you do.” This co-researcher identified his experience of powerlessness as a major component of his vicarious trauma.

He admitted, “[powerlessness]....would get me....that was the stuff that would chip away at me...”

A co-researcher who worked with adults experiencing chronic homelessness, mental health issues, addiction, and violence on the streets, shared his cycles of helplessness with a particular client, after attempting multiple interventions. He stated, “...I really...really tried every strategy I had, I tried everything I could do....persuasion, manipulation, pleading, rationalization, intellectualization, any of that stuff just didn’t take, cuz he was gonna drink and he was gonna drink till he died...” This co-researcher witnessed, first-hand, the unfolding physical damage his client experienced as a result of his addiction, constantly wondering when the bottom would drop: “...some of the damage he was doing to himself was exceptionally graphic, like when he fell into the mirror and broke it on his head and had to have....stitches, you know, there were these big bolts in his head, and I was like, ‘Dude, if that’s not rock bottom, what the fuck is rock bottom?’ ...you know what I mean?”

This sense of helplessness emerged as physical symptoms and sensations for one co-researcher as she reported experiences of physical immobilization and chronic headaches connected to feeling helpless in her work. She located her helplessness as a fight between “wanting to do good, with wanting to...take care of myself...” while describing “there’s just something icky about [vicarious trauma]...just....an ickiness.”

My embodied writing sessions further revealed the presence of power as a major topic within co-researcher’s vicarious trauma stories, whether this sense of powerlessness or the resulting desire for more power. After one co-researcher interview, my embodied

writing honed in on the co-researcher's recollection of the moment she received confirmed news that a past client had been raped in the streets:

“...emotion and powerlessness (and dare I say, slices of anger) emerge in her eyes, in their reddening, dropping, and tearing...(weight, pause) ‘the worst moment of my career’ she says. I feel this ‘worst’ in my jaw, at my upper chest and make sound to connect, to acknowledge [her sharing], my weight drops further into my chair... [as] her hand floats to her upper chest...”

Another co-researcher experienced consistent difficulties breathing throughout our interview, while at the same time, she was sharing this same quality of never feeling like she could get a full breathe during her period of vicarious trauma. My embodied writing session, after this co-researcher's interview, captured her recollection of the moment she realized she, and as a result humans, were “fucked” and powerless in any attempts to make change in the world:

“...‘fucked...we’re fucked,’ she said...yet she wants a full breathe, she seeks a deep full breathe, yearning to be listened to, yearning to find power in quieting, slowing, stopping...”

For the majority of co-researchers, significant experiences powerlessness and helplessness in the form of feelings, sensations, and thoughts were major components of their experiences with vicarious trauma.

### **Hypervigilance/Fear of the Future**

Experiences, feelings and sensations of hypervigilance emerged from the majority of co-researcher narratives in connection to their vicarious trauma. These experiences including overarching feelings of being “on-guard,” overly anxious, and experiencing irrational fear, along with often unconscious behaviors of obsessive

checking and vigilant posturing. Sensations of anxiety were a prominent component of hypervigilance for one co-researcher who noticed his anxiety mounting at the start of his drive to the supportive housing complex where he worked with adults living with trauma, addiction, and chronic mental health issues. He shared, “on the drive....I would start to get a little anxious....or I would start to....become more vigilant, drive around the compound and see if there was anything off...and then go to my office.”

Another co-researcher, a critical care emergency room nurse, noted the nature of his job being that of “car[ing] for people that are in these extremely vulnerable states...” and how this naturally makes him, “incredibly vigilant about all of the possible bad things that could happen [to people]...all the complications.” However, this co-researcher noticed his professionally trained vigilance become hypervigilance when he started having dreams and “obsessive thoughts...that I knew were irrational.” His dreams and thoughts involved “worst case scenarios...me doing things that would cause harm, not intentionally you know but being very terrified...” After five years of nursing experience, even though the co-researcher knew his thoughts were irrational, they still “...became almost paralyzing,” and helped him to realize, “woah...I need to step back from this [work] for a little bit.”

For most of these co-researchers, feelings and sensations of hypervigilance seeped into their personal lives as well, interrupting their ability to be present outside of work, as they experienced a constant hyper-awareness of the potential for danger at all times. This emerged for one co-researcher quite literally, as her rape-crisis advocate job required her to be on-call, carrying a pager at all times. As she spoke about wearing the pager, the co-researcher gestured to the side of her lower back, while recalling, “there was a sensation

there, like in that spot where I would wear my pager...yeah, it was just like a presence, maybe like a knot, but more like an energy.”

This same co-researcher shared her experiences of “not being able to....be present in what I was doing because there was this sense that...you could always be....interrupted and thrown into this really like violent and emotional situation...at any time....and that included sleeping or having sex or eating.” In fact, this co-researcher recalled a moment, during sex, where she had experiences of “...wanting to hide...wanting to be really small and invisible and covered.” Experiences of her hypervigilance interrupting intimate moments in her personal life became key component of this co-researcher’s eventual decision to leave her job.

Beyond day-to-day life, co-researchers shared beliefs that vicarious trauma had begun to influence how they viewed the world around them, thus impacting how they traveled through their days and settings. One co-researcher shared that he was always aware of the potential to experience trauma, no matter where he was, noting “...sometimes we can be one degree away from trauma...sometimes you’re in the room when someone’s yelling, sometimes...you’re in a crowd and someone starts punching someone” admitting his hypervigilance always at work, “...in my personal life, how I gauge situations...you know, if I walk into a room I can pretty much suss out the person that I don’t trust...I get a feel for who is more likely to act out.”

Another co-researcher, having worked in psychiatric hospital and therapeutic day center settings with kids experiencing severe trauma, abuse, and violence, echoed these observations. She noted the need in her work settings to be constantly aware of “...where violence was coming at you because...at some point you might get hit or....something



thrown at you...” She linked this hypervigilance at work to a larger sense of feeling “always hypervigilant...everywhere I go and then just getting really sad about...the life situations.”

In this way, five co-researchers revealed a sense of fear or anxiety about the future as it related to the impact of vicarious trauma in their personal and professional lives. In these cases, even if a co-researcher had reached a sense of resolution or understanding with their experiences of vicarious trauma, they still conveyed this sense of tentative, cautious unknown about the future. They felt uncertain and anxious about how vicarious trauma might continue to impact their lives.

One co-researcher expressed his hope that his symptoms of vicarious trauma “don’t ever come back again...cuz [the possibility of vicarious trauma returning] kinda still does...creep me out.” He reflected on the fact that, “even looking back, it wasn’t really clear symptoms.... [vicarious trauma] is only scary because it just seemed to pop out of nowhere.” Another co-researcher wondered about her ability to “outgrow” vicarious trauma, knowing there were experiences that would always stay with her, but also wondered out-loud, “...Am I gonna get over some of that stuff?...cuz, I know it totally fucked me up...”

Some co-researchers shared this sense of fear and unknown as a component of larger existential and life questions generated from their work and experiences of vicarious trauma. This uncertainty of the future often tapped into the co-researcher’s own humanity, vulnerability, and mortality, placing themselves into closer alignment with the clients with whom they worked. One such co-researcher recounted his experiences working with adults living with dementia made him consider the possibility that ending

his life living with dementia, "...might be my future..." On a daily basis his work brought up major existential questions like, "in the end...what's really gonna matter?" along with constant reminders that, "...life will end, I will lose everything in my life." This co-researcher identified daily encounters with mortality, as a result of his work with adults often dying alone and in pain, as a key component of his vicarious trauma, but had come to understand the dynamic as "both a blessing and a trauma."

My embodied writing sessions additionally captured the nuances of co-researcher's nonverbal and body-based anxiety, fear, and questions about the future implications of their vicarious trauma. After one co-researcher's narrative interview, I wrote:

*"...] sense a tentative remaining, reverberating of the residue...'I hope it doesn't come back' he echoes into space...as if sending out a request."*

After another co-researcher admitted to me his worry about the future, he left me to ask the same questions about the unknown qualities of vicarious trauma. My post-interview embodied writing session, captured the co-researcher's worry in his stillness, along with a sensed of invitation to question the future along with him:

*"...and then we stop....'dehumanized' he says, 'I worry about myself sometimes...'...deceleration, stillness, pause, down, binding in...and yes, we worry, we worry, I worry...what has happened to us, what will happen to us, how to stay/remain human?...his stillness gives me time to worry myself..."*

In another embodied writing session, the quality of hypervigilance emerged as I reflected on the effort qualities and sensations of one particular co-researcher toward the end of our narrative interview:

“...she is tentative, with a rawness, questions...a bit floaty, nervous...left with solidarity, but waiting, waiting, waiting, waiting, waiting space...seems also in the body, a holding...she said ‘I’m prepared, ready for what is in progress....on the ready,’ when I asked how she feels, how her body feels as we finished the interview.”

For the majority of co-researchers, their experiences of vicarious trauma came with feelings, sensations, and behaviors of hypervigilance and guardedness. In addition, co-researcher’s vicarious trauma was accompanied by an overarching sense of fear or worry about the future impacting their view of others and the world around them.

### **Physical Symptoms/Sleep Disturbances**

Shared experiences of physical and physiological symptoms were described in connection with seven co-researcher’s vicarious trauma material and experiences. These symptoms included chronic exhaustion, chronic headaches, sweating, shaking, along with acute and chronic illnesses. Four co-researchers spoke of feeling consistently tired and exhausted almost all of the time, so much that, as one co-researcher shared, “I’d come home [from work] and just fall on the bed....with my jacket and my shoes still on and falling asleep...waking up an hour later...just still being there with my cats pawing me wanting food...”

Three co-researchers shared stories of ongoing acute and chronic illnesses that significantly impacted both their work and personal life, and of which they attributed to experiences with vicarious trauma. For one co-researcher, the culmination of his symptoms of vicarious trauma manifested physically as his “system shut down big time...” as he was unable to cope with “...any kind of stress what so ever...” Another co-researcher’s health became so impaired that she needed to leave both her work and home in order to get better, as she shared, “...I could not get better until I left...and it took two

months of being fully away for a month... and I was starting to feel so much better... as soon as I went back to work all of my symptoms returned and that's when the doctor was like, 'You have to quit work'..." For these co-researchers the culmination of physical symptoms and illnesses connected to vicarious trauma often forced them to take serious action or make a drastic change in their life in order to address their health.

For six co-researchers, another set of their physical symptoms of vicarious trauma emerged in the form of prominent sleep disturbances, including stories of nightmares and chronic sleeplessness or insomnia. One co-researcher shared a pinnacle moment of his experience with vicarious trauma, as he recounted waking up in the middle of the night, breathing rapidly, with "...pain in my chest...I felt like I was on the brink of having like a mental break, I felt like I was going nuts..."

Another co-researcher described "the haunting quality" of her vicarious trauma, which came to her at the end of the day while trying to fall asleep, "...I get in bed at night and remnants of clients...[remain]...the haunting quality, it's just...like a bad dream...you wanna go to bed, [but]...memories [of clients], you've got memories."

Seven co-researchers shared experiences with specific and chronic physical and physiological symptoms, including chronic exhaustion, chronic headaches, sweating, shaking, and acute/chronic illnesses, in conjunction with their experiences of vicarious trauma.

### **Overarching Sense of Responsibility**

Most co-researchers conveyed the shared and prominent sense of responsibility they felt and experienced throughout their vicarious trauma. This sense of responsibility extended far beyond the assigned tasks and duties of their professional role, instilling an

all-encompassing sense of responsibility for the entirety of a client's situation or fate, or in some cases, a responsibility to an entire population of people or for the entirety of a social issue. This over-arching responsibility fueled increased anxiety, exhaustion, and feelings of being constantly overwhelmed.

One co-researcher, working as a critical care nurse, shared how he, "...felt almost responsible for the totality of the situation even though that wasn't true at all...I didn't make somebody's aneurism... blow....or I didn't make them have a heart attack, but you know you almost feel like responsible for that in some way and I carried that..." Another co-researcher held the belief she was, "the only person in the world that really gave a shit about 'em [clients]..." contributing to feelings of increasing pressure, causing her to "...wake up in the middle of the night [thinking], 'Oh my gosh, did I remember this appointment? Did I remember to do this...?' because nobody else would, there just wasn't anybody who cared...admitting this pattern, "...manifested itself into me feeling overwhelmed and exhausted all the time."

For two co-researchers, their sense of responsibility included the very literal task of physically holding or containing a child if and/or when that child experienced a triggered state of escalation or dysregulation, often as a result of past trauma. These co-researchers both described and physically re-enacted how they used their bodies to hold and often transport the child to a seclusion room until the child could emotionally and physiologically re-regulate, admitting, "...that was traumatic for me to have to restrain kids in that way." A co-researcher told stories of, "...one poor guy that I had to do holds with every day..." noting how stressful this became, and eventually realizing mid-story that her experiences of restraining kids everyday, "...kinda pushed me over the edge."

After one such narrative interview, as the co-researcher recalled and re-enacted her experience of containing a child, my embodied writing session captured my experience of witnessing the embodiment of “containment:”

“...living with, immersed in containing...containment, containing in the body, holding breathe, tensing, binding in....tensing and breath holding as her body replicated containing a kid, a triggered state...a responsibility to contain trauma with containing...”

Most co-researchers spoke about a shared and overarching sense of responsibility throughout their experiences of vicarious trauma, accompanied by consistent anxiety, exhaustion, and feeling of being constantly overwhelmed.

### **Head-Body Disconnect/Numbing**

Five co-researchers shared experiences of disconnection from the body in relation to their vicarious trauma, also described by co-researchers as disassociation, head/body split, or experiences of numbing in/from the body. One co-researcher recounted after an especially intense night supporting a survivor of sexual assault, “I was having a really hard time...feeling....I knew it was an intense experience and I was just kind of going through it...I think I was pretty numb.”

Some co-researchers located specific sensations of disconnect, often locating it in specific parts of their body during the in-progress narrative interview. One co-researcher, a current yoga therapist and licensed mental health counselor, gestured to her head and upper body as she noted her vicarious trauma sensations existed, “...all up here, tight shoulders and buzzing head, less sensation down in my lower body, my head even starts to hurt a little bit, a lot up here [gesturing to head] and less when we go down into the

shoulder and chest...the jaw too...all a disconnect from the body completely,” as she admitted, “...I can feel it right now...”

Another co-researcher identified her feelings of disconnection and disassociation within her patterns of “...staying up late watching bad TV...not wanting to go to sleep because I’m so burnout.” She identified these late night behaviors as signals her work is becoming “too much.” A co-researcher, working with youth experiencing homelessness and trauma on the streets, noticed how he actively holds back and disconnects from challenging feelings while at work because “...you’ve got kids to attend to and they can smell sadness like shit on a shoe.”

For two co-researchers, alcohol or drugs played a prominent role within their experiences of vicarious trauma, used as ways to cope or self-soothe amidst their symptoms of vicarious trauma, often resulting in experiences of numbing and head/body disconnect, further compounding vicarious trauma. Co-researchers shared observations about the larger presence of substance and substance abuse as coping mechanisms within their co-workers, professional teams, and workplaces.

During her narrative interview, one co-researcher spoke of “drinking a lot” during her vicarious trauma experiences, linking her wine drinking to a specific bodily sensation: “...it’s like a shudder, like where my upper jaw meets my lower jaw, it’s almost like you’re gonna shiver cuz you’re cold, it’s [a] deep, deep shudder almost like you’re gonna be cold, maybe the beginning of when you’re gonna cry...” In the midst of her interview, the co-researcher noticed she was re-experiencing this same deep jaw shudder that she was currently describing, but experiencing it in the present moment as she spoke of her past interview past periods of vicarious trauma and substance abuse.

As another co-researcher shared her own use of heavy drinking during years of vicarious trauma, she observed, "...there are a lot of unhealthy, medicated, not-dealing-with-their-shit, service providers," believing if service providers "...talked more about what we were actually experiencing, we probably wouldn't be so reliant on anti-anxiety, anti-depressants, booze, other recreational drugs." These co-researchers noted the chronic and unaddressed role of alcohol, drugs, and other substances in perpetuating disconnect between the head/body, serving to numb the body in order to cope with vicarious trauma.

In my embodied writing session after one interview, I wrote about my own experience of witnessing and sensing one co-researcher disconnect from her body and her emotions of loss:

"I wonder...has she really felt her loss? Has she surrendered to herself?...in our opening grounding exercise she welled up in her throat with sadness, and said, 'I wanted to cry but didn't...not yet'...managing her feelings, facilitation as her trained skills.... but where is her loss located? where is her loss located in her body...in her story... in her work...?"

For five co-researchers, shared experiences of disconnection from the body, including disassociation, head/body split or numbing, often involving specific parts of the body, accompanied their experiences of vicarious trauma. In addition, alcohol or drug use played a significant role in their experiences of disconnection, further contributing to their experiences of vicarious trauma.

### **Primary Trauma within Vicarious Trauma**

I continued to consider my research questions –How is vicarious trauma for providers working with individuals who have experienced trauma? What are the roles of



the body and narrative process? – as the lens through which I received co-researcher’s vicarious trauma experiences. In this process, the role of primary trauma, and its variety of sources, emerged as a significant theme. Although not all co-researchers identified as having experienced primary trauma themselves, the topic did emerge within the majority, ten out of 11, of co-researcher’s vicarious trauma narratives.

The role of primary trauma within vicarious trauma took the form of stories, sensations, images, memories, and questions that wove in and out of vicarious trauma stories. Often co-researchers wondered out-loud about the boundaries of their experiences of primary trauma and vicarious trauma, perpetually asking where one stopped and the other started. They were concerned with how, for better or worse, their primary and vicarious trauma experiences might influence and inform each other.

Within co-researcher interviews, the sources of primary trauma varied, but generally fell into one of the following categories, primary trauma experienced on the job or in the workplace; primary trauma experienced in past personal life; primary trauma from both past personal life and on the job. These three categories will be presented and discussed in further detail below.

**Primary trauma experienced on the job or in the workplace.** Five out of the eleven co-researchers explicitly shared stories of experiencing primary trauma within their workplaces or while performing their job duties. These situations included physical assaults, discovering dead bodies, encountering physical threats, containing/holding kids, or providing services or care in the midst of critical care, life or death situations. All of these stories emerged in the context of each co-researcher sharing their stories of vicarious trauma, and were often integrated into symptoms of vicarious trauma.

One co-researcher recalled the physical assault she experienced while working at a supportive housing residence, "...it wasn't even a bad assault, there wasn't a lot of physical pain...but [then] I started having nightmares about [the assault]..." Immediately after the assault, she remembered her boss asking if she needed to go home. She responded, "No, I'm totally fine..." but then later realized, "I wasn't fine...my body was processing [the assault] differently than I was."

During the time she worked as a staff member for a wilderness camp for kids who had experienced severe trauma, one co-researcher recounted incidents when campers put her in chokeholds or threw axes at her. She recalled how her job responsibilities required her to, "...[have] my body physically in on the containment of something really traumatic and violent..." whenever a camper acted out or was experiencing emotional dysregulation.

Another co-researcher identified experiences of primary trauma occurring within his workplace setting. He believed these instances were partly a result of his work with clients, and partly influenced by interactions with co-workers and overall workplace culture. This co-researcher recounted the story of confronting a co-worker in the midst of a staff meeting, for having previously physically attacked another co-worker. As a result of this confrontation, the co-researcher spoke of the ensuring fear he felt at work, stating, "...this [coworker] is a big, huge, muscle-bound goon kindof guy, so I was actually afraid for my life..." The co-researcher later admitted that during our interview he "...started having some intrusive thoughts of that [coworker's] face..."

For these five co-researchers, stories, emotions, and sensations of primary trauma were experienced either in relationship to their clients, or in connection to fellow co-

workers, and were additionally exacerbated by overall work place culture. This combination of elements related to primary trauma within the workplace percolated as a prominent theme within their larger narratives of vicarious trauma.

**Primary trauma experienced in past personal life.** For three co-researchers, vicarious trauma stories were accompanied by stories of childhood or past primary trauma. These stories included: childhood/adult sexual or physical abuse and assault, childhood loss of parent, family substance abuse, early adult process of coming out as queer, and critical injury and chronic pain from car accident. These childhood or past primary trauma stories also wove in and out of vicarious trauma experiences and emerged as a key component of how vicarious trauma was experienced in their later professional life.

As co-researcher shared her experiences of vicarious trauma in her work as a dance/movement therapist and psychologist, she began to talk about her own experiences of childhood sexual abuse. In her recounting this story, she identified the potential for her primary trauma to be a risk factor in her work. She noticed, "...when someone else's bigger scars come up against my smaller scars all in the same topic, that's when it gets really bad, that's when it becomes much bigger for me..."

At the same time, she also identified the asset of her primary trauma within her work, especially when working with survivors of childhood sexual trauma. She stated, "I've had a flavor of what it's like to be more neglected, and used, and have unexplainable feelings...I'm a perfect therapist for that kind of person, cuz I have enough of the empathy, I know what it feels like..." With this in mind, she spoke at length about the importance of her growing awareness and mindfulness around her own

trauma, especially as it related to not only her work with clients, but also her awareness of her vicarious trauma.

In his work with kids experiencing homelessness and violence on the streets, another co-researcher shared, "...sometimes I'll witness something [in my work], [that will] actually activate an old childhood situation and....so it just transcends what's happening now, and reactivates [that] old trauma..." He likened this experience to a "...pinball game, where you're bumpering up against old trauma, plus new trauma, plus not real trauma..." In these situations, he pointed toward the importance of developing and using a "quick set of self-soothing skills" while on the job.

**Primary trauma from both past personal life and on the job.** Two co-researchers shared experiences of primary trauma that occurred both in their personal past history, as well as within their professional life. For these co-researchers, primary trauma instances included: childhood and adult loss of parent, sudden and unexpected death of close friend, providing critical-care services in life or death situations, physical containment of clients, physical threats of violence and burglary.

During her interview, one co-researcher described her past Peace Corp work in Nicaragua as a "very guarded time." After being robbed, she noted, "it was a constant exertion, output of effort to keep my guard up and not get taken advantage of regularly...I felt betrayed...and then I wanna suspect everyone..." In the course of her vicarious trauma narrative, this co-researcher also spoke about the relationship between her childhood experiences of losing her mother and growing up with an abusive stepmother, to her professional experiences working with others experiencing their own loss. She reflected, "...there's something about loss that just gets me, when I see other

people's loss, it just touched my own..." At a particularly poignant part of her interview, she wondered out-loud, "...you know, [maybe] it's my own primary trauma getting touched by the secondary trauma or something?"

Another co-researcher, working as a critical-care emergency room nurse, spoke about his process of grieving the sudden and unexpected death of his close friend. He shared, "when I first heard the news [of my friend's death], I was almost like, 'Wow I'm kind of cold to this.'" As he attended the memorial service, he recalled, "...that's when I really felt loss in a real emotional way, whereas before it was almost like this problem..." He noted the intersections between his personal loss and his work, which at the time involved providing critical medical care and life-support to patients who had experienced drug overdoses.

For the majority of co-researchers, personal and/or professional primary traumas were significant components of their experiences of vicarious trauma. Many co-researchers questioned the intersections between the two topics, wondering where one started and the other stopped. And yet, for almost all co-researchers, their experiences of primary trauma played a significant role in how they ultimately experienced vicarious trauma.

### **Gifts/Resiliencies**

Within all 11 co-researcher narratives, the topic of gifts and resiliencies within experiences of vicarious trauma emerged as a major shared theme. Though co-researchers spoke of and made sense of the gifts and resiliencies they'd received in different ways, all co-researchers noted an increased sense of resiliency and distinct gifts received from their vicarious trauma. Sub-themes within this category, to be elaborated on below, include,

narrative process; joy/purpose of work; human connection; gratitude; increased boundaries/limits; widened perspective on life.

**Narrative process.** Seven co-researchers noted the process of participating in the narrative interview and/or reading their own vicarious trauma narrative as sources of resiliency in relation to their vicarious trauma. For some co-researchers, the narrative experience served as an impetus for increased self-care, along with reminders of the tools and skills they had developed along the way. One co-researcher found his experience of reading his vicarious trauma narrative “reassuring [of] how far I’ve come...[with a reminder of] tools I have to help me when things arise personally and professionally.” For another co-researcher, reading her vicarious trauma narrative reminded her of how “adversity makes me stronger, more compassionate, empathic, wise.”

For other co-researchers, the narrative provided a chance to feel validated and witnessed in their vicarious trauma experiences, along with learning from their own words and stories. A co-researcher experienced this sense of validation from reading his narrative, along with the discovery that “...reading my own words helps me feel witnessed and witness myself...what a gift that is.” Another co-researcher realized when she read her own narrative she “...became my own teacher... learn[ing] from my own words.”

One co-researcher admitted she usually tries to avoid talking about the impact of her work because, “I just have a lot of fear and anxiety about what I’m doing with my life...” Yet, she also noted the value of taking the time to sit and talk about her vicarious trauma. Within her feedback, she wrote, “...I appreciate this opportunity to actually be witnessed in [my vicarious trauma].”

Another co-researcher echoed these thoughts, sharing, “there’s something about telling your own narrative, being able to tell stories to somebody who’s listening....” She continued, “...usually our stories get told one little tiny snippet at a time, [so] there’s something so deeply satisfying about being able to talk and connect them... it really feels like I’m being heard...” For seven co-researchers, the process of participating in the narrative interview and/or reading their own vicarious trauma narrative became a part of their vicarious trauma story, while also serving as a source of resiliency.

**Joy/purpose of work.** Five co-researchers shared how a reconnection to the purpose of their work, as well as the joy within their work, emerged as a part of their vicarious trauma experiences. These co-researchers noted how those moments that reminded them about the joy and purpose of their work served as a major source of resiliency, as well as a gift of their vicarious trauma experiences. Co-researchers shared moments of realization about what originally drew them to their work, in statements such as, “...that’s why we’re here” and “this work needs to be done.” They spoke about the opportunities they had to recognize the ongoing learning and growth that resulted from the challenges of their work.

As he reflected back on his early and most significant symptoms of vicarious trauma, one co-researcher recalled, “...every time something horrible would happen [I thought], ‘Ok good,’ it just kindof popped me up to another level of being able to understand people’s challenges and helping people...I have more compassion by a million miles, far less judgment...I don’t think I would change [my experiences with vicarious trauma] in hindsight, I can see me growing up, each step of the way...”

Some co-researchers understood the shared intimacy with clients and those with whom they worked, along with the ways this intimacy had altered their perspectives on life, as gifts of their experiences with vicarious trauma. One co-researcher declared, "...for sure I see the world differently, and I see people differently, and I see culture differently in innumerable ways, it's really beautiful, it feels like a gift...to be in on people's most intimate and emotional, primitive, primal processes."

Another co-researcher recounted a past conversation with a particular client, who was feeling shame about being in counseling after an abusive relationship. The client asked the co-researcher, "... 'Isn't it depressing to work with all these people like me?'..." to which she responded, "... 'No, it's not...I feel inspired by people like you'..." The co-researcher continued to reflect, "people's ability to survive is just amazing and I want to participate in that, I want to be a small part of that happening for people." Five co-researchers noted that a reconnection to the purpose and joy within their work emerged as a source of resiliency and gift of their experiences with vicarious trauma.

**Human connection.** Four co-researchers noted an increased sense of connection with others, along with an overarching sense of connection to humanity, as a major part of their vicarious trauma, offering resiliency. This sense of human connection, expressed by some co-researchers as a feeling of being "in this together," occurred among clients, patients and/or co-workers. These co-researchers spoke of connections between the increased vulnerability of their vicarious trauma and an increased sense of openness and interconnection with others. One co-researcher stated, "...there's a capacity in which [vicarious trauma] has really opened me to my own humanity and the interconnection of all of us, and the way in which everybody suffers... these universal experiences of being



alone, and being in struggle, and being in pain...doing that with people is such profound work.”

For these co-researchers, the choice to remain open to the potential for human connection within their work, and within their experiences of vicarious trauma, helped them cope with the difficulty of both. One co-researcher described this process as, “lightening...how heavy this [work] actually is,” in order to, “make this work more meaningful.” A co-researcher who works with people living with dementia and near the end of their lives, expanded on the potential for human connection within his work, while also recognizing the vulnerability of this choice. He stated, “...we can’t numb selectively, so when we have to numb, we also numb to the connection that we could have to the residents, which does entail grief...cuz they’re gonna die, they’re sick, they have really hard stories sometimes, but that’s part of the connection.” Four co-researchers identified an increased sense of connection with others and humanity as a gift and source of resiliency within their experiences of vicarious trauma.

**Gratitude.** The majority of co-researchers mentioned the topic of gratitude within their vicarious trauma narratives. However, two co-researchers in particular conveyed the significance of an ongoing practice of gratitude as a gift of their vicarious trauma. This consistent gratitude practice further served as a source for resiliency within co-researcher’s ongoing experiences of vicarious trauma.

One co-researcher noted her natural tendency toward gratitude, believing “gratitude is the antidote to hopelessness and cynicism.” She further recognized the role of her work with impoverished farmers in Nicaragua, and her resulting vicarious trauma, as a “catalyst” to her consistent gratitude practice. Amidst her current work in animal

welfare, this daily gratitude practice serves as one of her sources of resiliency that has emerged from her experiences of vicarious trauma. While gratitude was a topic mentioned by the majority of co-researchers throughout their vicarious trauma narrative, two co-researchers in particular, noted a consistent gratitude practice as a gift and form of resiliency from their experiences with vicarious trauma.

**Increased sense of boundaries/limits.** For two co-researchers, an increased ability to locate and practice setting boundaries, both personally and professionally, emerged as a gift and source of resiliency within vicarious trauma experiences. In this process, they developed a clearer understanding of their own limits. These co-researchers shared vicarious trauma experiences that pushed them beyond their means and limits – physically, emotionally and psychologically.

One co-researcher spoke about her process of testing and ultimately learning her limits, an experience that culminated in departures from her job, home and city. As a result, she emerged with a new desire to “figure out how to be healthy and take care of [myself] and acknowledge what [I’m] feeling...figure out how to not let [work] suck the life out of [me].” As a result of these past challenges to her health and capacity, this co-researcher felt a stronger and more determined belief in her ability to uphold her limits within her continued work with people experiencing chronic mental health issues and trauma. At the end of our interview, she declared, “...it is a really, really, really good thing to want to give of yourself and at the same time to not lose yourself while you’re doing [the work].”

Likewise, a re-enforced awareness of the limitations of time, energy and capacity emerged for another co-researcher within his day-to-day work with adults living and

dying with dementia. This work asked him to face larger life questions about “...what really matters in the end,” ultimately understanding these existential questions as both “a blessing and a trauma.” Two co-researchers identified their increased ability to notice and set personal and professional boundaries as both a gift and source of resiliency within their vicarious trauma experiences.

**Widened perspective on life.** Within their interviews, two co-researchers shared how their vicarious trauma experiences contributed to a widened perspective on life. They believed this sense of widened perspective was a gift of their experiences with vicarious trauma, as well as a source of overall resiliency in their work going forward. One co-researcher noticed how easy it was to “...get so focused on this grief” within her past work with farmers in poverty, as well as her current animal welfare work. Though she noted the importance of acknowledging loss within her work, she also shared how her experiences of vicarious trauma included connecting to others that have helped her understand “...there’s this whole giant world out there.” This sense of widened perspective led this co-researcher to start a new career facilitating compassion fatigue workshops for other animal welfare workers.

For another co-researcher, her vicarious trauma informed how she “see[s] the world differently, see[s] people differently, see culture differently, in innumerable ways.” This has changed how she lives her personal life, engages in relationship with others, and where she directs her energy. Continuously reflecting on the “gift” of this worldview shift, she shared how her experience of vicarious trauma encouraged her to keep trusting her unfolding, day-to-day experience. In this process, she continues to ask herself, “what is your truth, what’s coming up and happening for you?” At the end of our interview

together, she looked me in the eye and said, "...[our truth] is really all we have..." For two co-researchers, the increased ability to generate a more widened perspective on life was a gift, as well as a source of overall resiliency, gained as a part of their experiences with vicarious trauma.

### **Non-Verbal/Body**

Amidst the verbal themes of co-researcher's vicarious trauma narratives, non-verbal/body themes also emerged within the shared-story-telling space between the co-researcher and myself. These non-verbal/body themes were collected through my informal interview notes, post-interview embodied writing sessions, and interview transcription process. With a focus on the interactive, embodied space between the co-researcher and myself, these themes further address the roles of the body and narrative within vicarious trauma.

**Strong weight.** During their process of recounting and sharing vicarious trauma experiences, ten co-researchers, displayed qualities of strong weight. That is to say, they demonstrated strength in their movement with a sense of power (Laban, 2011). One co-researcher summed up his vicarious trauma experience as "a thorough pounding." This quality of strong weight was revealed in my embodied writing session after a co-researcher's interview. My writing captured her use of increasing pressure through her visual shift in weight, along with pressing her fingers, and rubbing her face:

*"...her lean forward, open palms shifting over the carpet, pressing fingertips into the ground, powerful weight press...to her face, hands to the face, hand to forehead, rubbing, blurring...shielding?"*

Another co-researcher displayed strong weight by rubbing, squeezing and pressing her hands into her glass water jar throughout her work stories of containing and

holding dysregulated kids, which she identified as a key component of her vicarious trauma:

“...hands carving, rubbing her tea jar, squeezing, rubbing, pressing into the glass ...her hands and feet in constant relationship to the glass jaw, feedback, pressure, interaction...”

For another co-researcher, the details of her vicarious trauma experiences included moments of hearing a client re-count their experience of being beaten or raped on the streets. After her interview, my embodied writing session captured her process of grappling with the unknown of her work and of her client’s fate in the world. These questions brought about strong weight for both of us:

“as she admits to the ‘not-knowing’...the unknown of her work and the world...our weight, increasing pressure together, emerged along with this ‘not-knowing’...”

For the majority of co-researchers, the verbal stories, statements and recounts of their vicarious trauma narrative material were also accompanied by non-verbal displays of strong weight.

**Indirecting eyes/gaze.** For the majority of co-researchers, indirected eyes or an indirecting gaze, that is multi-focused attention to more than one thing at once, emerged as a non-verbal/body theme throughout their vicarious trauma stories (Bartenieff, 2002; Hackney, 2002). Indirected eyes and indirecting gaze were displayed most often when co-researchers were recollecting the past, and most especially as it related to a memory, incident or specific component of their vicarious trauma experience. My embodied writing session captured a co-researcher’s transition between zeroing in and directing her gaze toward me, then indirecting her gaze and attention out into the larger space of the

apartment. This pattern occurred while the co-researcher was remembering an incident involving a past client from years ago, which she linked to her vicarious trauma:

*“] search for her eyes, for the moments she directs her gaze to mine quickly and then away again, back to the space of the apartment, seeming to expand into the larger space beyond our conversation, reaching into her memory bank, it seems... widening eyes as they float into the larger apartment, in recollection, her eyes search, expand in assistance, before they narrow and punctuate the story in the present...connecting with my gaze.”*

Another co-researcher displayed an indirected gaze in conjunction with a past story from her Peace Corps work. Then, soon after, she directed her gaze and met my eyes, bringing us both back into our present task and interview together. In my embodied writing following this interview, I captured this moment within her storytelling:

*“...memory, recounting, bringing...urging her eyes out and away in front of her and down, then coming back to meet mine with pressure, with emphasis, almost re-orienting to the present and our interview together...”*

For the majority of co-researchers, displays of indirected eyes and/or gaze, that is multi-focused attention to more than one thing at once, was a prominent non-verbal/body theme during the vicarious trauma material shared in their narratives.

**Chest narrowing and hollowing.** The majority of co-researchers displayed an overall shrinking within their body, resulting in a closing-in, narrowing, or hollowing shape change of their upper chest and torso (Kestenberg Amighi, et al., 1999). While sharing details of their vicarious trauma material, co-researchers often spoke of sensations they noticed that were located in and/or directed toward their chest and upper torso, while also consistently non-verbally gesturing toward this area of the body. One

co-researcher described his feelings connected to vicarious trauma as a "...contracting in my chest," while gesturing to his chest with his right arm and hollowing his torso away from his arm.

In these cases, after I observed shape changes of the upper chest and torso from co-researchers, I would often experience similar shape changes in my own body. These shape changes, including narrowing in or hollowing of my upper chest and torso, would re-appear throughout my embodied writing sessions and within the process of transcribing interviews. I experienced these moments as non-verbal/body resonance between the co-researcher and myself.

While a co-researcher shared how she was helping a woman in the emergency room who had just been sexually assaulted, she also noticed she was experiencing "hollowness at my chest..." then stated, "I think I'm gonna cry..." This same co-researcher spoke of feeling "discarded" at her workplace, with an accompanied hand gesture toward her chest, followed by a hollowing of her chest away from her hand. While reading their written vicarious trauma narratives, two co-researchers reported experiencing "hollowness, dull anxiety...in [my] chest," along with "recoiling...chest contracting."

One of my post-interview embodied writing sessions captured hollowing of the upper chest and torso for one co-researcher as she spoke of the moment she received news of a client's death. I wrote:

"...one accented moment of accelerated exhale, chest hollowing away from her clawed hand to chest... as the word..."email" enters her story, news of him drowning in a fountain..."

For the majority of co-researchers, increased awareness of and gesturing toward their chest and upper torso, with hollowing and narrowing shape change, emerged as a prominent non-verbal/body theme in connection to their verbalized vicarious trauma material.

**Fluctuations of acceleration-deceleration.** The majority of co-researchers displayed fluctuations between acceleration, moving quickly and urgently, and deceleration, moving slow and prolonged, while they described specific moments of vicarious trauma (Bartenieff, 2002). These fluctuations in timing usually occurred immediately following one another. For example, when a moment of deceleration highlighted a particularly emotive and significant section of the verbalized story, accelerated timing accompanied the change of topic to focus on the resulting effects of that significant occurrence.

While one co-researcher spoke of the specific details of her vicarious trauma material, she consistently struggled to catch her breath, fluctuating between accelerated and decelerated timing in breathing and body movements. At the same time, she identified breathing troubles as a characteristic of her initial experiences of vicarious trauma years earlier. In this way, the fluctuations of acceleration and deceleration within her breath and body wove throughout her stories. I captured this pattern in my post-interview embodied writing:

“ time...pace, accelerate, decelerate...  
she mentioned not being able to catch a breathe,  
both then and now...yes...moments of rest for our narrative,  
for the space between us, for the story when she...paused...decelerated...  
that was when her memory retraced...  
vicarious trauma came into the room, initiated, guided...”



my own slight awareness of needing to keep-up with her shifting timing...walk briskly beside her, nodding lots because my nodding was real and from life, from resonance in this material...in this matched, almost slight uphill pace challenge...I could sit back (literally, figuratively) in my chair and allow her to unfold...her eager unfolding, slowing, rushing... and back again, to slowing...her eagerness and material filled the space between us..."

Another co-researcher's narrative cycled between topics of fear, uncertainty and ongoing grappling to make sense of his vicarious trauma, alongside details of his interactions with the children and families with whom he used to work. As he fluctuated between the details of these topics, he also nonverbally fluctuated between moments of quick, acceleration and slow, deceleration. My embodied writing session captured this pattern:

"Ongoing curiosity of his experience...circling back to a slowing down, a deceleration in his desire for knowing...back to quick time in response, in recollection, linear, directing...his body and mine too traveled on a wave of slowing and then racing ahead...only to linger in time again..."

One co-researcher shared detailed stories, along with physical re-enactments of his experiences assisting a particular emergency room patient. He verbally and nonverbally accelerated at the height of his story recounting his role providing life-or-death CPR. Then, he fluctuated to lingering, prolonged deceleration as he asked questions about his future. My embodied writing captured some of this fluctuation pattern:

"the accelerated physicality of critical care, CPR pillow pumping as he spoke in front of me...he is tired as he urgently continues...  
| exhale  
| exhale  
| exhale

...as the pillow gets pumped in front of me over and over,  
his eyes widen, his pace quickens.... | exhale, | exhale, | exhale to the critical care  
physicality...the mortality normalized on the couch in front of me,  
knowing, sensing it comes from another part of life-source, and all | can to do is  
exhale...and he pumps urgently...

...and then we pause... 'dehumanized' he says... '| worry about myself  
sometimes...' deceleration, stillness, pause, down...  
and yes we worry, we worry what has happened to us,  
what will happen to us, how to stay and remain human?"

Throughout the specific and detailed recounts of vicarious trauma material, the majority of co-researchers displayed nonverbal fluctuations between acceleration-quick time, and deceleration-slow time.

**Advancing.** Six co-researchers displayed nonverbal advancing into space, that is to say, a shape change of the body where either a part of the body (gestural) or the whole of the body (postural) moves forward (Moore, 1988). In one embodied writing session, I captured one such co-researcher's nonverbal advancing into space. In my writing, I also noted the acceleration with which she advanced, in conjunction with her verbal stories of intervening with kids who experienced trauma:

"| wonder about her forward and back...forward  
urgency in the advancing as she speaks of the kids  
and her responsibility to watch, restrain, keep alert..."

After a different co-researcher's interview, my embodied writing session captured her whole body, postural advancing. She often held and maintained this postural shape change throughout the details of her stories about her experiences holding, containing and helping to regulate kids working through trauma. My writing further noted the contrasting qualities that emerged when she retreated, moving her posture back in space:

“I’m aware of needing to accept her holding,  
her posture forward in space while she shares about her interactions,  
her work with the kids yet...feeling and sensing relief and respite in my body, and from  
hers... when she shifted back, gave into the couch behind her,  
and free flowed...in torso, chest, neck...”

Consistent displays of non-verbal advancing forward into space, and thus changing the shape of the body, emerged from six co-researchers while verbally sharing details of their vicarious trauma material.

**Active hands.** During verbal stories and recounts of vicarious trauma material, seven co-researchers displayed prominent and ongoing nonverbal activity of their hands. This activity included circular/cyclical gestures in front of their bodies, along with repeatedly moving hands to and from their face, head or chest. One of my post-interview embodied writing sessions captured the constant activity of one co-researcher’s hands while he recalled details of his work with children experiencing abuse:

“his hands in the front space, moving along horizontal in and out,  
washing over and out in front of his body...  
I wonder if this is in effort to shift...transform...  
his feelings of...powerlessness, helplessness?...  
‘powerlessness...that’s the worst’ he says...  
stacking his hands in front of him in space...my own hands buzz now.”

While verbally recounting interactions with past clients who lived with chronic addiction and mental health issues, one co-researcher consistently gestured toward her chest with her hands. These gestures punctuated poignant and emotive moments of her stories attributed to vicarious trauma. I captured one of these moments in my post-interview embodied writing session:

“when details of her stories and interactions with clients emerge,

when they spill- and I write spill because she is such a container,  
always explicitly noting her 'okness'-when the details do spill  
(because it doesn't seem as if she meant them to spill)...her hands come to her chest  
over and over again, hands to chest...hands to chest...  
is she trying to keep the container? Is she trying to keep being 'ok?'..."

For seven co-researchers, consistent activity of their hands, whether moving and cycling in front or to the sides of their bodies, or gesturing to parts of their head or upper torso, emerged as a prominent nonverbal pattern while they verbally shared vicarious trauma material.

**Spreading/widening.** For at least five co-researchers, a prominent pattern of nonverbal spreading into space emerged as they shared details of their vicarious trauma. This is to say, moving outwards or away from the midline of the body, often involving widening one's stance or posture (Moore, 1988). Additionally, throughout my experiences of witnessing and listening to the vicarious trauma material of these co-researchers, I noted my own prominent desire for increased space around and between co-researchers and myself. This resulted in my own patterns of spreading and widening outwards into space.

After one interview, my embodied writing captured my own desire for increased space and widening while I listened to a co-researcher speaking of his work with kids experiencing abuse at home:

"...me now, my jaw widening, as he talks about his fear that his vicarious trauma may return...I have a consistent desire to open my frame, uncross my legs, indulge in more space...and want to give him permission to open up, widen his body and frame as well..."

In another embodied writing session, I again captured my desire to spread and widen into space, along with my own awareness of an instinct to withhold this impulse:

“opening up in my chair, width, inviting width,  
maybe wanting to invite width in her too, spreading, expanding, releasing...  
but aware of needing to accept her holding, her posture...”

Again, after another co-researcher interview, my embodied writing session revealed my desire for increased space, along with my own emerging thoughts and questions about this pattern:

“I find more need to shift and move and roll and open and close and sigh than she does as stories unfold...I remain amazed at her fixed posture, at times I feel self-conscious of my need for movement, contrasting her more fixed position and posture, I wonder about this fixed composure...my body reacts to it, do I expect something else from her? Am I shifting and moving and cycling for her?... for me?”

A significant pattern of nonverbal spreading/widening into space emerged for five co-researchers as they shared their experiences of vicarious trauma. In addition, I experienced my own consistently occurring pattern of nonverbal spreading and widening in response to co-researcher’s accounts of their vicarious trauma, with a desire for increased space between the two of us.

For the 11 co-researchers involved in this study, eight verbal thematic categories and six non-verbal/body themes emerged in response to the research questions: How is the lived experiences of vicarious trauma for providers who have worked with individuals experiencing trauma? What are the roles of the body and narrative process within vicarious trauma? Within these thematic categories, co-researcher’s direct quotes, non-verbal postures or Effort qualities are presented, offering greater nuance and embodied

detail about their experiences. Now that these findings have been presented and elaborated on, I turn toward a discussion of what these findings might mean in relation to this study.

### **Transition**

But first, return to your breath. Inhale deeply. Exhale fully. Feel the points of connection between your body and what is supporting your body. Open and close your jaw, wiggling it side-to-side. Drop your tongue from the roof of your mouth. Notice the space around you; colors, textures, shapes. Close and then open your eyes. Inhale, expanding out in all directions. Exhale, come back to your center.

## **Chapter 5: Discussion**

As I turn toward a discussion of my findings, I revisit my research questions: How is the lived experience of vicarious trauma for providers who have worked with individuals experiencing trauma? What are the roles of the body and narrative process within vicarious trauma? Eager to gather information from first-hand experiences, I also wanted to invite the body into this research as a valuable and often forgotten source of lived experience.

I wondered about the potential intersections between the 11 co-researcher's stories, along with how they might respond to the chance to receive and re-read their own stories. Curious about what the story-telling, narrative process between each co-researcher and myself would offer, I sought to understand vicarious trauma in a multi-faceted and embodied way. Lastly, I was eager to present findings in the spirit of illuminating the phenomenon of vicarious trauma from the perspectives of those who had actually lived it. What might this illumination offer toward the work of addressing and mitigating negative impacts of vicarious trauma, while recognizing its potential for increased resiliency?

My findings answered my research questions by offering a qualitative description of how vicarious trauma is for 11 co-researchers who identified as having experienced it. These findings convey the major shared themes and patterns of vicarious trauma for the majority or a significant number of co-researchers. Both verbal and nonverbal themes are

presented as this research seeks to understand and portray how vicarious trauma is in as multi-faceted and embodied of a way as possible. Sub-themes offer greater textual descriptions by including perceptions, observations, sensations and moments of body awareness from co-researchers and myself.

My own embodied writing selections are integrated into the findings to offer an additional layer of visceral and descriptive detail. These sections present the interactive nature of each co-researcher's narrative and attempt to utilize sympathetic resonance with the reader in order to further convey findings (Anderson, 2001). This multi-sensory quality of my findings answers my research questions in an embodied and interactive way, aligning with my methodologies.

My qualitative research methodologies are founded on the desire to seek knowledge from human experience, while actively engaging co-researchers within the research. Therefore, the nature of this study does not point toward empirical certainty, nor proof about the experience of vicarious trauma. Instead, it seeks the first-hand knowledge and understanding of co-researchers.

Together, co-researchers and I sought to illuminate vicarious trauma as a lived phenomenon, and I believe, in my own lived experience of this process, we did so. Because this is a qualitative research study, it is ultimately up to the reader and future studies to determine if this occurred (Cruz & Berrol, 2004). As my beliefs may be clearly influenced by my own bias and involvement in this study, I will discuss my understanding of co-researcher's lived experience of vicarious trauma as it relates to my own lived experience of hearing, documenting, and holding space for their stories. To the



best of my ability and within the constraints of this study, I brought attention to the role of each co-researcher's body, my own body and the narrative that unfolded between us.

### **The Shifting Nature of Vicarious Trauma**

Alongside the distinct verbal and non-verbal themes of vicarious trauma, I began to simultaneously observe the emergence of another significant, but more overarching quality. Many times, this quality presented itself while a co-researcher was articulating their awareness and understanding of a specific component or symptom of their vicarious trauma. Immediately following this verbalization, the topic changed to focus on brand new manifestations of vicarious trauma. These new manifestations often asked the co-researcher to re-evaluate, and in a sense, re-visit their experiences in order to make sense of what was newly emerging in day-to-day life. I began to understand this pervasive and overarching pattern, woven throughout the distinctly shared themes, as the shifting nature of co-researcher's vicarious trauma.

The shifting nature of vicarious trauma presented itself both in co-researcher's verbally reported stories and non-verbal/body-based displays. Within the interview, however, I often first noticed this quality surface in subtle fluctuations of nonverbal movements and postural shifts. These included: indirect to direct eye contact, prominent displays of light weight to strong weight, advancing into space fluctuating into retreating, prominent fluctuations from acceleration into sustained pauses or deceleration. Generally, these body-based fluctuations also brought about a significantly felt change within the shared space between the co-researcher and myself.

Then, following these non-verbal displays was a significant verbal articulation by the co-researcher echoing a specific way they had experienced their vicarious trauma alter or manifest anew within their daily life. In these moments, some co-researchers spoke about making the decision to leave their job. For others, who chose to remain in their job and/or within their field, the topic was related to a significant work or personal life event, such as the death of a friend, a serious health issue, a spiritual connection, a change to a significant relationship, speaking out at work, or moving into a new home. And still, in these moments, other co-researchers spoke about how they believed they were consistently discovering how to “be with” and “work with” the ways their vicarious trauma continued to manifest in their lives, a process they understood to be ongoing and life-long.

In all these cases, vicarious trauma’s shifting nature was continuously illuminated to me first within co-researcher’s non-verbal/body-based fluctuations, followed by an element of their verbalized story in which they explicitly shared a change in how vicarious trauma presented in their life. This pattern seemed to suggest a relationship between the co-researcher’s initial non-verbal/body shifts and fluctuations to how they had newly experienced vicarious trauma, thus re-enforcing the shifting nature of the phenomenon. Though this narrative pattern played out differently within co-researcher’s day-to-day lives, its presence supported the existence of a shifting nature within vicarious trauma. As a result, the shifting nature emerged as a distinct and overarching element of “how” vicarious trauma was experienced for co-researchers.

Both Judith Herman (1992) and Laura van Dernoot Lipksy (2009) re-enforced the evolving and non-linear nature of traumatic experiences and trauma exposure. Herman

recognized that traumatic syndromes are “oscillating and dialectical in nature.” (p. 155). She warned against the simple ordering of experiences of trauma, instead drawing attention to the complexity with which traumatic syndromes infiltrate all aspects of a person’s functioning and life.

Van Dernoot Lipsky noted that consequences of trauma exposure “often occur on a continuum: Some changes are very slight...while others may be dramatic and life changing.” (2009, pp. 42-3). Because trauma exposure can manifest in such a variety of ways and with varying intensities and manifestations, originating causes can be even more difficult to locate. As a result, when someone experiences trauma indirectly, as in vicarious trauma, they can also experience increased feelings of denial or displacement, guilt, and numbing, making it difficult to “remain aware of one’s own responses” (p. 43).

My observations of co-researcher’s experiences of vicarious trauma reflected Herman and van Dernoot Lipsky’s understandings of the complex and oscillating nature of traumatic phenomenon. Though major verbal and nonverbal themes of vicarious trauma did emerge, these same themes were couched within an overarching shifting nature, consistently changing and manifesting anew. Even if a co-researcher began to notice and make sense of their current experience of vicarious trauma, they often soon discovered a significantly new quality or manifestation causing them to re-examine. However, throughout this shifting nature of vicarious trauma, co-researchers still continued to refer to and understand their experiences as vicarious trauma.

Without a way to clearly locate the boundaries of vicarious trauma, it appeared the majority of co-researchers found it increasingly difficult to understand what was happening to them and from where their experiences were originating. At the same time,

their professional roles required them to consistently engage with the traumatic material of their clients. This intersection often left co-researchers without the time, support, or resources to make sense of what they were experiencing mentally, emotionally, or physically. As a result, co-researchers felt isolated, helpless, and afraid of what was ahead. Their symptoms of vicarious trauma often manifested in subtle, yet all-encompassing ways that could easily remain illusive. Once a co-researcher became aware of their vicarious trauma, new manifestations emerged, keeping them guessing or scrambling in response.

My observations and synthesis of these findings led me to believe that the shifting nature of vicarious trauma contributed to its increased pervasiveness and persistence for co-researchers. One co-researcher spoke often about his fear of the unpredictability of his experiences with vicarious trauma, feeling as if his symptoms "...just seemed to pop out of nowhere." In a different co-researcher's post-interview embodied writing sessions, I noted this consistent experience of her "not-knowing" throughout her interview:

*"...she admits, over and over again, to the not-knowing...our weight, increasing in pressure together, pulls us down together into this ongoing not-knowing of her vicarious trauma..."*

Without a clear sense of borders around what their vicarious trauma was, or how it might change moment-to-moment, co-researchers appeared to be at a higher risk for extended and more insidious experiences of vicarious trauma.

**Gifts and resiliencies.** And yet, the shifting nature of vicarious trauma was also represented in the thematic category: gifts and resiliencies. This category captured another kind of manifestation of vicarious trauma noted throughout narratives. Six shared sub-themes presented either gifts or qualities of resilience that were a part of co-

researcher's experiences of vicarious trauma. The existence of this category further reflects vicarious trauma's shifting nature. Ivey, Bradford Ivey, Myers, and Sweeney (2004) reported on the important roles that trauma and loss can often play for some people as they regain health. In these cases, it was understood that trauma can become a way to reorganize a once disorganized life, providing new sources of meaning and honing new sources of personal power (Ivey, et al.)

The most prominent sub-theme within this category included co-researcher's experiences of this study's narrative process as an increased source of resiliency or empowerment. The narrative process included both the in-person interview, as well as the co-researcher's opportunity to receive and respond to their narratives by sending back written feedback. In this process, one co-researcher reported feeling "centered, [a] greater sense of calmness, power, taking steps..." after sending her written feedback. Another wrote that the process of reading her narrative motivated her to take better care of herself and find a way to reconnect to the purpose of her work. Yet others shared feeling reassured, grateful, validated, and excited after reading their vicarious trauma narratives, noting how much they "learned from my own words." Though three co-researchers did not explicitly report experiences of increased resiliency within their written feedback, they did share that their participation within the narrative process gave them new questions or perspectives to consider.

Daniel Siegel (1999) promoted the relational role of stories, noting that stories are "created within a social context between human minds" (p. 330). In this way, he understood the process of narrative as foundationally social and interactive. With this in mind, within the in-person, relational narrative process with each co-researcher, I utilized

methods of attunement. Siegel understood the process of attunement to bring both members of an interaction into “mutual influence,” a characteristic he describes as resonance (p. 281). According to Siegel, this state of alignment between two people continues to exist even after the initial interaction comes to an end. Simply put, the experience of resonance created between two people, and I’ll add between two bodies, lives on.

Within dance/movement therapy, this state of resonance is facilitated through the process of kinesthetic attunement. This is understood as the “process of translating movement qualities observed in another person’s into one’s own body (Kestenberg Amighi, et al., 1999, p. 13). Throughout interviews, I employed kinesthetic attunement with co-researchers, attempting to match changes within their patterns of muscular tension and release as a way to foster empathy and promote a sense of resonance (Loman, 1995; Kestenberg Amighi et al., 1999).

With this research in mind, along with co-researcher’s feedback and my own embodied writings, these findings lead me to believe the narrative process itself may have offered a structure or source of resilience for co-researchers. Though no co-researchers explicitly mentioned the term resilience within their feedback, the majority did report many characteristics associated with resilience. These characteristics included, increased sense of calm and reassurance, increased meaning-making, reconnection to self and others, and an increased sense of power and ability to take action (van Dernoot Lipksy, 2009; Siegel, 2010). Siegel understood resilience to represent a person’s ability to “move toward challenges rather than withdraw from them” (2010, p. 153). Here again, these connections call for future research. How might the narrative process offer a structure for

resilience? How might the narrative process be a tool or mode of intervention in working with those experiencing various modes of trauma exposure?

**The role of primary trauma.** As I continued to notice the complex and shifting nature of vicarious trauma for co-researchers, I wondered about the role of past trauma histories. Stories of personal and professional primary traumas emerged as a major theme within the majority of co-researchers vicarious trauma stories. How might past primary traumas contribute to the shifting nature of vicarious trauma?

Both Babette Rothschild (2006) and van Dernoot Lipsky (2009) noted how personal histories of trauma have the potential to play a significant role within the effects of indirect trauma exposure and vicarious trauma for clinical professionals. Van Dernoot Lipsky further highlighted how important it is for those within the helping professions to understand if past personal traumas might have a part in why they do the work they do. She believed this personal factor could shape how it is professionals might experience their own trauma exposure.

It is important to note that one co-researcher did not report personal or professional primary trauma within her vicarious trauma narrative. And yet, her vicarious trauma narrative also reflected similar patterns of a shifting and oscillating nature, along with the rest of co-researchers. I wondered what might have been unique within this particular co-researcher's experiences to account for this distinction.

Returning to this particular co-researcher's narrative and my post-interview embodied writing, I discovered repeated mentions, yet again, of her sense of "not-knowing," along with verbal mentions and non-verbal displays of detachment. After her interview, I wrote:

“[ nod to her repeated mentions of detachment, detachment as a key, as a method, as a way to shift vicarious trauma...] feel and witness her feet extend off the couch, to the floor and ...detach, I suppose, from the couch and the trunk of her body....and yet, I feel a still present wondering, still brewing...nestled inside her dropped weight, expanded gaze, she, we are placed somewhere trying to ‘make sense...’ ”

I wondered about the role of this method of detachment and the potential coping mechanism it may have served for not only this co-researcher’s experiences of vicarious trauma, but also any potential primary traumas. And yet, within this selection, this co-researcher also verbally and non-verbally supported the in-progress, shifting nature quality of vicarious trauma. Is it possible the shifting nature of vicarious trauma further contributes to the challenge of understanding where one’s own experiences, such as past primary traumas, start and end, and the experiences of vicarious trauma begin? Could this be the case with this co-researcher? Clearly, this is an area for future research.

With this shifting nature of vicarious trauma in mind, I had to wonder how it was that co-researchers, or anyone else experiencing vicarious trauma, could even begin to address vicarious trauma. And more specifically, how was it that the co-researchers in this study were able to understand their experiences with enough clarity in order to identify with and participate in this study? What made it possible for each co-researcher to engage with and share their experience of vicarious trauma in a way that conveyed meaning?

### **The Body within the Research Process**

Throughout my data collection and analysis stages, I discovered many insights about the role of the embodied researcher as they related to this research and my research questions. The role of my own body as both a valuable research tool, as well as a vehicle



for self-care emerged prominently at unexpected moments. The process of embodied writing also emerged as a key link between my research questions and my own role within the study. This played out as I discovered embodied writing as a more nuanced data collection tool, as well as a way to become aware of my own parallel processes alongside co-researchers. I will discuss these topics in greater detail below.

**Embodied writing as data collection and analysis.** In embodied writing, the quality of sympathetic resonance between the written word and the reader acts as a form of increased efficacy and validity (Anderson, 2001a). In this way, I believe my use of embodied writing enhanced my ability to attune with each co-researcher, creating an atmosphere of trust and empathy. And, though I must leave the ultimate call to the reader and future studies, I also believe my use of embodied writing led me to collect richer nuances of internal and external information from co-researchers vicarious trauma experiences (Mertens, 2005).

This belief is evidenced by my experience that as my embodied writing sessions progressed, my ability to attune to each co-researcher became more natural, immediate, and focused. My embodied writing sessions increased in length and breadth. Throughout subsequent interviews, I began noticing and connecting more themes and patterns. These themes included, hypervigilance/fear of future, body disconnect, isolation, overarching responsibility, and powerlessness/helplessness. My ability to sense these verbal and non-verbal themes on my own body level, employing a “felt-sense,” increased in frequency and deepened in breadth (Levine, 1997).

In this way, my own somatic experiences and sensations within embodied writing sessions paralleled many of the same major non-verbal themes reported from co-

researchers. These most significantly paralleled themes between co-researchers and myself included experiences of strong weight, chest narrowing/hollowing, indirecting gaze and eyes, fluctuations of acceleration and deceleration, and active hands.

Additionally, my embodied writing sessions revealed the significance of the non-verbal pattern of widening/spreading in my own body. This non-verbal theme occurred throughout in-person interviews, as well as throughout embodied writing. Within my embodied writing, I hypothesized about the potential recuperative function of this shape change. It appeared that I displayed widening/spreading on a consistent basis as a response to co-researchers major verbal and non-verbal themes that brought the body into a more held, static, and narrowing shape. Regarding this shape change pattern, I wrote:

“...me now, my jaw widening, as he talks about his fear that his vicarious trauma may return...as he speaks, I have a consistent desire to open my frame, uncross my legs, indulge in more space...I want to give him permission to also open up, widen his body and frame and gaze, as well...”

After another co-researcher’s interview, my embodied writing noted this same non-verbal widening and spreading pattern through my upper torso. This time, it was in response to the co-researcher’s talk about his increased recommitment to his health and garden:

“...a widening occurred throughout our conversation about his new practice, his commitment to his garden, his awareness of needing to tend to vicarious trauma...widening physically in his body, torso, moving expression from one side of the body to the other side of his body, and then ultimately integrated sides, full body expressions.... encouraging, inviting my body to do the same... my ongoing awareness of remaining receptive, open, widened, expanded and spread across my torso, receiving his shift...shifting together”

Within verbal and non-verbal themes, supported through my embodied writing, it appeared my display of non-verbal spreading/widening provided a recuperative function, but also paralleled co-researcher's verbal themes of increased health, wellness, sustainability and resilience. This indeed, is an area awaiting future research, with potential of developing new body-based methods and tools for those working within the field of trauma.

**Parallel process with co-researchers.** During data analysis, my data wanted to explode out of its columns, challenging me with its disorder and grey area. I found it immensely challenging and often painful to “let-go” of any pieces of data, any word, quality, noticing, or body posture I had captured, afraid something might be lost or forgotten. At one point within my data analysis process, I declared to my thesis advisor, “I can't get these stories off of me!” I recalled a similarly visceral and declared sentiment from one co-researcher, “get it off of me!” as he described his experiences with vicarious trauma.

Around this same time, while I was transitioning original interview transcriptions into narratives, I shared this visceral feeling with my partner. I admitted I had been experiencing increased anxiety, along with new images or scenarios flashing through my head. These scenarios involved dangerous events that could possibly occur when I was walking, driving or at home. I recalled these sorts of feelings and scenarios during some of my own outreach work in Chicago, while I was working with people experiencing homelessness, mental health issues, addiction, and violence on the streets. As I shared these experiences with her, I also sensed my strong belief in my coping skills, supportive resources, and sense of preparedness. I realized that I had come to believe in my ability to

take care of myself and find the resources I needed when this kind of anxiety and fear surfaced.

**The body within researcher self-care.** Within healing professions, it is invaluable to find and create a personally coherent life narrative, which Siegel (2010) understood as an ongoing act of self-care. As my study progressed, embodied writing emerged as a vital foundation for my own ongoing process of seeking coherence, wellness and self-care. After each interview, my structured return to embodied writing became a ritual allowing me to slow down and settle back into my own skin. Here I could sift through all of the internal and external data that had surfaced within co-researcher's often heightened, emotive and intimate vicarious trauma stories. I could hone in on my own embodied moments of sympathetic resonance while interviewing and observing, gleaning these rich nuggets of data.

In reflecting on the practice of embodied writing, Anderson writes, "...deliberately slowing down and heeding the nuances...requires steady and mindful attention to detail." (2001, p. 86). Through this slowing, my mindfulness and self-awareness as a researcher grew. I could acknowledge the history of vicarious trauma that lived in my own bones, give it voice, and from here, return to my role of researcher more mindfully, more fully embodied.

Similarly, during my process of transcribing each co-researcher's interview from audio recording into written account, I also organically began transcribing both the opening and closing grounding sessions I had offered to co-researchers. Here, I discovered another unexpected opportunity to somatically return to each interview myself.

Through this tedious transcription process for eleven interviews, I began to follow my own verbal guidance in each of these grounding sessions, partaking from the perspective of the co-researcher. These grounding sessions offered valuable recuperation in the midst of the lengthy, often overwhelming, and arduous transcription process. It was as if I kinesthetically returned to the initial interview, often times re-considering that particular co-researcher's perspective and story as a result.

As a result, I was surprised to often find myself newly resourced, regaining connection to my spine, shifting my feet to the ground, reconnecting to my breathe. I was coming back to my own body, re-affirmed in my mission. Time slowed, my chest welled with the material within which I was immersed and my jaw tugged from the intensity of this work. There, in my seat at the local coffee shop or library, with laptop and notes sprawled in front of me, I understood my research. I was filled with my research. I sat in and took in the "how?" of my research. How is vicarious trauma...? Gratitude washed over me as I opened to the immensity of this question. I rested in the gifting of each provider's intimate and vulnerable stories, gratitude in my bones, in my cells, in the conviction of the questions.

In these moments, seemingly mundane to those sharing public space around me, I knew I was doing my research. I knew I was analyzing as I should. I knew I was "with" my research, as my thesis advisor kept encouraging me to be. These moments were significant and kept me plodding along in my research process. I believe these are the moments that will continue to inform my clinical and creative path going forward.

## **Limitations**

As I've mentioned, my own role in this study is important to illuminate, as I am not an unbiased researcher. I approached this research with my own personal and professional histories, including my past experiences working with those who have experienced trauma. Since my body was one mode of data collection and analysis, my observations were filtered through my own sensations and perceptions, including my body prejudices and affinities.

Janesick (1998) recommends that researchers work to remain aware of their inherent bias within observation and coding. Ongoing observation exercises and methods of self-evaluation are recommended as ways to address this ongoing researcher bias (Janesick, 1998). Within the field of DMT, this practice extends further into the inherent and often unconscious bias of our own personal body knowledge and body prejudice (Moore, 2010). I used my embodied writing sessions after and between co-researcher interviews, along with ongoing communications with my thesis advisor throughout my research process, as opportunities for ongoing self-observation. These served as places to also explore the ways my own meanings and prejudices of movement might be influencing my study.

Limitations also existed within the structure of my research. My choice to conduct a phenomenological study, inherently interested in the subjective, human experience of others, is a foundational limitation. Because this study was interested in the lived experience of vicarious trauma for the 11 co-researchers involved, the results cannot be generalized across all providers working within the trauma field.

However, this study could serve as a model for future efforts directed toward understanding how vicarious trauma, and other kinds of trauma exposure responses, play

out in day-to-day life for providers. This increased knowledge might then inform the most effective ways to address the ongoing care and sustainability of providers, along with their potential for increased resiliency in their work.

Individual, in-person interviews with each co-researcher only occurred one time, lasting between 60-90 minutes. This interview format was a limitation to this study as it didn't necessarily allow for the greatest prolonged and substantial engagement with each co-researcher. However, by sending each narrative back to its co-researcher for review and feedback, an additional credibility step of member checking, I prolonged my amount of interaction and engagement with co-researchers. Also, by using several methods of data collection-in-person interviews, audio recordings of interviews, written interview transcriptions, narratives, and embodied writing-I could interact with data multiple times throughout the study.

Co-researchers held differing professional titles, working within a variety of human service fields. Diversity of co-researcher background, training, and title added another limitation to the ability to generalize findings of this study. Due to logistical practicalities, along with upholding the co-researcher choice of location, interview settings and locations varied. While all interviews occurred in a mostly private and confidential setting, some interviews did occur in the co-researcher's workplace, during work hours. This setting likely could have influenced the co-researcher's comfort and/or their ability to disclose particular details of their experiences.

Ten co-researchers were based in or around Seattle, WA, with one co-researcher based in Chicago, IL. This variation in co-researcher geographic location, along with the overall lack of geographical diversity, served as study limitations. How might this study

and its findings have differed if co-researcher's geographic locations represented more national and/or international diversity?

In addition, my own past histories with co-researchers, or lack thereof, may have served as another limitation to this study. Since I recruited from within my existing networks, the resulting set of co-researchers was a mix of people with whom I either had a past personal or professional connection, or had never previously met. This variable likely played a role in the degree of comfort and trust within each interview, along with the kinds of personal details co-researchers chose to share or withhold.

How might findings have differed if I recruited co-researchers with whom I had no previous history? On the other hand, how might my past professional and/or personal relationships with co-researchers have enhanced the study and/or recruitment process? At first it appeared that my past relationship histories with seven co-researchers did help to facilitate a more immediate felt-sense comfort within interviews (i.e. ease in transitions, more immediate and intimate interview content). However, as the study progressed, I found it to be true that I experienced a deep breadth of interview content, as well as narrative response accountability, sprinkled throughout all eleven interviews, regardless of our past history. This factor of past personal and/or professional history with co-researchers is a valuable area for future research.

As this study progressed, it became clear that the existence of primary trauma within some, though not all, of co-researcher's vicarious trauma experiences became a significant variable. While I expected this topic to emerge, I did not account for its prominence as a variable between co-researcher narratives. I often felt underprepared in how to adequately track the emergences of primary vs. vicarious trauma, but strived to



also remain focused on my main research question of “how” vicarious trauma is for co-researchers. In future versions of this study, I might explicitly address the potential role of primary trauma within initial co-researcher recruitment, as well as within semi-structured interview questions. And yet, I also wonder how this explicit, up-front mention of primary trauma might color co-researcher’s narratives?

### **Future Research**

My suggestions for future research follow theories that were sparked as a result of my findings, as well as ideas for how to address the limitations of this study. First, I suggest further research should focus on the potential of narratives and the narrative function as a way to work with providers experiencing vicarious trauma and other modes of trauma exposure. Daniel Siegel (2010) believed that “developing a personal understanding of memory and narrative processes enables you to change how you make sense of your life” (p. 71). Those who experience vicarious trauma experience significant alterations in how they make meaning in their lives (McCann & Pearlman, 1990). Therefore, future studies that focus on the sense-making potential of our narrative function seem appropriate and rich with possibility.

In addition, future research should continue to highlight the differing ways humans share and make sense of their lives, especially through non-verbal, creative, image and body-based modes. This focus holds rich potential for professionals and clients alike. It is important to continue bridging these modes of communication, supporting the body as one of these modes and a valuable topic of research.

In this way, Siegel’s concept of narrative integration encourages the joining of our “bodily experience...the non-verbal realm of right-mode processing with the logical,

linear, linguistic, and observing left mode processes,” as a way to create coherent narratives (2010, p. 244). This sense of coherence can offer us a way to “mak[e] sense of our life...feeling fully the sensations of our lived experience, moment by moment, weaving these with memory and with our visions for a new future (Siegel, 2010, p. 244). I suggest that future studies focus on this idea of narrative integration as a path toward coherence for professionals experiencing vicarious trauma.

Dance/movement therapists and the larger field of dance/movement therapy have long been utilizing non-verbal communication, body-based expression and creative movement as modes of clinical intervention, treatment and research (Levy, 1988). As Siegel stated, using our bodily experiences to make meaning of varying personal stories, can be the path toward a whole and coherent personal narrative. In this way, dance/movement therapists help facilitate links between verbal and non-verbal, supporting creative and body-based storytelling. Related to this study, dance/movement therapists can offer techniques in mirroring, kinesthetic attunement, movement phrasing, Laban Movement Analysis and Effort modulation, that might assist in addressing vicarious trauma and the entire spectrum of trauma exposure responses that providers might experience when working with others experiencing trauma (Levy, 1988).

Specifically, I suggest dance/movement therapists conduct future research that explores the major themes of this study through movement. The researcher could use both non-verbal and verbal themes of vicarious trauma to create a movement phrase or piece of choreography. A second movement phrase could then be created comprised of those body actions or Effort qualities that provide recuperation from the first phrase. Co-researchers in the study could be instructed to execute each movement phrase, as the

researcher observes and interviews in between each movement phrase. How might attention toward finding recuperative body actions and Effort qualities for providers play a role in the mitigation of vicarious trauma?

This movement phrasing study might also occur as a case study, following one co-researcher through a progression of sessions. What is the potential of the dance/movement therapist non-verbally echoing both the participant's vicarious trauma movement phrase, as well as the recuperative movement phrase alongside the participant? Additionally, the co-researcher could be invited to tell their narrative through movement, exploring their lived experience of vicarious trauma without stating a word. What might emerge from a purely body-based narrative?

Another rich area for ongoing future research is the role of embodied writing as a bridge between verbal and non-verbal modes of communicating and sense-making. How could providers working with people experiencing trauma utilize embodied writing as both a clinical tool and mode of self-care? How might embodied writing help to address or mitigate vicarious trauma, potentially addressing beginning stages of burnout before a provider progresses into other modes of trauma exposure?

As a way to test the themes presented in this study, I would suggest future studies recruit more concentrated and select groups of co-researchers. How is vicarious trauma for dance movement therapists and other body-based therapists? For clinicians? For direct-service workers? For those working in the medical field? For supervisors and administration? Also, I'd suggest this study be implemented within specific workplace-settings. How might different workplace cultures and systems influence vicarious

trauma? How is vicarious trauma for human service providers within different agencies and systems-of-care?

### **Transition**

As I close my discussion, I once again, invite the reader to pause. Return to your breath. Soften your jaw, allowing the teeth to separate and the tongue to drop from the roof of your mouth. Inhale deeply. Exhale fully, letting out an audible sigh. Bring your awareness to where you feel the center of your body. Inhale from that center place, expanding out in all directions. Pause. Exhale slowly, coming back in to the center of your body. Close your eyes and then pause. Open your eyes again. Notice the sensations of your body in this moment.

### **Summary**

Once again, I revisit my research questions: How is the lived experience of vicarious trauma for providers who have worked with individuals experiencing trauma? What are the roles of the body and narrative process within vicarious trauma? Eager to understand the day-to-day, lived experiences of vicarious trauma for those who actually lived it, I sought the experience-based knowledge and understanding of my co-researchers. As a dance/movement therapist, I wanted to very actively invite the body into this research, illuminating it as a valuable and often forgotten source of lived, embodied experience. The story-telling, narrative process offered an interactive way to share and witness the vicarious trauma stories of 11 co-researchers. I engaged in embodied writing throughout this study as a way to capture additionally nuanced and multi-sensory details of co-researcher's experiences, along with presenting the interactive nature of each story-telling exchange.

This phenomenological study offers a qualitative description of how vicarious trauma is for 11 co-researchers who identified as having experienced it. This description reveals the major shared verbal and non-verbal/body themes and patterns of vicarious trauma for these co-researchers. Supported by co-researcher's direct quotes, as well as selections of my own post-interview embodied writings sessions, I offer my understanding of the lived experience of vicarious trauma as it relates to my own lived experience of hearing, documenting, and holding space for co-researcher's stories.

As I draw a close to this study, I am certainly left with many questions related to future research. How might trauma exposure responses, including vicarious trauma, be more fully understood when we first seek the knowledge of the human service providers who are actually experiencing them? Furthermore, what might the body, as a valid and rich source of this knowledge, contribute to future efforts of understanding and addressing vicarious trauma? How might the field of dance/movement therapy offer a natural and fitting bridge?

My experiences of sitting down, face-to-face with co-researchers in order to witness, observe, and collect their stories has most certainly left me with a very visceral and deeply-felt sense of the transformative potential of this narrative exchange. What does the embodied narrative process offer to the process of understanding and working with vicarious trauma and other trauma exposure responses? How might the body and narrative process serve as tools for self-care, clinical supervision, consultations groups, employee wellness and retention, as well as overall workplace sustainability within agencies that work with traumatic material? What are the roles of supervisors and

administrators, along with dance/movement therapists, in regards to addressing vicarious trauma and other trauma exposure responses within agencies?

I could not have conducted this study without the active engagement of my body as a research tool, along with the bodies of each co-researcher. What might the intentional inclusion of the body as both a research topic and research tool offer to future research? What might the body, in particular, offer to future phenomenological research that aims to illuminate the lived experiences of human beings who indeed encounter and interact with the world through the vehicle of their body? How might dance/movement therapists play an important role in bridging verbal and non-verbal realms within research?

Narratives are believed to encourage a sense of purpose and belonging, capable of “reveal[ing] truths about human experience” (Riessman, 2008, p. 3). Amidst my questions, and as I draw this thesis to a close, I return to this potential; to the truth within human experience. In so doing, I find myself back with each co-researcher, sitting together in shared exchange, observing their work settled within their bones. Summoning the words and body sensations of our interaction together, I recall a flow of past, present, future: individual stories become woven into a whole, coherent narrative.

And then, I find myself back in my body, in my experience of this present moment. I return to the wisdom of the body to hold knowledge, to tell our stories, to reveal our truths. And once again, gratitude settles around me. I rest in the gifting of each co-researcher’s intimate, vulnerable and resilient story, just as they have likewise held the vulnerability and resilience of those alongside whom they have worked. Gratitude in my bones, in my cells, in the conviction of our journey together.

## References

- Adler, P.A. & Adler, P. (1994). Observational techniques. In N.K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 377-392). Thousand Oaks, CA: Sage.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4<sup>th</sup> ed.). Arlington, VA: American Psychiatric Publishing.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5<sup>th</sup> ed.). Arlington, VA: American Psychiatric Publishing.
- Anderson, R. (2001). Embodied writing and reflections on embodiment. *The Journal of Transpersonal Psychology*, 33, 83-98.
- Anderson, R. (2002a). Embodied writing: Presencing the body in somatic research, Part I. *Somatics: Magazine/Journal of the Mind/Body Arts and Sciences*, 13(4), 40-44.
- Anderson, R. (2002b) Embodied writing: Presencing the body in somatic research, Part II, Research Applications. *Somatics: Magazine/Journal of the Mind/Body Arts and Sciences*, 14(1), 40-44.
- Bartenieff, I. (2002). *Body movement: Coping with the environment*. New York, NY: Routledge.
- Bernstein, B. (1995). Dancing beyond trauma: Women survivors of sexual abuse. In F. Levy (Ed.), *Dance and other expressive art therapies: When words are not enough* (pp. 41-58). New York, NY: Routledge.

- Body [Def. 1, 3]. (n.d.). In *American Heritage Dictionary of the English Language Online*, Retrieved October 4, 2013, from <http://www.ahdictionary.com>.
- Bride, B., & Figley, C. (2009). Secondary trauma and military veteran caregivers. *Smith College Studies in Social Work*, 79, 314-329.
- Chang, M. & Leventhal, F. (1995). Mobilizing battered women: A creative step forward. In F. Levy (Ed.), *Dance and other expressive art therapies: When words are not enough* (pp. 59-68). New York, NY: Routledge.
- Cruz, R. F. & Berrol, C. F. (2004). *Dance/movement therapists in action*. Springfield, IL: Charles C Thomas Publish, Ltd.
- deVries, M.W. (1996). Trauma in cultural perspective. In B. van der Kolk, A. McFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body and society* (pp. 398-413). New York, NY: Guilford Press.
- Eckberg, M. (2000). *Victims of cruelty: Somatic psychotherapy in the treatment of PTSD*. Berkeley, CA: North Atlantic Books.
- Figley, C. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In C. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 1-20). New York, NY: Brunner/Mazel, Publishers.
- Figley, C. (1999). Compassion fatigue: Toward a new understanding of the costs of caring. In B. Hudnall Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 3-28). Lutherville, MD: Sidran Press.



- Forester, C. (2007). Your own body of wisdom: Recognizing and working with somatic countertransference with dissociative and traumatized patients. *Body, Movement & Dance in Psychotherapy*, 2(2), 123-133. doi:10.1080/17432970701374510
- Freud, S. (1959). Future prospects of psychoanalytic psychotherapy. In J. Strachey (Ed., Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 2, pp. 139-151). London: Hogarth Press. (Original work published 1910).
- Gentry, J. (2002). Compassion fatigue. *Journal of Trauma Practice*, 1(3-4), 37-61.  
Retrieved from <http://ehis.ebscohost.com.emils.lib.colum.edu>
- Grohol, J. (2013). DSM-5 changes: PTSD, trauma & stress-related disorders. *Psych Central*. Retrieved from <http://pro.psychcentral.com/2013/dsm-5-changes-ptsd-trauma-stress-related-disorders/004406.html>
- Hackney, P. (2002). *Making connections*. New York, NY: Routledge.
- Herman, J. L. (1992). *Trauma and recovery*. New York, NY: HarperCollins Publishers, Inc.
- Ivey, A. E., Bradford Ivey, M., Myers, J. E., & Sweeney, T. J. (2004). *Developmental counseling and therapy: Promoting wellness over the lifespan*. Boston, MA: Houghton Mifflin.
- Janesick, V. J. (1998). *Stretching exercises for qualitative researchers*. Thousand Oaks, CA: Sage Publications.
- Joinson, C. (1992). Coping with compassion fatigue. *Nursing*, 22 (4), 116-122.

- Kestenberg Amighi, J., Loman, S., Lewis, P., & Sisson, K.M. (1999). *The meaning of movement: Developmental and clinical perspective of the Kestenberg movement profile*. New York, NY: Brunner-Routledge.
- Laban, R. (1974). *The language of movement*. Boston, MA: Plays, Inc.
- Laban, R. (2011). *The mastery of movement* (L. Ullmann, 4th rev. & enl. ed.). Alton, United Kingdom: Dance Books. (Reprinted from *The mastery of movement on the stage*, by R. Laban, 1950, London: Macdonald & Evans).
- Lengerich, S. (2001). *An investigative study of staff burnout using DMT principles on an outpatient psychiatric unit* (Unpublished master's thesis). Columbia College Chicago, IL.
- Levine, P. (1997). *Waking the tiger: Healing trauma*. Berkeley, CA: North Atlantic Books.
- Levy, F. (1988). *Dance movement therapy: A healing art*. Reston, VA: NDA AAPERD.
- Levy, F. (1995). *Dance and other expressive art therapies: When words are not enough*. New York, NY: Routledge.
- Maslach, C. (1982). *Burnout: The cost of caring*. Englewood Cliffs, NJ: Prentice-Hall
- McCann, L., & Pearlman, L.A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*. 3(1), 131-149.
- Mertens, D. M. (2005). *Research and evaluation in education and psychology*. (2<sup>nd</sup> ed.) Thousand Oaks, CA: Sage Publications, Inc.
- Moore, C. & Yamamoto, K. (1988). *Beyond words: Movement observation and analysis*. New York, NY: Routledge.

- Moore, C. (2010). *Introduction to Laban movement analysis and harmonic theory* (abridged version). (Unpublished manuscript).
- Morrison, J. (2006). *DSM-IV made easy: The clinician's guide to diagnosis*. New York, NY: The Guilford Press.
- Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage Publications, Inc.
- Munnell Trif, E. (2010). *A dance/movement therapist's experience of vicarious trauma and burn-out: An autoethnography* (Unpublished master's thesis). Columbia College Chicago, IL.
- Norcross, J. C., & Guy, J. D. (2007). *Leaving it at the office*. New York: The Guilford Press.
- Pearlman, L.A., & Saakvitne, K.W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York, NY: Norton.
- Riessman, C. K. (2008). *Narrative methods for the human sciences*. Thousand Oaks, CA: Sage Publications, Inc.
- Rothschild, B. (2000). *The body remembers: The psychophysiology of trauma and trauma treatment*. New York, NY: W.W. Norton & Company.
- Rothschild, B. (2006). *Help for the helper: The psychophysiology of compassion fatigue and vicarious trauma*. New York, NY: W.W. Norton & Company.
- Salmon, P. (2008) Some thoughts on narrative research. In M. Andrews, S. Squire, & M. Tamboukou (Eds.). *Doing narrative research in the social sciences*. (pp. 78-89) London: Sage.

- Siegel, D. (1999). *The developing mind: Toward a neurobiology of interpersonal experience*. New York, NY: The Guilford Press
- Siegel, D. (2010). *The mindful therapist*. New York, NY: W.W. Norton & Company, Inc.
- Stamm, B. H. (1997). Work-related secondary traumatic stress. *PTSD Research Quarterly*, 8, 1-6.
- Tortora, S. (2006). *The dancing dialogue: Using the communicative power of movement with young children*. Baltimore, MD: Paul H. Brookes Publishing, Co.
- Trippany, Kress, & Wilcoxon, 2004. Preventing vicarious trauma: What counselors should know when working with trauma survivors. *Journal of Counseling and Development*, 82(1), 31.
- Turner, S., McFarlane, A., & van Der Kolk, B. (1996). The therapeutic environment and new explorations in the treatment of posttraumatic stress disorder. In B. van der Kolk, A. MacFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 214-241). New York, NY: Guilford Press.
- van der Kolk, B. (1996). The body keeps score: Approaches to the psychobiology of posttraumatic stress disorder. In B. van der Kolk, A. MacFarlane, & L. Weisaeth (Eds.), *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 214-241). New York, NY: Guilford Press.
- van Dernoot Lipksy, L. (2009). *Trauma stewardship: An everyday guide to caring for self while caring for others*. San Francisco, CA: Berrett- Koehler Publishers, Inc.

Winters, Allison. (2008). Emotions, embodiment and mirror neurons in dance/movement therapy: A connection across disciplines. *American Journal of Dance Therapy*, 30(2), pp. 84-105.

## Appendix A

### Definition of Terms

#### **Attunement**

A process of relying on the “felt-sense” in order to remain aware and present to the multi-sensory details of one’s internal and external information (Levine, 1997, p. 91).

A technique used within dance/movement therapy and movement observation, allowing a person to “sense the movement process” by drawing upon “our sense of sight, hearing, touch, and kinesthesia to establish a contact with what we see...” (Moore, 1988, p. 212).

#### **Body**

“The entire material or physical structure of an organism, especially of a human or animal”; “The physical aspect of a person”; “A human, a person” (The American Heritage Dictionary of the English Language online).

#### **Dance/Movement Therapy (DMT)**

“The psychotherapeutic use of movement as a process which furthers the emotional, cognitive, social, and physical integration of the individual” (Levy, 2005, p. 11).

#### **Embodied Writing**

Embodied writing is a technique that seeks to convey the kinesthetic, visceral, perceptual, imaginal, and somatic senses of the writer, fostering a quality of sympathetic resonance in the reader (Anderson, 2001, 2002a, 2002b). Embodied writing strives to “give the body voice” by tuning the writer and reader inward, relaying human experience as if the reader were having the experience in their own body (Anderson, 2002a, p. 41).

## **Lived Experience**

A person's lived experience is their detailed, nuanced, and subjective experience, including individual perceptions, meanings, understandings, descriptions, and felt somatic sense of a particular experience from their first hand point of view; the essence of an experience for that particular person (Mertens, 2008).

## **Narrative**

A narrative is comprised of intentionally selected, organized, and connected events that the speaker deems as meaningful for a particular audience, and as a result, a narrative can, "reveal truths about human experience" (Riessman, 2008, p. 10).

## **Narrative Process**

The narrative process involves a speaker connecting events into a meaningful sequence that has value for later action; capable of encouraging others to remember, engage, mobilize, and change by providing a sense of strategy, function, purpose and belonging (Riessman, 2008). The narrative process is a way to create stories about the events and interactions of one's life, helping to make sense of these events and the resulting mental experiences (Siegel, 1999).

## **Provider**

A person that provides any variety of professional practice, activities, or methods concerned with direct observation, assessment, treatment, or social services to a client, patient or participant, including, but not limited to mental health counselors, therapists, social workers, psychologists, psychiatrists, medical doctors, case managers, art therapists, music therapists, dance/movement therapists, yoga therapists, direct service workers (overnight and short term shelter staff, emergency food center staff), supportive

housing staff, nurses, emergency response team members, or others providing direct care within a professional setting.

### **Trauma**

Trauma is understood to occur when a person experiences, witnesses, or is confronted with a traumatic event(s) involving actual or threatened death and intense fear, horror or helplessness (Herman, 1992; Morrison, 2006; Rothschild, 2000). This can result in disruptions within that person's ongoing experiences and development, including profound alterations to their brain and psychobiology, as well as loss of identity and sense of self (Levine, 1997; deVries, 1996; van der Kolk, 1996).

### **Vicarious Trauma**

Vicarious trauma is the transmission of traumatic stress through observing, exposing oneself to, and/or hearing stories of traumatic events or suffering of an individual, and the resulting changes that may occur in your thoughts, feelings, body, relationships and beliefs about yourself, others, the world, and the future (McCann & Pearlman, 1990; Forester, 2007; van Dernoot Lipsky, 2009).



## Appendix B

### Recruitment Email

Greetings,

My name is Ambryn Melius and I am a graduate student in the Dance/Movement Therapy and Counseling program at Columbia College Chicago. I write to extend a warm invitation to participate in my emerging research study exploring the phenomenon of vicarious trauma for providers. You're being invited to participate because you are a provider who either currently works or has worked with individuals who have experienced trauma.

The purpose of this study is to gather first-hand accounts and narratives from providers, like you, who have experienced vicarious trauma as a result of their work. The study further intends to focus on the role of the body and narrative process in these experiences, along with addressing the impacts and potential shifting of vicarious trauma.

In order to participate in this study, you must first self-identify as having experienced vicarious trauma, as operationally defined for this study:

Vicarious trauma is the transmission of traumatic stress through observing, exposing oneself to, and/or hearing stories of traumatic events or suffering of an individual, and the resulting changes that may occur in your thoughts, feelings, body, relationships and beliefs about yourself, others, the world, and the future.

If you self-identify as having experienced vicarious trauma as stated above, you must also identify as either; 1) Not currently experiencing vicarious trauma symptoms, or 2) currently experiencing vicarious trauma symptoms, but also engaged in therapy or counseling support outside of the study. Since the role of the main researcher is not intended to offer additional clinical support, you will be provided with information for accessible counseling and therapy centers to utilize, if needed, throughout the study.

If you self-identify with the above qualifiers and remain interested in participating in this study, please refer to the attached informed consent form for further details. I greatly appreciate your response to this invitation within a week of having received it. Please feel free to contact me with further questions about the study or the informed consent form.

Thank you for your consideration and for the important work you do.

With appreciation, Ambryn D Melius



C O L L E G E C H I C A G O

## Informed Consent Form

Consent Form for Participation in a Research Study

### **Title of Research Project:**

The Lived Experience of Vicarious Trauma for Providers: A Narrative Phenomenological Study

**Main Researcher:** Ambryn Melius

**Faculty Advisor:** Kyla Gilmore, LCPC, BC-DMT

**Chair of Thesis Committee:** Laura Downey, BC-DMT, LPC, GL-CMA

### **INTRODUCTION**

You are invited to participate in a research study to explore the phenomenon of vicarious trauma in providers who have worked or are currently working with individuals who have experienced trauma. This consent form will give you the information you will need to understand why this study is being done and why you are being invited to participate. It will also describe what you will need to do to participate and any known risks, inconveniences or discomforts that you may have while participating. You are encouraged to take some time to think this over. You are also encouraged to ask questions now and at any time. If you decide to participate, you will be asked to sign this form and it will be a record of your agreement to participate. This process is called 'informed consent.' You will receive a copy of this form for your records.

You are being asked to participate because you are a provider who either currently works or has worked with individuals who have experienced trauma. Based on participatory action research methodology theories, you will be considered and identified as a co-researcher within this research study. As a co-researcher you will be included as a collaborator throughout the entire research study, with importance placed on your first-hand experience, reflections and feedback as a foundation of the research process.

### **PURPOSE OF THE STUDY**

The purpose of this research study is to gather first-hand accounts and stories from providers who have experienced vicarious trauma as a result of their work with individuals who have experienced trauma. Further study explorations will focus on the

role of the body and narrative process in the experience of vicarious trauma, along with addressing the impacts and potential of shifting the experience of vicarious trauma for providers.

## PROCEDURES

If you agree to participate in this study, you will be asked to do the following:

- Self identify as having experienced vicarious trauma as defined by the research study:  
Vicarious trauma is the transmission of traumatic stress through observing, exposing oneself to, and/or hearing stories of traumatic events or suffering of an individual, and the resulting changes that may occur in your thoughts, feelings, body, relationships and beliefs about yourself, others, the world, and the future.
- If you are currently experiencing vicarious trauma, as defined above, you agree to be engaged in therapy or counseling support outside of the study, and plan to remain engaged in these supportive services throughout the study. You will be provided with contact information for local and accessible therapy and counseling services at the start of the study.
- Participate as a co-researcher in the research study, with involvement within the research process, sharing your feedback, input, recommendations, and concerns throughout the study.
- Utilize outside personal and professional support structures, including counseling or therapy services, as needed during, throughout, and after the research study.
- Participate in an audio taped 1-1.5 hour individual interview, either in person, by phone, or by Skype, to answer 6-8 pre-set interview questions regarding the research topic. Questions will ask about your experiences of vicarious trauma, how this experience affected you, how it may have shifted, and how it relates to your life.
- Grant permission for portions of your interview to be included and possibly quoted in the final presentation of the research study. You will have the choice of whether you prefer to identify yourself or remain anonymous throughout the research study, with opportunity to change your study identification choice at any time throughout the study.
- If over the phone or via Skype, interviews will be conducted in a safe and comfortable setting of your choice, with the main researcher in a private setting at home. If in person, interviews will be conducted in a safe, private, and comfortable setting agreed upon ahead of time by you and the main researcher. Whenever possible, interviews will be scheduled outside of your workplace or professional setting to increase confidentiality and minimize risks of increased stigma or symptoms.
- After your initial interview, you will be contacted again at a later stage of the study to review your written interview narrative, provided to you by the main researcher. You will be invited to provide feedback, clarifications and/or

additional information you feel is relevant to your research data. At this point, you will also be provided an opportunity to review your initial choice of study identification and make any desired changes or withdraw your data.

### **POSSIBLE RISKS OR DISCOMFORTS**

The risks in this study include:

- The interview process, which may bring up physical, emotional, psychological, and social symptoms of your past vicarious trauma experience. These risks may occur immediately, before, during, or after the interview process. The role of the main researcher is not intended to provide clinical and therapeutic support. In order to minimize these risks, you will be provided with a list of local and accessible counseling and therapy centers to utilize, if needed, throughout the research process. You will have permission to choose what you do or don't want to share, and if/when you wish to stop the interview or take breaks.
- Shared details of interview transcriptions, narratives, and quotations in written findings may un-intentionally reveal your identity or the identity of others mentioned in your interview. To minimize this risk, you have the choice to remain anonymous, with pseudonyms assigned to you, or to remain identified by your real name throughout the research process. You will indicate this confidentiality choice in the section below. If at any point in the research process you change your mind regarding this confidentiality choice, you can contact the main researcher and your data will be adjusted accordingly via an updated informed consent form.
- Pseudonyms will be assigned to clients, coworkers, or any other people mentioned by you throughout the interview, along with altering subsequent identifying information of these individuals in both written and audio-recorded data.
- Audio recordings, typed interview data, and study records will be protected via password and firewall protection on the main researcher's computer, with password access only available to the main researcher. When not in use, computer and personal files will be stored in a home office safe located in the main researcher's residence, with access to the safe available only to the main researcher.

Possible inconveniences as a result of the study procedures may include the time it takes to complete the interviews, the time it takes to review written narratives, and any unforeseen interruptions.

### **POSSIBLE BENEFITS**

The possible benefits of being in this study include:

- Sharing your vicarious trauma experiences in a safe, supportive environment, outside of your workplace and professional setting, with a witness.

- The opportunity for potential relief, respite, and transformation of physical, emotional, psychological, and social symptoms or negative impacts from your experience of vicarious trauma.
- Contribution to the increased acknowledgement, understanding, and accountability of vicarious trauma on individual, organizational, and societal levels.
- Contribution to the increased knowledge of the role of the body and narrative process in the experience of vicarious trauma.
- Contribution to future research and programming related to addressing vicarious trauma for providers, including possible dance/movement therapy methods, programming, and research.

### **CONFIDENTIALITY**

As a co-researcher in this research study, you have the choice of to be identified by your real name OR choose a different name (pseudonym) to accompany your interview data. At any time in the research process, you can decide to change your identification preference by contacting the main researcher and an updated informed consent form will be completed.

Please check **one** option below:

\_\_\_\_\_ I prefer to be identified by my real name, including any other identifying information, when the main researcher is writing about me or talking about me with others, such as the main researcher's supervisors.

\_\_\_\_\_ I prefer to be assigned a different name (pseudonym), including changing any other identifying information about me, when the main researcher is writing about me or talking about me with others, such as the main researcher's supervisors.

- In order to protect co-researcher privacy and confidentiality, audio recordings and written interview data will be located on the main researcher's password protected computer, while backup and paper study documents will be stored in a locked home office safe located in the main researcher's residence. Because this study will involve the use of the internet, email communication, and electronic record keeping, firewall protection on the main researcher's computer will help provide as much confidentiality as possible. No co-researcher contact information will be saved via cell phone records, with all records of co-researcher phone communication deleted immediately after each call.
- Study records will be kept for two years in a locked home safe in the main researchers home, with access available only to the main researcher. Audio taped interviews will be transcribed and viewed only by the main researcher and stored via main researchers password protected computer. When not in use any audio recording equipment, including tapes, will also be stored in a locked home office safe located in the main researcher's residence.
- Personal study notes may be kept indefinitely with the data stripped of all identifiable information. When not in use, personal study notes will also be stored in a locked home office safe located in the main researcher's residence.

- When study data is released, it will be furnished to the main researcher's Faculty Advisor, Kyla Gilmore, LCPC, BC-DMT, and to the Columbia College Chicago Dance/Movement Therapy and Counseling Thesis Committee. Information to be furnished will include selected interview narrative data, direct interview quotes, nonverbal body and somatic observations, along with data analysis and research findings. If provided by co-researchers, additional creative and visual representations may also be furnished. The purpose of this disclosure is to represent and share, as accurately and authentically as possible, the experiences and stories of vicarious trauma provided by co-researchers. The confidentiality choice of each individual co-researcher, as indicated on their consent form, will be honored in regards to use of names and identifying information in the study.
- In the situations of reports of child abuse and neglect, or harm to self or others, confidentiality cannot be guaranteed.

The following procedures will be used to protect the confidentiality of your information:

1. The main researcher will keep all electronic interview, narrative, and study records on main researcher's personal computer with password and firewall protection, with password only available to main researcher. When not in use, main researcher computer and other written study records or backup study files will be stored in a locked home office safe in the main researcher's residence. Access to this home office safe will only be available to the main researcher.
2. Any audiotapes will be destroyed after two years.
3. Information about you that will be shared with others will respect your confidentiality choice as indicated on this consent form. If at any point in the research process you change your mind regarding this confidentiality choice, you can contact the main researcher and use of your identifying name will be adjusted accordingly.
4. Pseudonyms will be assigned to clients, coworkers, or any other people mentioned by you throughout the interview, along with altering subsequent identifying information of these individuals in both written and audio-recorded data.
5. No one else besides the main researcher and you as a co-researcher will have access to your original data.
6. At the end of this study, the main researcher may publish their findings. Your identification choice as indicated on this consent form, along with any possible changes to this choice throughout the study, will be respected in any future publications or presentations.

### **RIGHTS**

Being a co-researcher in this study is voluntary. You may choose to withdraw from the study at any time without penalty. You may also refuse to participate at any time without penalty. You may contact the main researcher with questions or changes related to your choice of how you continue to be identified throughout the research study.

We will be happy to answer any question(s) you have about this study. We appreciate your response to this informed consent form within a week of receiving. If you have further questions about this project or if you have a research-related problem, you may contact the main researcher, Ambryn Melius, or the faculty advisor, Kyla Gilmore, LCPC, BC-DMT. If you have any questions concerning your rights as a research subject, you may contact the Columbia College Chicago Institutional Review Board staff (IRB).

**COST OR COMMITMENT**

- You may incur minimal fees from your involvement in this research study, such as parking fees, public transit costs, or cell phone charges.
- The time commitment includes the travel time to and from potential interview location, 1-1.5 hour interview, and additional time for future narrative data review.

**PARTICIPANT STATEMENT**

This study has been explained to me. I volunteer to take part in this research. I have had opportunity to ask questions. If I have questions later about the research or my rights as a research participant, I can ask one of the contacts listed above. I understand that I may withdraw from the study or refuse to participate at any time without penalty. I will receive a copy of this consent form.

\_\_\_\_\_  
Co-researcher Signature

\_\_\_\_\_  
Print Name:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Main Researcher  
Signature

\_\_\_\_\_  
Print Name:

\_\_\_\_\_  
Date

Appendix D

Interview Questions

**The Lived Experience of Vicarious Trauma for Providers:  
A Narrative Phenomenological Study**

Ambryn Melius

---

Date: \_\_\_\_\_ Interview location/mode: \_\_\_\_\_

Co-researcher  
name/pseudonym: \_\_\_\_\_

Provider title during vicarious trauma experience: \_\_\_\_\_

City: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Race: \_\_\_\_\_

---

- What do you hope to gain from this study?
- Can you describe a time in your life when you experienced vicarious trauma?  
What were the qualities that encapsulated that experience?
- Can you recall images and/or body sensations connected to your vicarious trauma experience?  
Are you aware of anything in your body right now?
- How did you shift vicarious trauma?
- When you think back to when you were experiencing vicarious trauma, can you identify what might have been helpful?
- How has vicarious trauma influenced your life?  
Ideas about yourself? Relationships? The future?
- What is most important to you about your telling of this experience?
- What about your experience do you most want to be heard?



## Appendix E

### Narrative Feedback Letter and Questionnaire

January 2013

Cheers!

I hope this note finds you very well and taking good care in the New Year.

I have completed eleven provider interviews and am moving into the next phase of my thesis research! This phase includes sharing your vicarious trauma narrative with you for feedback and review.

To construct each narrative, I returned to the audio recording of our in-person interview together and transcribed the most substantial and potent parts of the interview-those intersections of the verbal content, audible cues, and my own somatic/body cues while listening. These potent sections are what is included below and have become your narrative.

#### Coding Key

*Italics*=content, audible, and somatic emphasis

CAPS=my insertion for reading clarity or flow

( )=laughter, movement, etc.

.....=significant pause and space

The intentions of this process are to reconnect with you, provide you a chance to receive your narrative, and most importantly, collect any and all feedback you may have, both about your narrative and your experience of reading your narrative.

This step also serves to increase my research validity, along with further including you as a study co-researcher.

I appreciate you taking the time to read your narrative, preferably in a comfortable, safe, and supportive space, and sending your honest feedback to me **within the next two weeks**. Use the questions below to assist OR share freely on a separate page. I can accept your response via email or via mail.

- 
- What comes up for you as you read your narrative?
  - Share any specific feedback about your narrative, including any or all of the following:
    - Additions and/or subtractions to the written content.
    - Contextual information about any part of the narrative.
    - Anything that has surfaced for you regarding your vicarious trauma experiences in the time between our interview and now.

Appendix F  
Cover Sheet Template

<u>Audio Interview</u>	<u>Embodied Writing</u>	<u>Interview Notes</u>	<u>Provider Feedback</u>	<u>OTHER</u>

## Appendix G

### Additional Thematic Categories

#### **A) Coping with Vicarious Trauma: What helps?**

- 1) Increased agency and choice
- 2) Supportive, like-minded colleagues
- 3) Normalizing experiences of vicarious trauma
- 4) Meaning-making/Existential questions: connecting with human experience
- 5) Interview and narrative as impetus for increased self-care
- 6) Engaging the body; gym, run, walk, move

#### Others:

- Acceptance (of the situation, of oneself)
- Focus on own learning
- Finding joy/purpose in work
- Finding energy state/somatic release within vicarious trauma
- Boundaries/Attention/Focus
- Gratitude
- Rituals

#### **Body/Nonverbal:**

- 1) Deceleration
- 2) Decreasing Pressure
- 3) Increasing→Decreasing Pressure
- 4) Free Flow

#### **B) Vicarious Trauma and Personal Relationships, Family, Social Life**

- 1) Increased compassion, perspective, patience for others/friends
- 2) Difficulties interacting/socializing with others:
  - “most people don’t hear about it [trauma]...” “less capacity for small talk”
  - “harder to live in pretense” “shit isn’t as important anymore...” “less patience for friends”
- 3) Family challenges
- 4) Isolation from family, partner, friends, others

#### **C) The Role of Systemic Issues, Organizational Culture/Administration**

- 1) Inadequacies of the System
  - “not enough messages” “pressure to do more” “system setting you up to fail”
  - “invisible at work” “system inadequacies” “inadequate funding”
  - “client not traumatized enough for service...”

2) Lack of Organizational/Administrative Support

“minimized” “no room for growth, no support” “you’re too sensitive”  
“hopeless” “suck it up...vicarious trauma is a weakness” “lack of support”

“You know, are you crossing all your *t*’s and dotting all your *i*’s? If you didn’t, they would throw you under the bus, so you’re dealing with this absolute messiness of people’s lives, trying to help, and then if you didn’t document something right, regardless of whether you’re doing the job right, you would get thrown under the bus. There was always this looming threat of professional trauma, if you will, which means not being able to pay for your mortgage or something like that...”

3) Ethical Tensions: containment model

“should I be restraining kids?”  
“trying to dysregulate kids...into explosive release, potentially re-traumatizing...kids escalate, become unsafe, we contain...terrible”

3) Stigma

“suck it up...vicarious trauma is a weakness”  
“ok to burnout, but too vulnerable to be vicariously traumatized”

4) Cultural Issues

“un-winnable” “clients will beat your ass...”

5) Primary Trauma at work

“I felt unsafe”

**D) Vicarious Trauma as a Label/Term**

Label is positive: (3/11)

“I like the term vicarious trauma...helps me let go responsibility...the trauma isn’t mine” “it validates vicarious trauma”

Label is problematic: (2/11)

“dangerous...wrong words...trauma not expected”  
“label is too solid, concrete...is harmful” “we need to expand the labels”

Labels are too open-ended: (2/11)

“definitions remain vast and varies...highlights the nebulous nature of vicarious trauma”  
“vicarious trauma is not well documented...we’re never gonna get anywhere unless we address that”

No mention/stated opinion: (4/11)