

## **Vicarious Trauma: Emotional Disruption and Approaches to Coping**

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Counselors attend to a variety of client situations in which exposure to traumatic information is frequent. A broad base of research exists regarding direct trauma experiences and research is beginning to examine its impact on the counselor. This paper explores a potentially pervasive and damaging condition referred to as vicarious traumatization. The underlying notion behind vicarious trauma suggests that counselors working with trauma survivors may be significantly impacted by repeated exposure to the trauma their clients share in session. The authors explore a foundation of clinical and anecdotal support and discuss construct clarity and research methodology. Suggested coping strategies are discussed along with the important recognition of underutilization. Information on coping is followed by a discussion focused on a new perspective, that of promoting the positive and beneficial aspects of trauma work in an effort to more fully understand the complexities of trauma work. Finally, recommendations for further research are presented and the need for additional information on specific populations discussed.

*Keywords:* vicarious traumatization, trauma, self-care, occupational stress

*“The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet” (Remen, 2006).*

### **Vicarious Trauma: Emotional Disruption and Approaches to Coping**

A traumatic situation is typically defined as an event in which an individual experiences an actual or perceived threat of serious injury or death (American Psychiatric Association, 2013). Exposure to trauma and traumatic situations permeates the work of mental health clinicians. Whether dealing with violence or other traumatic situations, counselors enter into intense, empathetic professional relationships with their clients resulting in exposure to a variety of hardships and incidences of suffering. Furthermore, widespread violence in our society results in the regular provision of services for trauma survivors (Brady, Guy, Poelstra, & Brokaw, 1999).

Trauma occurs on many different levels. First, the Federal Bureau of Investigation (2010) in 2009 reported 806,843 aggravated assaults, 408,217 robberies, 88,097 forcible rapes, and 15,241 murders/manslaughters in the United States. Second, 144 natural disaster events occurring since 1980 reached the billion-dollar level or higher (National Climate Data Center, 2013). In fact, natural disasters in particular accounted for over 1,000 deaths during the previous two years. Third, worldwide terror incidents in 2009 numbered close to 11,000. These incidents impacted over 58,000 victims (National Counterterrorism Center, 2010). Additionally, military

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operations occurring around the world related to this terrorist activity and other foreign issues resulted in countless exposure to extreme situations and events for military personnel. This population includes war veterans who often experience a variety of related struggles, including PTSD symptomatology (Wood, 2013). Researchers confirmed that typical trauma scenarios encountered in the counseling setting include clients exposed to physical and sexual abuse, domestic violence, school or work related violence, war conflict, and natural disasters such as earthquakes and tornadoes (Trippany, White Kress, & Wilcoxon, 2004). Finally, Somer (2008) pointed out that prejudice and racism contribute to intergenerational or multicultural trauma. The implication, as noted by Trippany et al. (2004), suggests "...counselors in virtually all settings work with clients who are survivors of trauma" (p.31).

The purpose of this paper is to examine what is known about vicarious traumatization, a concept that asserts that counselors may experience a negative and substantial impact from repeated exposure to their clients' trauma material (McCann & Pearlman, 1990). A definition, explanation of the process, and a summary of the research are provided. In addition, the authors discuss strategies for coping with and preventing vicarious traumatization. Finally, a discussion offering a new perspective highlighting the benefits and strengths that may emerge from working with clients who survive trauma is presented. Many opportunities exist for the counselor's growth while involved in this difficult work.

Mental health literature describes the *helper* in a variety of ways, including therapist, counselor, psychologist, clinician, or helping professional. For the sake of focus and continuity, we use *counselor* throughout to characterize the helper. Additionally, *trauma material* is used to reference the issues exposed in the therapeutic environment by trauma survivors. Since this work focuses on *vicarious traumatization*, literature omitted included crisis response, direct trauma experience, and overlapping definition/constructs (i.e., compassion fatigue, secondary trauma, burnout, etc.).

### **Conceptualization of Vicarious Traumatization**

While counselors customarily work with emotional struggles, they must often focus on assisting clients with more severe levels of trauma exposure. Sexton (1999) noted, "...therapists are being called upon to assist survivors of violent crime, natural disasters, childhood abuse, torture, acts of genocide, as well as refugees and war-trauma victims" (p. 393). Much of the previous research in the area of trauma focused on the direct impact to the survivor (Iliffe & Steed, 2000). Additionally, many researchers examined issues or developed systems for responding to the mental health needs of workers dealing with crisis situations (North, 2010; VandePol, Labardee, & Gist, 2006; Vernberg, Jacobs, Watson, Layne, Pynoos, Steinberg, Brymer, Osofsky, & Ruzek, 2008).

McCann and Pearlman (1990) first identified and defined the psychological impact of trauma work, developing a model that articulated the symptoms and unavoidable process in what they termed *vicarious traumatization*. The underlying notion behind vicarious traumatization suggests that counselors working with trauma survivors may be significantly impacted by repeated exposure to the trauma experiences of their clients (Brady et al., 1999; Culver, McKinney, & Paradise, 2011; McCann & Pearlman, 1990). Vicarious traumatization develops as a response to specific information coming from clients and occurs in service providers working with trauma survivors (McCann & Pearlman, 1990; Trippany et al., 2004). McCann and Pearlman (1990) emphasized that the impact of working with trauma survivors differs from that

of other populations “because the therapist is exposed to the emotionally shocking images of horror and suffering that are characteristic of serious trauma” (p. 134).

The problem of vicarious traumatization is twofold. First, a potential negative impact exists for the counselor. Vicarious trauma possesses the potential to permeate the counselor’s worldview (Harrison & Westwood, 2009) with a pervasive ability to affect multiple areas of a counselor’s life (McCann & Pearlman, 1990; Trippany et al., 2004). Others suggested that these worldview changes impact counselors’ existential and spiritual dimensions (Decker, 1993; Herman, 1992). It tends to develop gradually, is cumulative in nature and may be permanent in the absence of intervention (Adams & Riggs, 2008; McCann & Pearlman, 1990). As such, vicarious trauma is currently viewed as an occupational hazard (Bride & Walls, 2006). Researchers cautioned that even though vicarious traumatization can have a significant impact on the counselor, it does not necessarily portend the development of psychopathology and should instead be viewed as a normal reaction to work with trauma material (Baird & Kracen, 2006; Pearlman & Mac Ian, 1995; Trippany et al. 2004). Second, vicarious traumatization may lead to a counselor becoming compromised or even impaired in his or her ability to fully and mindfully attend to client’s disclosures, and thus negatively impact the overall provision of care (Sexton, 1999; Somer, 2008). Disruptions in perception, decreased empathic abilities, defensive reactions, and a decreased concern for clients may occur in counselors suffering from vicarious trauma (Culver et al., 2011; Trippany et al., 2004; Sexton, 1999).

A lack of clarity regarding the construct of vicarious traumatization presents one of the significant challenges in this area of research (Lerias & Byrne, 2003). Previous studies explored a number of concepts related to trauma work such as compassion fatigue, secondary trauma, burnout, and countertransference. Many of these concepts overlap one another in various ways, and in the case of vicarious traumatization, it is often used interchangeably with compassion fatigue and secondary trauma, especially in earlier studies (Trippany et al., 2004). However, there are important operational delineations.

Several authors emphasized that the widely held notion of vicarious traumatization as developed by McCann and Pearlman (1990) tends to be more encompassing (Trippany et al., 2004). While burnout describes a gradual and prolonged process, researchers suggest vicarious traumatization may have a sudden onset, has the potential to impact the counselor in several aspects including their life outside work, and may be pervasive (Harrison & Westwood, 2009; McCann & Pearlman, 1990; Trippany et al., 2004). Vicarious traumatization differs from countertransference because it is a reaction to external client information, not to the personal life experiences of the counselor (Harrison & Westwood, 2009; Trippany et al., 2004). Therefore, a central feature of vicarious traumatization is that it originates from issues occurring outside the counselor. Examining the psychological impact vis a vis the process of vicarious traumatization provides insight into these differences.

### **Psychological Impact: The Process of Vicarious Traumatization**

McCann and Pearlman (1990) proposed a theoretical model for what occurs in counselors working with trauma material. This work is foundational to our current understanding of the underlying process of vicarious trauma and to date most subsequent research has been conducted within this framework (Robinson-Keilig, 2014). They developed a constructivist self-development theory based upon the idea that human beings construct their own personal realities. They explained the theory is “...interactive in that it views the therapist’s unique responses to client material as shaped by both characteristics of the situation and the therapist’s unique

psychological needs and cognitive schemas” (p. 136). This results in a constantly evolving framework that enables one to make sense of the world and understand events through beliefs and expectations (Astin, 1997; McCann & Pearlman, 1990). Continued experiences contribute to cognitive schemas that evolve and become increasingly complex over time (McCann & Pearlman, 1990).

Changes to cognitive schemas are central to the development of vicarious traumatization in counselors especially as they relate to psychological needs, disruptions, and memory. For example, McCann and Pearlman (1990) explained that research in the area of trauma points to several fundamental psychological needs including safety, trust, power, esteem, intimacy, independence, and frame of reference. The aforementioned schemas are expressions of these needs and may be disrupted by trauma. This disruption tends to be unique and will differ between individuals based on experience and the need areas most salient for them (McCann & Pearlman, 1990; Moulden & Firestone, 2007; Steed & Downing, 1998; Trippany et al., 2004). For instance, a counselor who is faced with a steady stream of traumatic material may begin to perceive that their own worldviews related to safety and trust are changing in a more pessimistic direction. Schemas are ever-evolving and represent the ongoing creation of our personal identities. In the case of trauma, “preoccupation with clients’ traumatic material often interferes with a therapist’s ability to be fully conscious and involved in his or her own life experiences” (Heese, 2002, p. 298). Empathy, serving as the foundation of therapeutic work, provides a direct conduit through which client trauma may be experienced (Hernandez-Wolfe, Killian, Engstrom, & Gangsei, 2015; Williams, Helm, & Clemens, 2012), allowing for an increased level of experiencing relative to the trauma material. Resulting changes may include increased emotional distance from others, cynicism, loss of hope and optimism, general emotional numbness, and increased vulnerability (Heese, 2002; Kaplan, 2015).

Another example provided by Astin (1997) offered an illustration of schema disruption and how schemas change through the process of assimilation and accommodation. Briefly, assimilation refers to the process of incorporating new information without changing internal structures, while accommodation describes the process of forcing change to internal structures in order to incorporate new information. One way to illustrate the trauma process is by referencing the “just world theory”, a schema that suggests the world is fair and just or “good things happen to good people and bad things happen to bad people” (p. 104). A survivor subscribing to this belief might be left without a way to fully understand what has happened during the trauma. Disruption occurs when presented with unimaginably difficult information (Kaplan, 2015). Essentially, the trauma experience conflicts with the currently held schema. Astin (1997) observed that rape survivors tended to over-accommodate in response to their experiences and realized during the course of treating these clients that her own schema changed as well. Also witnessed were various ways in which over-accommodation, as a vicarious reaction, manifested itself emotionally as indicated by tense and irritable feelings, trouble sleeping and intrusive thoughts related to the experiences of clients (Astin, 1997). As counselors accommodate or learn information about the traumatic events experienced by their clients, they may find their positions on trust, safety, self-understanding, and sense of control challenged and disrupted. Ultimately, the identity and worldview of counselors may be altered in significantly less adaptive ways (Heese, 2002; Kaplan, 2015).

Additionally, McCann & Pearlman (1990) suggested that changes occur in the memory system as well. They believed counselors “who listen to accounts of victimization may internalize the memories of their clients and may have their own memory systems altered

temporarily or permanently” (p. 142). Other researchers also suggested that taking in clients’ traumatic material may lead counselors to form images within their memory systems that are later recalled as their own (Moulden & Firestone, 2007). These memories can then contribute to further changes in cognitive schema(s) (McCann & Pearlman, 1990).

Sexton (1999) summarized that counselors may ultimately, “...begin to experience feelings of fear, pain and suffering similar to those of their clients, and to experience similar trauma symptoms ... as well as changes in their relationships with the wider community, their colleagues, and their families” (p.393). Vicarious trauma may manifest through a threatened sense of safety and security, decreased emotional accessibility, and compromised professional conduct (Astin, 1997; Iliffe & Steed, 2000; Trippany et al., 2004). Psychological domains potentially impacted may include “affect tolerance, fundamental psychological needs, deeply held beliefs about self and others, interpersonal relationships, internal imagery, and experience of their body and physical presence in the world” (Steed & Downing, 1998, p. 2). Changes to identity, worldview, spirituality, relationship needs, and the understanding of world events may also occur (Pearlman & Saakvitne, 1995). Finally, other symptoms may include nausea, headaches, exhaustion, anxiety, suspiciousness, depression, intrusive thoughts and feelings, avoidance, and feelings of personal vulnerability (Adams & Riggs, 2008; Iliffe & Steed, 2008; Pearlman & Mac Ian, 1995).

In summary, vicarious trauma is implicated in a number of adverse reactions as a consequence of working with trauma material. In the course of bearing witness to the pain and fear of trauma clients, subsequent reactions have implications for the counselor’s life outside of their work with those clients. The disruption to a counselor’s worldview is a serious consideration as it has implications for the counselor’s wellbeing as well as the care received by clients. To date, the examination of vicarious trauma has been conducted almost entirely from a cognitive and constructivist viewpoint. The next section examines research evidence on this phenomenon.

### **Summary of the Empirical Research**

While there is a wealth of clinical and anecdotal support for the concept of vicarious traumatization (Jordan, 2010; Sexton, 1999; Steed & Downing, 1998), there is a paucity of formal empirical research (Brady et al., 1999; Iliffe & Steed, 2000; Moulden & Firestone, 2007; Pearlman & Mac Ian, 1995; Steed & Downing, 1998). This is also true of studies that explored causation and mitigation factors (Harrison & Westwood, 2009). The research generally yields inconsistent findings regarding the impact of working with trauma (Brady et al., 1999). Additionally, empirical findings in this area tend to be compromised by design issues such as small sample size, and excessive focus on a single theoretical framework, contributing to an inability to generalize or validate results across broader populations (Baird & Kracen, 2006; Harrison & Westwood, 2009; Lerias & Byrne, 2003; Moulden & Firestone, 2007; Steed & Downing, 1998). Furthermore, much of the research is cross-sectional in nature and does not address the etiology of vicarious trauma (Moulden & Firestone, 2007).

Researchers hypothesized several predictive factors for vicarious trauma. These included severity of the disaster, level of empathic engagement, an external locus of control, life experience, gender, perceived threat, degree of exposure, age, previous life stress and mental well-being, social support, negative coping styles, and level of education (Lerias & Byrne, 2003). While some of the research appears to support the consensus thinking on vicarious trauma, other studies do not (Brady et al., 1999). For example, one of the core elements hypothesized in the

development of vicarious trauma centers on the empathy process in counseling; yet other studies suggested deep empathic engagement may act as a protective factor (Harrison & Westwood, 2009). Additionally, Baird and Kracen (2006) performed a meta-analysis of available research and found there was a reasonable level of evidence that suggested the amount of exposure to trauma material is not a factor in vicarious trauma.

Examination of the short research history of vicarious traumatization reveals inconsistent results and various limitations. Research findings included variation and in some cases disagreement over the factors that lead to vicarious trauma. Many of the findings are based upon research with methodological issues. Furthermore, virtually every study reviewed is based upon the constructivist model developed by McCann and Pearlman (1990). This model is stable and has changed little over time. While it has been useful in framing our conceptualization of vicarious trauma, this singular focus limits possible contributions from other perspectives that could inform our understanding of the concept. Researchers also noted the need to begin investigating vicarious trauma from the perspectives of other models in order to validate the constructivist model (Williams et al., 2012). Broader studies will also help shed light on protective strategies to help mitigate the negative impact of vicarious trauma. The next section provides an overview of suggested coping strategies.

### **Coping and Protective Strategies**

The negative impact concerns relative to vicarious trauma naturally lead to questions about effective prevention and treatment. A strong narrative emerged from the literature regarding the importance of ameliorating factors and self-care. Moulden and Firestone (2007) stressed that the "...purpose of examining this phenomenon is to understand what differentiates those who experience lasting trauma reactions from those who do not, and in doing so identify both risk and protective factors" (p. 80). However, most recommendations largely stemmed from anecdotal and clinical points of view. Limited research also exists targeting management and prevention (Trippany et al., 2004).

Some researchers directly explored the experience of vicarious trauma and the role of coping strategies. Adams and Riggs (2008) hypothesized that exploring counselors' defense mechanism styles may shed some light on subsequent vicarious trauma development (or lack thereof). Defense styles of participants in their study were skewed in the direction of adaptive and self-sacrificing tendencies. These styles may be socially beneficial due to their facilitation of interpersonal connection but may leave a person open to emotional vulnerabilities. While generally considered positive, the self-sacrificing style "...was associated with significantly higher levels of trauma symptomatology..." (Adams & Riggs, 2008, p. 31). Harrison and Westwood (2009) examined protective practices, or practices that protect against the formation of vicarious trauma. The study group consisted of 6 "master clinicians" who then completed a three-part interview process. Results pointed to nine major themes as protective practices: 1) countering isolation (professional, personal and spiritual), 2) mindful self-awareness, 3) consciously expanding perspective to embrace complexity, 4) active optimism, 5) holistic self-care, 6) maintaining clear boundaries and honoring limits, 7) exquisite empathy, 8) professional satisfaction, and 9) creating meaning. These practices complimented the findings of Voss Horrell et al. (2011) and their general recommendation of social support and spirituality as important coping strategies. Another study concluded regular attention to wellness across multiple dimensions might serve to prevent the development of vicarious trauma (Williams, Helm, & Clemens, 2012).

Suggested self-care practices to date largely center on awareness, openness and balance. Several researchers noted the importance of peer discussion and other supportive relationships that allow one to work through beliefs challenged or altered by trauma work (Astin, 1997; Harrison & Westwood, 2009; McCann & Pearlman, 1990). Some promoted the need to create balance in their lives and separation from work (Ben-Porat & Itzhaky, 2009; Steed & Downing, 1998). Others espoused the need for balanced caseloads, engagement in diverse professional tasks, maintenance of appropriate boundaries, legitimization of feelings, and increased levels of supervision (Adams & Riggs, 2008; Astin, 1997; Ben-Porat & Itzhaky, 2009; Bober & Regehr, 2006; Iliffe & Steed, 2000; Kaplan, 2015; Sexton, 1999). Finally, researchers also suggested that counselors tailor specific coping strategies based on the negative impact they are experiencing (Kaplan, 2015).

While scholars offered many coping strategies, research findings to date have demonstrated mixed results relative to the effectiveness of these suggested strategies (Bober & Regehr, 2006; Kaplan, 2015). Perhaps more significant, even though participants in one study believed that recommended coping strategies were helpful in mitigating the impact of vicarious trauma, this belief did not translate into more time being devoted to engagement in those activities (Bober & Regehr, 2006). Researchers repeatedly found that the extent of engagement in coping activities was not strong (Bober & Regehr, 2006; Culver et al., 2011). This is indicative of a context in which counselors may focus on client wellness to such an extent that it overshadows their own wellness (Dang & Sangganjanavanich, 2015). Sexton (1999) pointed out that simply having supportive practices in place does not ensure utilization and asserted that organizations have the responsibility to "...foster an environment in which work-related stress is accepted as real and legitimate..." (p. 398).

In summary, scholars identified many coping strategies and protective factors. Recent studies found many of the aforementioned strategies helpful to counselors working in the trauma area (Gerding, 2012). Others found engagement in wellness activities helps to diminish cognitive distortions (Williams et al., 2012). However, the widespread practice of these strategies appears weak. Many of the suggested strategies are anecdotal and generally lack research backing as directly implemented in cases of vicarious trauma. It is important to continue work in this area given that personal wellness is critical to the ability of counselors to render effective service (Dang & Sangganjanavanich, 2015). The next section provides a new framework from which to view trauma work.

### **Wellness and the Embracing of Trauma Work**

The literature to date on vicarious trauma overwhelmingly focused on the potential negative aspects. Little work exists that examines possible areas of growth (Ben-Porat & Itzhaky, 2009). A focus on wellness may offer significant insight into effective protective strategies. While many studies found that counselors became more distrusting because of vicarious traumatization, Steed and Downing (1998) observed that perhaps these counselors simply became more mindful of the realistic concerns reflected by trauma survivors. Also suggested is that researchers failed to draw a distinction between increased awareness and disturbances in cognitive schema. Several of the participants in their study experienced positive changes to their sense of identity, for instance (Steed & Downing, 1998). Astin (1997) suggested that as an outcome of this work, one can "...have the opportunity to live more realistically" (p. 108) relative to trauma experiences. Furthermore, Brady et al. (1999) observed that some counselors with higher exposure to trauma material "...reported a more existentially and spiritually

satisfying life than those with less exposure...” (p. 391). Others asserted there are rewards for those who work with trauma material such as increased appreciation of life, personal growth and enhanced social/political meaning (Herman, 1992; Sexton, 1999; Steed & Downing, 1998).

Mindful practice has received considerable attention in recent years and may be important to mitigating the impact of vicarious trauma as well. Kaplan (2015) noted that mindful practice provides counselors “...with a sense of grounding and safety in their everyday surroundings, and in addressing the disruptions to the memory system that often accompanies vicarious traumatization” (p. 139). Mindfulness also helps counselors with a history of their own trauma maintain an awareness of triggered emotions and memories so they may be addressed, and countertransference minimized (Williams et al., 2012). Other potential benefits of mindful practice include diminished emotional exhaustion, increased self-care and greater acceptance of emotional reactions (Kaplan, 2015). The benefit of increased self-care directly addresses the aforementioned concern about engagement in other coping strategies.

Recent attention focused on vicarious resilience and trauma stewardship. Vicarious resilience is similar to the notion of vicarious trauma. Hernandez, Gangsei, and Engstrom (2007) observed that counselors also learn about overcoming difficulty from their clients. Just as counselors may be transformed negatively by a client’s experience, they may also be transformed positively by engaging with a client effectively working through their difficulties. They argued that vicarious resilience may help counselors feel less victimized by the experiences of their clients, increase motivation for work in this area and encourage better self-care (Hernandez et al., 2007). Others suggested that counselors might come to better recognize their own strengths as they appreciate the strengths of their clients (Silveira & Boyer, 2015). Trauma stewardship reframes the task of trauma work by embracing the idea that pain is an inevitable part of living. van Dernoot and Burk (2009) emphasized that transformation and growth can take place during times of suffering. They encouraged counselors to care for themselves while viewing the opportunity to assist trauma survivors as a “gift”. Hernandez-Wolfe et al. (2015) emphasized, “trauma work is a source of both stress and joy, involving a developing perspective of how one approaches personal challenges” (p. 163). Both of these concepts deserve more attention as potential protective factors in working with survivors of trauma. Viewing the impact of trauma work from this perspective emphasizes a shift toward wellness and the emotional health of counselors.

### **Discussion**

An overwhelming recommendation in the literature is the need for further training, professional development, and inclusion of trauma counseling courses in graduate level academic programs (Adams & Riggs, 2008; Culver et al., 2011; Pearlman & Mac Ian, 1995). Others suggested these training programs should include mindfulness training with attention paid to self-reflection and self-care practices (Harrison & Westwood, 2009), which would address a promising aspect of coping. Some have called for longer term, trauma-focused training for those working in this area (Adams & Riggs, 2008; Somer, 2008). Additionally, examination of vicarious trauma from an ethical standpoint is critical. Somer (2008) asserted that this is mandated by professional organizations. American Psychological Association (APA) guidelines contain a specific point mentioning the training of therapists on coping with exposure to trauma material. Additionally, the American Counseling Association (ACA) and Council for Accreditation of Counseling & Related Educational Programs (CACREP) standards both have guidelines that either directly or indirectly support trauma training (Somer, 2008). While



unknowns remain, the potential impact of vicarious trauma warrants attention on a professional issues (wellness) and ethical (client welfare) basis.

Multicultural considerations remain as a significant gap in the vicarious trauma literature. Most studies approach the topic in a broad way. However, several findings reveal specific areas warranting further investigation. For example, results from one study indicated that older clinicians had lower stress levels (Bober & Regehr, 2006). There also exists some support for spirituality serving as an effective protective factor (Decker, 1993; Kaplan, 2015). Additionally, authors repeatedly noted the importance of therapy for counselors with a personal history of trauma (Bober & Regehr, 2006; Jordan, 2010; Sexton, 1999; Trippany et al., 2004). Kaplan (2015) cautioned against blindly implementing a specific coping strategy for a specific trauma work population (i.e., sexual assault survivors, natural disaster survivors, war violence exposure, etc.) since there is insufficient work examining the efficacy of strategies with different populations.

Additionally, while researchers and scholars suggested coping strategies and advocated a multifaceted wellness model to address challenges and issues these counselors face (Dang & Sangganjanavanich, 2015), there remains a lack of research on a comprehensive or holistic approach to wellness and how it addresses the amelioration of vicarious trauma (Williams et al., 2012). Others called for more attention on the process of vicarious resilience as well and personal factors that may undergird its development (Silveira & Boyer, 2015). Thus, these authors suggest future research explore the positive impact of working with trauma survivors and the complex realities of trauma exposure. This promising area has implications for the expansion of what it means to engage in trauma work.

The research on vicarious traumatization is still in the early stages (Voss Horrell et al., 2011) and the majority of the researchers included in this paper agreed that more research is needed to fully understand the impact of working with trauma material. Lerias and Byrne (2003) asserted, "vicarious...trauma has been assumed to take on the same role or experience for the victim, as direct trauma" (p. 136). Given the theorized potential of vicarious trauma to pervasively disrupt the worldviews of counselors, and the subsequent impact that may have on client care, it is important to move beyond assumptions and generalizations. Efforts to refine and study the construct of vicarious trauma should continue. While the research on vicarious trauma is inconsistent, most observed that trauma work is impactful. Given the prevalence of trauma in our society and the counselor's role in working with survivors, it is imperative to understand the nature and degree of this impact along with mechanisms that may enhance counselor wellness in the face of human suffering.

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