The Experience of Secondary Traumatic Stress in Counselors Who Work With Sexually Abused Adolescents

by

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A Dissertation

In

COUNSELOR EDUCATION AND SUPERVISION

Submitted to the Graduate Faculty of Texas Tech University in Partial Fulfillment of the Requirements for the degree of DOCTOR OF PHILOSOPHY

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May 2015
ACKNOWLEDGEMENTS

I would like to thank The Lord for this opportunity, which I believe was given to us by Him to make an impact on our community as a whole. Without Him, this could have never been possible and I am grateful and humbled that He found us worthy of such an endeavor. To my wonderful husband, Stephen, without whom I could have never completed this journey. My love and appreciation for you has grown beyond belief during this time. Your love, support, and encouragement are without limits and I love you with all of my heart.

To our parents, children and grandchildren, I want to thank you for your encouragement, and love throughout this time. I love you all so very much. We hope that this accomplishment is a continuation of a life legacy that makes you proud of us. To our staff, interns, and fellow counselors, thank you for your time, feedback, endless discussions on our topics, and many hugs. You are all such a blessing to us. You are very special to us and we love sharing our lives with all of you.

To my committee: Dr. Janet Froeschle Hicks, Dr. Charles Crews, and Dr. Lee Duemer, I thank you for your countless hours of phone calls, emails, and words of encouragement. Your expertise, time, and guidance are priceless. I feel truly blessed to have worked alongside you in this research project. To Dr. Marcelo Schmidt, for all of your help and guidance during the last phases of this project. You deserve more credit than you will allow me to give you, so I will simply thank you, knowing that we could not have gotten here without your help. Dr. Stacy Carter, thank you for agreeing to be my Graduate School representative on my defense committee.
I want to say a special thank you to all of my participants. Thank you for your time, insight, and words of wisdom. You were not only helpful in this endeavor, but your insight will bring this topic to a greater light and improve the counseling community as a whole.

To our beloved 2011 cohort, we love you guys and thank you for being there to walk this journey with us. To my special friends Leigh, Melissa, and Nicole, I do not have the words to thank you for the very special things you each did for me during this journey. You all demonstrated a true love not only for research, but also showed a special interest in helping me through this process. You all are precious to me and I thank you so much for your love and support.

And last but not least, to our friend, Steve G., thank you for all of the time, energy and expertise you spent editing and helping me prepare this document for each phase of approval. Your assistance was deeply appreciated and highly valued.

This endeavor was a labor of love and a quest to keep counselors well in the rewarding and challenging field of caring for others, and because of all of you is now complete. Thank you!
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ABSTRACT

The therapeutic treatment of traumatized individuals has steadily increased over the past several decades due to natural disasters, school shootings, and the increase in physical and sexual trauma in communities across America. With this increase has also come a phenomenon known as secondary traumatic stress within the helping professions (Figley, 1995, 1999; Stamm 1995, 1999). This phenomenon, much like Post Traumatic Stress Disorder, has long lasting effects that can be difficult to manage and overcome.

This qualitative study explored the effect of secondary traumatic stress on counselors who specifically treat sexually abused adolescents through interviewing counselors about their experiences and the management of secondary traumatic stress in their lives. Although the research on secondary traumatic stress continues to expand, there have been no grounded theory studies, to present, that have discussed the experience of secondary traumatic stress in counselors who treat sexually traumatized adolescents. The research findings can be utilized to increase awareness of secondary traumatic stress in counselors, aide in implementing further training and graduate school curriculum regarding secondary traumatic stress, and to promote advocacy in the counseling field regarding secondary traumatic stress in counselors.
LIST OF ABBREVIATIONS

ACA – American Counseling Association

APA – American Psychiatric Association

CACREP – Counsel for Accreditation of Counseling and Related Educational Programs

CSA – Child Sexual Abuse

DMS-III/DSM-III-R - Diagnostic and Statistical Manual of Mental Disorders, 3rd ed./ 3rd ed. Revised

DSM-IV/DSM IV-TR - Diagnostic and Statistical Manual of Mental Disorders, 4th ed./ 4th ed. Text Revision

DSM-V – Diagnostic and Statistical Manual of Mental Disorders, 5th edition

LPC – Licensed Professional Counselor

LSOTP – Licensed Sex Offender Treatment Provider

PTSD – Posttraumatic Stress Disorder

STS – Secondary Traumatic Stress

TFBCT – Trauma Focused Cognitive Behavioral Therapy
CHAPTER 1
INTRODUCTION

Professional counselors assist their clients in the development of coping strategies to help them manage issues and traumas that arise in their lives. Professional counselors are trained to guide their clients to gain self-awareness, with the ultimate outcome of therapy being the achievement of client autonomy. In this process, counselors may experience an unexpected personal impact, or trauma due to a lack of their own self-awareness to the information that is shared by the client. Counselors offering support and assistance to their clients who are experiencing an emotional crisis may deplete their own emotional energy and coping resources (Kadambi & Ennis, 2004). In addition, counselors working with victims of sexual trauma carry a high risk of suffering from secondary traumatization, or secondary traumatic stress unless preventive management factors are employed. Effective preventive management factors include: self-care, solid professional training, therapeutic self-awareness, regular self-examination by collegial and external supervision, limiting caseload, continuing professional education and learning new concepts in trauma treatment, maintaining a balance between empathy and a proper professional distance to clients, et cetera (Pross, 2006). Symptoms of secondary traumatic stress may include a sense of isolation and confusion, helplessness, disconnectedness from events that are causing the symptoms, forgetfulness, irritability, apathy, disillusionment, tendency to blame oneself for issues they cannot control, and a feeling that their job is too heavy a burden (Pross, 2006). Figley (1995) states that the confusion, and isolation from friends and relatives, which can create the same symptoms as Post Traumatic Stress Disorder (PTSD) can be distinguished from chronic burnout
syndrome, which can occur in all aid professionals. Additionally, counselors may experience a shift in their perceptions of the world and may experience a heightened sense of personal vulnerability, lack of safety, lack of trust, loss of control, diminished self-esteem, and diminished relationships with others (Van Hook & Rothenburg, 2009). Kleinman and Maeder (1999) call secondarily-traumatized therapists “wounded healers,” who, through their own traumatic experiences, possess a greater capacity for empathy; however, their need to heal others helps them avoid contact with their own unresolved traumas.

Research indicates that academic and supervisory preparation is not adequate to protect a counselor from secondary traumatic stress, and further indicates the necessity for improved preventative educational processes to help counselors with this issue (Bush, 2009; Figely, 1995; Pross, 2006).

Statement of the Problem

The American Counseling Association Code of Ethics (2005; 2014) addresses the concepts of (a) promoting the welfare of clients, and (b) avoiding the harming of clients in the process of counseling services. Mental health professionals are at higher potential risk of experiencing secondary traumatic stress by practicing the vocation they worked so diligently to learn. There is a need to explore the presence of risk levels in the population of counselors in the panhandle of Texas who deal with sexually traumatized clients, the means with which they manage these stressors, and how effectively these management tools work to diminish the effects of the secondary traumatic stress experienced. According to the American Institute of Stress, and the National Child Trauma Stress Network, secondary traumatic stress is the least researched area of traumatology. The
dearth of literature regarding counselor experiences with secondary traumatic stress, specifically, shows this to be an under-researched area.

**Significance of the Study**

Kleinman and Maeder (1999) refer to secondarily-traumatized therapists as wounded healers. These are people who, through their own traumatic experiences, possess a greater capacity for empathy; however, their need to heal others helps them avoid contact with their own unresolved traumas (Pross, 2006). Figley (2002) stated the importance for “us to elevate these issues to a greater level of awareness in the helping professions. Otherwise, we will lose clients and compassionate psychotherapists” (p. 1440). Figley (1995), also, states that secondary traumatic stress is an occupational hazard to the profession of counseling, and there is a general consensus in the literature that professional caregiving, such as counseling, has negative associated effects.

This study, in essence, gave depth to the current literature by studying the ways in which trauma-informed treatment providers, in the Texas panhandle, respond to and manage their own secondary traumatic stress. This study identified patterns in the coping skills and management tools that work on the individual level, as well as on a more universal level. Additionally, the study identified skills and tools that are not productive. This study focused on counselors who have been in the counseling field for more than two years.

**Purpose of the Study**

There have been few studies of secondary traumatization among those who treat victims of extreme violence (Pross, 2006). There is some research that addresses secondary traumatic stress in first responders, law enforcement, emergency room
personnel, forensic interviewers, nurses, hospice care workers, and other respondent type professions; however, there is a paucity of research specific to how secondary traumatic stress impacts counselors and how they can best manage the effects of this phenomenon, causing the need for this study.

The purpose of this study was to determine some of the effective skills counselors utilize to manage secondary traumatic stress experienced in their practices.

**Research Questions**

This study sought to answer the following questions:

1. What identifiable traits are present in counselors who experience secondary trauma stress when counseling victims of sexual trauma?

2. What particular skills do counselors who manage secondary traumatic stress utilize?

3. What identified skills were noted as acquired in graduate school? Post graduate school?

**Theoretical Framework**

The theoretical framework used in this study was qualitative with a grounded theory focus. Grounded theory operates almost in a reverse fashion from traditional social science research. Charmaz (2006) posits the purpose of grounded theory as the expression of the association between conceptual categories and the specific conditions under which theoretical relationships arise, change, or are preserved. Rather than beginning with a hypothesis, the first step is data collection through a variety of methods. This information is then organized into categories (Glaser & Strauss, 1967). The emphasis remains on the data, while themes and interpretations emerge from the data.
This process “grounds” the categories to the data from which they are derived (Berg & Lune, 2012), thus developing a theory by which the research is interpreted and completed. The consistent utilization of a constant comparative method takes place through the interpretive process and is completed in different forms (Glaser & Strauss, 1967). This contradicts the traditional model of research, where the researcher chooses a theoretical framework, and only then applies this model to the phenomenon to be studied. However, this process provides a guideline to “understand people’s experiences in as rigorous and detailed a manner as possible by identifying categories and concepts that emerge from text and link these concepts into substantive and formal theories” (Denzin & Lincoln, 2005, p. 782).

Assumptions

Several assumptions were apparent in this research study. First, it was assumed that secondary traumatic stress would be present in counselors who work with sexually traumatized adolescents. Secondly, it was assumed that this form of secondary traumatic stress would differ from other secondary traumatic stress experiences of other counselors. Finally, it was assumed that because of the secondary traumatic stress experienced, the counselors would have certain methods by which they managed this phenomenon.

Delimitations

One of the research delimitations present in this research study was conducted on counselors in the Texas panhandle. Because it is only from one region of the United States, the research findings may not be transferable to other regions in the United States. Another delimitation of this study involves the data collection methods. Data was
gathered through semi-structured, in-depth interviews that relied on the participants’ willingness to be open and honest in relaying their experiences to the interviewer.

**Limitations**

Several limitations that impacted the findings are implicit in this research study. First, the data was collected utilizing in-depth, self-report interviews of the participants in an area of the country that values individual strength and resilience in professional counselors. Second, the findings of this research are not generalizable to other areas of the state or country based on the qualitative basis of the study. Third, based on interactions with the participants (counselors), being that the researcher was, also, a counselor, the researcher could show bias in favor of the participants and empathize with the participants too closely. Finally, a limitation to the research is related to utilizing purposeful sampling methods. The convenience related to utilizing purposeful sampling methods also limits the sample by which this researcher will have the opportunity to enlist in the research.

**Definition of Terms**

- **Adolescent/Adolescence.** Defined as the period of life between 10 and 21 years of age though slight variations are frequently reported (Flannery, Torquati & Lindemeier, 1994). For the purposes of this study, adolescents will be defined as young persons between the ages of 10 and 17 years of age, which is within the age range as stated by Flannery, et al. (1994).

- **Burnout.** Defined, specifically in mental health professionals, as the syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment
(Rank et al., 2009). Gentry and Baranowsky (1998) defined burnout, to include, the chronic condition of perceived demands outweighing perceived resources.

- **Compassion.** Lies at the core of what it means to be human, seen as a state induced by another person’s suffering, a painful emotion that one person experiences for another (Kanov, Maitlis, Worline, Dutton, Frost, & Lilius, 2004). This is coupled with the wish to relieve the suffering (Alkema, Linton, & Davies, 2008).

- **Compassion Fatigue.** A state experienced by those helping people in distress; it is an extreme state of tension and preoccupation with the suffering of those being helped to the degree that it is traumatizing for the helper (Figley, 1995).

- **Empathy.** The feeling of emotional concern for others (Pulos, Elison, & Lennon, 2004). A person’s feelings of warmth, compassion, and concern for others (Davis, 1980). This is considered to be a key common factor in developing a working alliance and positive counseling outcomes (Hatcher, Favorite, Hardy, Goode, Deshelter, & Thomas, 2005).

- **Personal Distress.** The negative feelings in response to the distress of others (Pulos et al., 2004). Personal feelings of anxiety and discomfort that result from experiencing another’s negative event (Davis, 1980).

- **Professional Counselor.** A professional who has earned a Master’s degree, or Ph.D. in counseling and met criteria for the state credential of Licensed Professional Counselor.

- **Secondary Traumatic Stress (STS).** STS refers to those who come into continued close contact with trauma survivors and their stories, including their
oral and visual evidence. STS is viewed as an occupational hazard of providing direct services to a traumatized population. It is a natural, consequent behavior and emotion resulting from knowledge about a traumatizing event experienced by another person and it is the stress resulting from helping or wanting to help a traumatized or suffering person (Figley, 1995).

- **Self-Care/Coping Strategies.** Engaging in healthy behaviors so that a person holistically takes care of their personal needs (Alkema, Linton, & Davies, 2008). This includes but is not limited to: managing boundaries, ethical decisions, time management, taking time for self-pleasure, balancing work and personal issues and time, meditating, visualization, engaging in support networks both personal and professional, debriefing, humor, creative activities, and self-awareness.

- **Self-Efficacy.** The beliefs or judgments one had about his or her capabilities to effectively counsel a client (Greason & Cashwell, 2009). It is the primary mechanism between knowing how to help and to execute effective counseling actions (Greason & Cashwell 2009). Self-Efficacy is assumed to affect aspects of counselor clinical functioning (cognitive, affective, and clinical behavioral responses) (Lent, Hill, & Hoffman, 2003).

- **Sex Offender Treatment Provider.** "Sex offender treatment provider" means a person, licensed by the council and recognized based on training and experience to provide assessment and treatment to adult sex offenders or juveniles with sexual behavioral problems who have been convicted, adjudicated, awarded deferred adjudication, or referred by a state agency or a court, and licensed in this state to practice as a physician, psychiatrist, psychologist, psychological associate,
provisionally licensed psychologist, licensed professional counselor, licensed professional counselor intern, licensed marriage and family therapist, licensed marriage and family associate, licensed clinical social worker, licensed master social worker under a clinical supervision plan approved by the Texas State Board of Social Worker Examiners, or advanced practice nurse recognized as a psychiatric clinical nurse specialist or psychiatric mental health nurse practitioner, who provides mental health or medical services for rehabilitation of sex offenders (Texas Council on Sex Offender Treatment, 2007)

- **Trauma.** Refers to an emotional response to a terrible event like an accident, rape, or natural disaster. Immediately after the event, shock and denial are typical. Longer-term reactions include unpredictable emotions, flashbacks, strained relationships, and even physical symptoms like headaches or nausea. While these feelings are normal, some people have difficulty moving on with their lives (American Psychiatric Association [APA], 2000).

- **Trauma Informed Services.** Trauma-informed services are those in which service delivery is influenced by an understanding of the impact of interpersonal violence and victimization on an individual’s life and development. To provide trauma-informed services, all staff of an organization, from the receptionist to the direct care workers to the board of directors, must understand how violence impacts the lives of the people being served, so that every interaction is consistent with the recovery process and reduces the possibility of re-traumatization (Elliott, Bjelajac, Fallot, Markoff & Reed, 2005).
• **Trauma Informed Treatment Provider.** Service providers who: (1) routinely screen for trauma exposure and related symptoms; (2) use culturally appropriate evidence-based assessment and treatment for traumatic stress and associated mental health symptoms; (3) make resources available to children, families, and providers on trauma exposure, its impact, and treatment; (4) engage in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma; (5) address parent and caregiver trauma and its impact on the family system; (6) emphasize continuity of care and collaboration across child-service systems; and (7) maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff resilience (National Child Trauma Stress Network [NCTSN], 2014).

• **Wellness.** Wellness is both a dynamic process of physical, mental, and spiritual optimization and integration and an outcome of that process. Hettler (1984), considered the father of the modern wellness movement, defined wellness as an active process through which people become aware of, and make choices toward a more successful existence. Myers, Sweeney, and Witmer (2000), concluded that wellness is:

> a way of life oriented toward optimal health and well-being, in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community. Ideally, it is the optimum state of health and well-being that each individual is capable of achieving. (p.252)
Organization of the Study

This research study consists of five sections: introduction, review of the literature, methods, results, and discussion. The review of the literature section includes the following: introduction, historical perspectives of stress, historical perspectives of secondary traumatic stress, historical perspectives on adolescence, the extent of adolescent abuse, and therapeutic interventions for adolescents. The methodology section will include the research questions, rationale, context of the study, data sources, data collection methods, data analysis, a data management plan, transferability and trustworthiness. The results section includes a presentation of the data as well as an analysis of the data. The discussion section will include implications for theory as well as a summary of the study.
CHAPTER II

REVIEW OF THE LITERATURE

Introduction

In qualitative research with grounded theory approach, there are two primary perspectives regarding the review of literature: the concept of reviewing literature causing contamination of the study (Glasser, 1992), and proactive engagement with the literature as a useful endeavor to the research (Strauss & Corbin, 1998). “Interweaving the literature throughout the process of grounded theory” can provide an additional voice to the development of the researcher’s theory (Strauss & Corbin, 1998, pg. 45). Strauss and Corbin (1998) continue by stating that reviewing the available literature can “stimulate our thinking about properties or dimensions that we can then use to examine the data in front of us (pg. 45).”

Counselors who work with sexually traumatized adolescents will often experience secondary traumatic stress. This review of literature includes the following: introduction, historical perspectives of stress, historical perspectives of secondary traumatic stress, historical perspectives on adolescence, extent of adolescent abuse, and effective therapies for treating adolescents, potential reasons counselors leave the field of counseling, and a conclusion.

Historical Perspective on Stress

According to the Institute of Stress, Hans Selye (1936) defined stress as the non-specific response of the body to any demand for change. Selye noted in numerous experiments that laboratory animals subjected to acute but different physical and emotional stimuli (blaring light, deafening noise, extremes of heat or cold, perpetual
frustration) all exhibited the same pathologic changes of stomach ulcerations, shrinkage of lymphoid tissue, and enlargement of the adrenals. He later demonstrated that persistent stress could cause these animals to develop various diseases similar to those seen in humans, such as heart attacks, stroke, kidney disease and rheumatoid arthritis (American Institute of Stress, 2014). During this time, it was discovered that the word stress had been utilized as a physics term for centuries to describe elasticity, the property of a material that allows it to resume its original size and shape after having been compressed or stretched by an external force. As expressed in Hooke’s Law of 1658, the magnitude of an external force, or stress, produces a proportional amount of deformation, or strain, in a malleable metal. Though, in this manner, stress actually means strain, it is easy to see why the word stress came to have a negative connotation thus its positive effects were ignored. However, stress can be helpful and good when it motivates people to accomplish more. Selye subsequently created a new word, stressor, to distinguish stimulus from response, thus allowing the definition of stressor to encompass the good and bad elements of stress. An example of this given by the Institute of Stress is: winning a race or election can be just as stressful as losing or more so; a passionate kiss and contemplating what might follow is stressful, but hardly the same as having a root canal (American Institute of Stress, 2014).

Types of Stress

Stress is present in the lives of most individuals. It can be somewhat challenging to assess the symptomology and the subsequent course of treatment at times due to the different types of stress studied over the years. According to the literature, there are
several distinct types of stress: acute stress, episodic acute stress, chronic stress, and traumatic stress.

**Acute Stress.** Acute stress is described in the literature as the most common type of stress. It comes from demands and pressures of the recent past and anticipated demands and pressures of the near future (Miller & Smith, 1993). Acute stress can be experienced when taking on a new challenge such as a challenging bike trail early in the day. This type of acute stress is exciting and thrilling; however, the same bike trail later in the day, when tired, can be experienced in a less than exciting manner and can be taxing (Miller & Smith, 1993). When acute, or short-term, stress is prolonged it can lead to physiological symptoms, such as stomachaches, headaches, etc. which are less favorable, but noticeable to most individuals who experience them. This type of stress is present in most individual’s lives, is manageable and can be easily treated, or reduced through self-regulation, self-monitoring, deep breathing, progressive muscle relaxation, and mind calming techniques.

**Episodic Acute Stress.** According to Miller and Smith (1993) acute stress suffered occasionally is simply termed acute stress, however, individuals who experience frequent bouts of acute stress, are considered as having episodic acute stress. Indicators of this type of stress are: hyper-arousal, incessant worry, overcommitted, possess a world view that is punitive and punishment oriented, are over concerned with “appearances”, etc. Treatment for this type of stress involves long-term professional help, such as, counseling due to the ingrained and habitual nature of this type of stress, and intervention on many levels, to include professional and personal intervention.
**Chronic Stress.** While there are parts of acute stress that can be deemed thrilling and exciting, according to the literature, chronic stress is described as a grinding stress that wears away at individuals, day after day (Miller & Smith, 1993). Chronic stress is a long-term, cumulative type of stress that is pervasive in nature. Miller and Smith (1993) state that chronic stress becomes a part of a person’s life to the degree they forget it is there and thus can be nearly impossible to treat without medical and psychological intervention, along with a good diet, exercise, and good stress management techniques. Chronic stress can be fatal through heart attack, stroke, suicide and violence, as well as other stressor related issues, if not treated.

**Traumatic Stress.** Traumatic stress is developed when overpowering trauma, such as rape, verbal abuse, mental abuse, physical abuse, sexual abuse, accidents, natural disasters, imprisonment, and extreme violence occur. This type of chronic stress is more formally known as post-traumatic stress disorder (PTSD). Miller and Smith (1993) postulate several factors that increase the stress of an acute trauma event. These factors include: the traumatic event being a deliberate act of aggression; the traumatic incident is a repeated, ongoing event with little hope of escape; the trauma was inflicted by a protective person in that individual’s life, like a parent, or adult family member; or lack of community support following the incident. Miller and Smith (1993) also postulate that individuals with personal, political, and religious beliefs that justify the trauma can minimize their psychological impact of the trauma. The following is an example: “The accident was terrible, and my car was totaled, but God wasn’t ready for me yet. I might walk with a limp but I am alive, and so is my son.” When the factors mentioned are present, this can cause PTSD, or severe traumatic stress. Treatment for this type of stress
includes medical and psychological treatment to include trauma-focused cognitive
behavioral therapy, and cognitive behavioral therapy, self-regulation, self-calming
techniques, thought stopping, meditation or praying, and hypnosis.

**Historical Perspectives of Secondary Traumatic Stress**

In 1978, Charles Figley stated that caring for people who have been traumatized
leaves marks on the victim’s family members. This lead to the warning that family,
friends, and professionals were susceptible to catching traumatic stress from those in
whom they invest their empathy and energy (Stamm, 1999). Figley (1983) referred to
this initially as burnout, a kind of secondary victimization, then later referred to it as
compassion fatigue is the cost of caring for others. As professionals listen to clients’
stories of fear, pain, and suffering, they may feel some of the similar fear, pain, and
suffering. This comes with a sense of losing oneself to the clients that are served, and
absorbing the suffering they are experiencing as well. Professionals who have an
enormous capacity for feeling and expressing empathy tend to be more at risk for
compassion stress or compassion fatigue (Figley, 1995).

English (1976) states:

This affront to the sense of self experienced by therapists of trauma
victims can be so overwhelming that despite their best efforts, therapists
begin to exhibit the same characteristics as their patients—that is, they
experience a change in their interaction with the world, themselves and
their family. They may begin to have intrusive thoughts, nightmares, and
generalized anxiety. They themselves need assistance in coping with their trauma. (p.191).

Figley (1983) argued that it is necessary for this to occur, asserting the need for our engagement in empathetic understanding of their pain in the counseling setting.

**Conceptual development of secondary traumatic stress.** The concept of Compassion Fatigue began in 1992, when Joinson (1992) coined the term in an article written for a nursing journal. She described this idea of compassion fatigue in “nurses who were worn down by the daily hospital emergencies” (p.16). While no study accompanied the article, it was impactful with the intent to raise awareness of compassion fatigue in the readers of the nursing journal. Kottler (1992) authored Compassionate Therapy emphasizing the importance of compassion in dealing with difficult and resistant patients. Unfortunately neither of these authors were able to succinctly define the term “compassionate,” however, both Kottler (1992) and Joinson (1992) noted that practitioners essentially lose their compassion as a result of their work with the suffering over a period of time. Since then, there have been numerous articles written where compassion fatigue is described within multiple populations outlining the symptomology, effects, and possible treatment modalities.

Compassion is defined as a "feeling of deep sympathy and sorrow for another who is stricken by suffering or misfortune, accompanied by a strong desire to alleviate the pain or remove its cause" (Webster, 1989, p. 229). Some research argues that it is wrong or improper for a practitioner to have deep feelings of sympathy and sorrow for their clients’ suffering with the caveat that practitioners need to understand their limitations in helping alleviate the pain suffered by their clients. Studies referring to the
effectiveness of therapy postulate that the therapeutic alliance between client and clinician as the ability to empathize to understand and help clients (Figley & Nelson, 1989). Without the presence of such, the process of therapeutic change is likely to be absent. Among the important factors in building a therapeutic alliance is the clients liking and trusting their therapist. These feelings are directly related to the degree to which the therapist utilizes and expresses empathy and compassion (Figley & Nelson, 1989).

There are several terms that have emerged since the early 1980s that describe the idea of compassion fatigue. It has been described as secondary victimization (Figley, 1982), secondary traumatic stress (Figley, 1983, 1985, 1989; Stamm, 1995, 1997), vicarious traumatization (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995), and secondary survivor (Remer & Elliott, 1988). In addition, there are also similar terms, such as emotional contagion, personal distress, and burnout, which are related to the concept of secondary traumatic stress.

Emotional contagion is defined as the process in which "an individual observing another person experiences emotional responses parallel to that person's actual or anticipated emotions" (Miller, Stiff & Ellis, 1988, p.254). Some related concepts include rape-related family crisis (Erickson, 1989; White & Rollins, 1981) and "proximity" effects on female partners of war veterans (Verbosky & Ryan, 1988).

Personal distress is derived from the negative feelings in response to the distress of others (Pulos et al., 2004). Personal distress reflects the individual’s own feelings of fear, anxiety, apprehension, and discomfort at witnessing the negative experiences of others (Davis, 1980). Personal distress is defined as a dynamic interaction between
person and environment where certain environmental tasks or situations are perceived as taxing, exceeding the person’s skills and abilities, or jeopardizing his or her well-being (Alkema et al., 2007, Pulos et al., 2004). Stressful events can be grieving families, personal grief, traumatic stories, events at work containing strong emotional states such as anger and depression (Alkema et al., 2007).

Burnout is defined, specifically in mental health professionals, as the syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment (Rank et al., 2009). Gentry and Baranowsky (1998) defined burnout, to include, the chronic condition of perceived demands outweighing perceived resources. The research indicates professional counselors are at risk of burnout as they face human suffering and absorb other people’s pain (Bush, 2009; Ruysschaert, 2009). Mental health professionals are specifically vulnerable to burnout when also experiencing personal isolation, ambiguous successes, and the emotional drain of remaining empathetic (Gentry et al., 2004). According to additional research, burnout, also relates to feelings of hopelessness, has a slow onset, and may affect all professional fields (Alkema et al., 2008; Van Hook & Rothenberg, 2009). Though these terms are similar to the idea of secondary traumatic stress, these terms, as is seen by their definitions, are intrinsically different.

Some in the field view difficulties with client traumas or traumatic issues as one of countertransference and has been discussed within the context of PTSD treatment (Danieli, 1988; Herman, 1992; Maroda, 1991; Wilson & Lindy, 1994). However, the concept of how secondary traumatic stress and PTSD is encased in a complex theoretical context can be difficult to measure from all other potential issues in a client-therapist transaction.
Figley (1993) defines secondary traumatic stress 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. Figley (1995) asserts a fundamental difference between the sequelae during and following a traumatic event for people exposed to primary stressors and for those exposed to secondary stressors. Secondary Traumatic Stress (STS) symptoms are closely related, and some would postulate as nearly identical to PTSD with the primary difference being with STS, the exposure to the knowledge of a traumatizing event happening to a significant person as the link to the STS symptomology, while the PTSD symptoms are identified as being directly affecting the person experiencing the traumatic event. The idea of secondary traumatic stress has been embodied as PTSD (APA, 1980) since it’s inception and conceived as a diagnosis the criteria “of experiencing an event outside of the range of usual personal experience and that would be markedly distressing to almost anyone” (APA, 1987, p.250). While the criteria does not necessarily discuss the implications of a person being confronted with the pain and suffering of others, it does take some small note of it in the assumption that it exists. Due to these differences, Figley (1995) delineated secondary traumatic stress, or compassion fatigue from PTSD by focusing secondary traumatic stress as resulting from deep involvement with a primarily traumatized person; compassion stress as experienced by helpers who knew about and were affected by traumatizing events, but did not reach STSD proportions; burnout which is experienced by a helper due to frustration, powerlessness to achieve work goals; and countertransference as experienced as the mechanism by which these helper symptoms are produced.
The phenomenon of secondary traumatic stress has received the least amount of attention from traumatology scholars and researchers, thus one of the reasons for this study. However, continued interest in this subject has caused an increase in the literature that would state being exposed to another’s traumatic material has the potential of producing traumatic stress in the caregiver (Figley, 1995; McCann & Pearlmann, 1990).

When this was postulated, the *Diagnostic and Statistical Manual, 3rd edition* (*DSM III*) was being utilized as the tool to treat those experiencing mental disorders or disruptions. The *DSM III* (APA, 1980) was the first to include the diagnosis of PTSD, which was considered to be a milestone in the area of traumatology (Figley, 1995). The criteria, which was experienced by a wide range of traumatized persons was viewed as a psychological or psychiatric disorder, one that could be diagnosed and treated. The popularity of this concept among professionals working with traumatized individuals continued to grow, as did the research regarding this disorder, which brought validity to the concept or disorder, as a whole. This, while yielding many reports of traumatized individuals, included reports regarding directly traumatized individuals and excluded reports of indirectly or secondarily traumatized individuals (Figley, 1995). The *DSM-III*, and *Diagnostic and Statistical Manual, 3rd edition revised ([DSM-III-R], 1987), denotes that “knowledge of another’s traumatic experiences can be traumatizing” (p.424). Figley (1995) discovered that people are traumatized directly and indirectly. Individuals can be traumatized without being physically harmed or threatened by harm; they can be traumatized by learning of the traumatic event.

In 1994, the *DSM-III-R* gave way to the *Diagnostic and Statistical Manual, 4th edition [DSM IV]* which stated more specific language focusing primarily on the person
and the event, rather than containing language that would allow for a traumatic stress situation due to caregiving, etc.

According to DSM IV (APA,1994) guidelines, a person must have “experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or threat to the physical integrity of oneself or others” (APA, 1994, p. 426). Whether, by this definition, listed criteria for traumatic stress may be met or not, many caregivers report experiences that are similar to those of Acute Stress Disorder and PTSD. Some of those reports include: recurrent and intrusive dreams, distressing memories, flashbacks and dissociative experiences, difficulty concentrating, difficulty sleeping, and psychological distress when exposed to symbols of the event, or the person being cared for (McCann & Pearlman, 1990).

Stamm (1999) suggested that viewing traumatic stress only from the context of a diagnosable pathology was not fully comprehensive; however, it is necessary to view it as part of the larger concept of stress, which includes but is not limited to Acute Stress Disorder, and PTSD. Stamm (1999) further suggests that stressful experiences, such as caregiving, can be conceived as a person’s individual experience in relation the event, their resources, and how the interaction of those elements can be stress-producing. A subsequent factor is the individual’s beliefs in life, in self, and in others can be disorganized, restructured, or at least challenged in these situations (Stamm, 1995).

The DSM-V (APA, 2013) moved to a more inclusive definition with the element of traumatic stress within the criteria, and added the additional qualifier “…in which the individual experiences first hand the repeated or extreme exposure to aversive details of
the traumatic event” (APA, 2013, p. 271). This change allows the continued exploration into validating traumatic stress, secondary traumatic stress and the effects thereof.

**Historical Perspectives on Adolescence**

The concept of adolescence began approximately 100 years ago around the time of the Industrial Revolution. During this time considerable social policy reforms were put in place to include the separation of the adult and juvenile justice systems, compulsory high school attendance and initial child labor laws were passed (Straus, 1994). Childhood, in essence, was extended and children remained in school longer, causing people to join the workforce later in life with a higher educational background. More emphasis was placed on the education and development of children to promote future success in their lives allowing a successful growth and transition into young adult life (Janus, McCormack, Burgess & Hartman, 1987). Since that time, adolescence has come to be known as the period of life ranging from 10 years of age through 18 years of age (Flannery, Torquati, & Lindemeier, 1994).

According to Gil (1996) when discussing adolescence as a whole, one needs to maintain a broad context by which to view the complexities of the concept of adolescence to include: physical, cognitive, emotional, personality, moral, sexual and spiritual development. During this stage of life there is a great motivation to grow and change, though the challenges experienced through negotiating opposing drives can be equally as imposing. Several “normal problems” encountered with this population can include: time distortion, an exaggerated sense of loyalty to their peers, generalized mistrust for adults, extreme self-consciousness, and suspension of logic (Schrodt & Fitzgerald, 1987). Discovering the developmental needs of adolescence is essential in understanding the
progression of phases and tasks that need to be accomplished and will serve a therapist well in developing the relationship with individuals in this stage of life. Gil (1996) reiterates Forehand & Wierson’s (1993) idea that viewing an adolescent in the context of his/her life stage will also prevent misunderstandings and miscommunications in the therapeutic process during the course of and during the termination of therapy.

Findings on Adolescent Maltreatment

In 2012, the National Child Abuse and Neglect Data System (NCANDS), a branch of the Children’s Bureau (Administration on Children, Youth and Families, Administration for Children and Families) of the U.S. Department of Health and Human Services published their findings on child maltreatment. The first report from NCANDS was based on data from 1990. This report for federal fiscal year (FFY) 2012 data was the twenty-third issuance of this annual publication.

Their findings documented statistics gathered, voluntarily, from all 50 states in the United States. The criteria by which they base their findings come from the Child Abuse Prevention and Treatment Act (CAPTA) (42 U.S.C. §5101). The CAPTA Reauthorization Act of 2010, retained the existing definition of child abuse and neglect as, at a minimum:

Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act, which presents an imminent risk of serious harm. (p.2)

According to the US Department of Health and Human Services (1995), most states recognize the following types of child maltreatment: medical neglect, neglect or
deprivation of necessities, physical abuse, psychological or emotional maltreatment, and sexual abuse (Gil, 1996). Though any of the forms of child maltreatment may be found separately, they can occur in any combination as well, and often occur in duplicate abuses, rather than singular abuse (Gil, 1996).

In 2008, the US Department of Health and Human Services, categorized this information into uniform definitive sections: maltreatment, acts of commission, and acts of omission. These definitive sections are described in the following:

**Maltreatment.** The U.S. Department of Health and Human Services (2008), defines maltreatment as any act or series of acts of commission or omission by a parent or other caregiver (e.g., clergy, coach, teacher) that results in harm, potential for harm, or threat of harm to a child.

**Acts of Commission (Child Abuse).** The US Department of Health and Human Services (2008) determined acts of commission to include:

Words or overt actions that cause harm, potential harm, or threat of harm to a child. Acts of commission are deliberate and intentional; however, harm to a child may or may not be the intended consequence. Intentionality only applies to the caregivers’ acts—not the consequences of those acts. For example, a caregiver may intend to hit a child as punishment (i.e., hitting the child is not accidental or unintentional) but not intend to cause the child to have a concussion. The following types of maltreatment involve acts of commission: physical, sexual and psychological abuse. (p.11,14)

This study pertains, specifically, to the impact of adolescent sexual abuse on counselors, thus a more specific definition regarding sexual abuse follows:

Sexual abuse. The US Department of Health and Human Services (2008) defines sexual abuse as: "any completed or attempted (non-completed) sexual act, sexual contact with, or exploitation (i.e., noncontact sexual interaction) of a child by a caregiver (p.14).” Specific acts that are included: “Sexual acts include contact involving penetration, however slight, between the mouth, penis, vulva, or anus of the child and another individual. Sexual acts also include penetration, however slight, of the anal or genital opening by a hand, finger, or other object” (Basile & Saltzman, 2002). “Genital on genital contact includes: penis to penis, penis to vulva, penis to anus (p.14).” “Mouth on genital contact includes: mouth to penis, mouth to vulva, or mouth to anus (p.14).” The US Department of Health and Human Services (2008) continues to describe that the above “sexual acts can be performed by the caregiver on the child or by the child on the caregiver. A caregiver can also force or coerce a child to commit a sexual act on another individual (p.14).”

The Extent of Adolescent Abuse

“During FFY 2012, Child Protective Service agencies received an estimated 3.4 million referrals involving approximately 6.3 million children. Among the 46 states that
reported both screened-in and screened-out referrals, 62.0 percent of referrals were screened in and 38.0 percent were screened out” (NCANDS, 2012, p.18). Investigations by Child Protective Agencies and alternative track responses such as family assessment responses, and differential responses are the primary manner by which these types of issues are managed from state to state depending on the severity of abuse that is reported, the situation in which the event(s) occurred, etc. (NCANDS, 2012).

It was determined that younger children were the most vulnerable to maltreatment. According to NCANDS, all 50 states report that more than one-quarter of victims reported were under the age of three; an additional percent were between the ages of three-five years of age. The percentages of child victims were similar for both boys (48.7%) and girls (50.9%). According to NCANDS (2012), of the children abused, approximately 78% were neglected, 18% were physically abused, and 9% were sexually abused. Additionally, another nearly 11% experienced “other” types of abuse to include “threatened abuse,” “parent’s drug use” or relinquishment of a child. Of the children who were sexually abused, nearly 51% were within the adolescent age group (12-14 years of age = 26.3%; 15-17 years of age = 20.9%; total for both groups= 47.8%).

Of the 62,551 children, in the state of Texas, identified as victims of abuse; 15,426 fell in the adolescent age range of 10-17 years of age. Utilizing the percentage given regarding adolescent sexual abuse, overall (47.8%), this would indicate that of those 15,426 adolescents abused in the state of Texas, approximately 7,376 were sexually abused.

Regarding the perpetrator-child relationship, approximately four-fifths (81.5%) were abused by either or both parents however this is regarding abuse overall, not
specifically sexual abuse, as the outcome did not specify this precise dynamic. Parents
are defined, in this study as, biological parent(s), adoptive parent(s), or step-parent(s).
This percentage also includes single and multiple or duplicate events that occurred. (US
Department of Health and Human Services, 2012).

When abuse to an adolescent occurs, they typically present with a range of
emotions, as well as, behavioral responses that can be effectively addressed in a
therapeutic environment. Adolescents who do not receive therapeutic services could
potentially display delinquent types of behaviors such as running away, stealing, sexually
acting out, and other illegal type behaviors that will draw the attention of the juvenile
justice system. These behaviors, when addressed in therapy, can prove to be a more
effective means of the helping the adolescent through the issue and thwart potential
delinquent behaviors.

**Effective Therapeutic Interventions for Adolescents**

Adolescents’ responses to traumatic events are often influenced not only by the
type of sexual abuse incurred, as well as their developmental level, but also by the
reactions of those close to them, such as, parents, relatives and friends. Adolescent abuse
is viewed by some professionals to not be as significant as the abuse of younger children,
according to Gil (1996). Gil (1996) postulates that this could be constituted by the
increased resources and abilities of adolescents, as compared to children; however, it
does not make this type of abuse less significant. According to Bagley (1995):

…prolonged and intrusive sexual abuse imposed on the physically
immature body and the developmentally immature psyche of an
adolescent child create an adolescent who cannot find adequate
solutions to the dilemmas of identity development…As a result, the adolescent is extremely vulnerable to stress and may develop in severe form a number of psychological disorders (e.g., suicidal ideas and behaviors, depression, eating disorders, alienation from school and peers, sexual problems, acting out behaviors and substance abuse) that have an increasing prevalence among adolescents… (p.135)

Finkelhor and Dziuba-Leatherman (1994) support Bagley by indicating sexual victimization has short-term and long-term effects on a child’s and adolescent’s mental health. They continue by stating sexually abused children appear to have a significantly increased lifetime risk for psychiatric disorders, substance abuse, as well as increased rates of acts of physical abuse and sexual abuse toward others. Friedrich, Grambsch, Damon, Hewitt, Koverola, Lang, Wolfe and Broughton (1992) found that sexual behavioral problems are consistently the most prevalent issue related to child sexual abuse.

Effective treatment of sexually abused adolescents is not only an asset to the current victims and their families, but could potentially prevent the abuse that could be caused by non-treatment or inadequate treatment provided.

**Trauma Focused Cognitive Behavioral Therapy (TFCBT).** Trauma-Focused Cognitive Behavioral Therapy (TFCBT) is the preferred method of treating adolescent sexual abuse. TFCBT is “an empirically supported treatment model designed to assist, children, adolescents, and their parents/families in the aftermath of traumatic experiences” (Cohen, Mannarino & Deblinger, 2006, p.32). TFCBT is a shorter-term treatment involving somewhere between 8-16 sessions.
The use of TFCBT implements several aspects of intervention to optimally treat traumatized children and families. These include: cognitive-behavioral principles, trauma-sensitive interventions, aspects of attachment, developmental neurobiology, family, empowerment, and humanistic theoretical models (Cohen, et al., 2006). This program is unique in that it offers individual sessions for the child, as well as individual sessions for the parents, then moves toward conjoint sessions with the children and their parents, or families. This enables the children to process through their abuse individually, then move toward openly sharing with what occurred through the use of a trauma narrative. In the sessions with the parents, they are also able to address their feelings regarding the incident(s) and are equipped to adequately and accurately offer the support and assistance their child needs at home in between sessions, and once sessions are concluded.

Trauma-informed treatment providers are trained in TFCBT as a means of helping traumatized children and their families. The training is one class consisting of approximately 10 hours offered through an online university, as well as, on-site. For a counselor to effectively and accurately utilize TFCBT, they must receive the certification from the training site indicating they are a trauma-informed treatment provider once they complete the training.

**Expressive Therapies.** According to Gil (2006), expressive therapies is a term used to define the therapeutic use of the arts and play with children and adults individually, in groups, or in family sessions. Expressive therapies include: play therapy, art therapy and sand therapy. Providing therapy to young children and adolescents can be challenging especially when they have experienced traumatic events.
When this occurs a counselor cannot always rely on a specific, more traditional approach and often will need to utilize creative approaches to help the children or adolescents express the feelings they have in relation to what they have endured. Gil (2006) states this approach was first initiated by Anna Freud in 1965 as a manner in which to “lure children into therapy and establish a therapeutic alliance between the counselor and the child, or adolescent” (Gil, 2006, p.71). Gil (2006) expands this idea by postulating once the alliance grows, in time, verbal responses are elicited from the child more effectively and easily.

Other approaches to expressive therapies are to substitute the play, art, or sand therapies for verbalizations. Klein (1932) considered play activities as data in which to base interpretations and viewed play as a child’s natural mechanism for expression and communication. All of these expressive therapies are common in that they can be experienced throughout the developmental process, engage multiple senses, and are typically a spontaneous activity that, even though directed in a therapeutic environment, can help a child express ideas, memories, etc. that they may not otherwise be able to express. Thus a counselor is able to gather information about the child through documenting their observations of the child, themes or stories in their play, and their feelings associated with the different elements of the themes or stories in their play. Subsequently, these therapies can be integrated into family work in the right context and can be successful in helping families through an ordeal such as sexual trauma.

Potential Reasons Counselors Leave the Field of Counseling

The question as to why counselors leave the field of counseling is a difficult one to answer. The dearth of literature available is the primary explanation for this. It is,
however, a topic that needs review and exploration. Several assumptions have been made over the years to answer this question, primarily, the concept of burnout, though there is no research available regarding this subject. In Counseling Today magazine, several articles have been published addressing this topic. Shallcross (2011), in Counseling Today, discusses burnout and the importance of implementing good wellness practices into daily living to improve the overall well being of counselors. She includes vacations, boundary development, collaboration and supervision, “making time for life,” performing “self-check ups” frequently, and maintaining a positive work environment as main ideas to prevent burnout from occurring. Elizabeth Venart, interviewed regarding burnout, in Counseling Today (2011), explains:

…burnout often arises from an accumulation of work-related stress, resulting in feelings of hopelessness and helplessness. It is typically created or exacerbated by the nature of the work and workplace. As a result, a change in work environment can dramatically improve one’s experience of burnout. (p. 30)

The article also discusses the lack of change in these areas causing possible impairment within the counselor, which could subsequently lead to unethical practice, and the counselor potentially leaving the field. With burnout as an implication for counselors leaving the field, it stands to argue that the influence of secondary traumatic stress on the experience of burnout, could impact counselors leaving the field, and thus, needs to be considered as an experience deserving more attention.
CHAPTER III

RESEARCH METHODOLOGY

Background of the study

This study was designed to examine the experiences of secondary traumatic stress in counselors who treat sexually abused adolescents. This section, which focuses on the methodology of this study, explains the research design and procedures for analysis for the study. The rationale for the study, the context of the study, data sources, data collection methods, data management, transferability, and trustworthiness will, also, be explained in this section.

Research Questions

This study sought to answer the following questions:

1: What identifiable traits are present in counselors who experience secondary trauma when counseling adolescent victims of sexual trauma?

2: What particular skills do counselors who manage secondary trauma utilize?

3: What identified skills were noted as acquired in graduate school? Post graduate school?

Rationale of the Study

Because of the paucity of research on secondary traumatic stress in counselors, this study utilized qualitative methods of research. Glesne (2011) posits that researchers using qualitative research methods attempt to make sense of the actions and narratives of the phenomenon they are studying. This study sought to inquire about the actions and narratives of the phenomenon of studying counselors’ experiences of secondary traumatic
stress. According to Berg and Lune (2012) qualitative research methods target “meanings, concepts, definitions, characteristics, metaphors, symbols, and descriptions of things. In contrast, quantitative research refers to counts and measures of things, the extents and distributions of our subject matter” (p.3).

In using qualitative research methods, this study used grounded theory. There were several reasons why grounded theory best accomplished the intentions of this study. First, this qualitative study did not follow positivist quantitative inquiry methods, which typically includes the concepts of validity, objectivity, reliability, and generalizability (Glesne, 1999). Secondly, this research was not approached in a conceptual, theoretical manner, but in an interpretivist manner. This approach sought to identify a variety of perspectives, while not reducing the interpretations to a norm (Glesne, 1999). Since this approach deals with multiple social realities or qualities that are complex and indivisible to concrete or discrete variables, they focus on the importance of interpretation of how the various participants construct the world around them (Glesne, 1999). Given that grounded theory uses data to discover theory, this method was optimal for this study, in that, no other theory was applicable (Glesne, 2011).

As in theoretical research, this investigation grounded the theory using the actual data collected in the study, as suggested by Glaser and Strauss (1967), and Glesne (1999). According to Glesne (1999), grounded theory may be either inductive or deductive; the development of inductive categories allows the researcher to ground these categories to the data from which they were derived. This not only ensures that the theory will fit the work, but that those impacted in the area to which the theory is applied will be better able to interpret, understand, and utilize it. Grounded theorists argue that theories should be
developed from the data collected in the field. Unlike quantitative researchers, grounded theorists neither test existing theory nor try to fit their data into preconceived concepts (Heppner & Heppner, 2004, p. 148). To make this point further, Strauss and Corbin (1994) stated, “One does not begin with a theory, then prove it. Rather, one begins with an area of study, and what is relevant to that area is allowed to emerge” (p. 23).

Grounded theory is used in many disciplines using qualitative research, including education, counseling, and nursing (Johnson & Christensen, 2007).

For this research, a qualitative study was selected as opposed to a quantitative study because qualitative research seeks to examine the motivations or intentions behind various actions, events, and individuals (Denzin & Lincoln, 2005). Qualitative research provides researchers an understanding of the perceptions of others and to explore what meanings individuals give to events in their lives (Berg, 2001). In depth interviews were be conducted with trauma informed treatment providers, who have been licensed as LPCs, or LSOTPs for at least two years.

Taylor and Bogdan (1998) postulate that in-depth interviewing is well-suited when the research interests are relatively clear and well-defined. Taylor and Bogdan (1998) continued by stating how research interests in qualitative research are usually broad and open-ended. This design allowed the researcher to understand how trauma-informed treatment providers manage secondary traumatic stress and how it affects them from their point of view.

There were disadvantages to conducting in depth interviews. First conducting in-depth interviews is time consuming. Another is that participants do not always respond
the same way in different situations, so what the interviewees state in an interview setting may differ from that of another setting (Taylor & Bogdan, 1998).

**Context of the Study**

This study occurred in the panhandle of Texas. This area was selected because it has numerous counselors who have been in practice for two or more years, are trauma informed treatment providers, and work with sexually-abused clients. Also, this area was selected due to the access of the targeted population. This researcher conducted the interviews in either the participants’ personal office(s), or a place of the participants’ choosing. The intention was to make the participant feel as comfortable, safe and at ease as possible, allowing for the participant to have a positive interview experience. To this idea, Taylor and Bogdan (1998), stated:

We emphasize the importance of the in-depth interviewing, getting to know individuals well enough to understand what they mean and creating an atmosphere in which they are likely to talk freely. In addition, we always recommend that interviewers try to spend time with individuals ‘on their own turf’ as they go about their day-to-day lives. (p. 92)

The study is representative of other small urban areas in the more conservative southern states in the United States that have similar demographics and populations. However, this study will most likely not be representative of large cities or remote rural areas in the northern regions of the United States that lend to more liberal thought.

**Data Sources**

This researcher employed several sources for data gathering in conducting this study. The primary source was the individual, in depth interviews. Another important
source was the published literature. The last source was the researcher’s observations within the context of the interviews conducted. Participants were posed with interview questions during the individual interviews. The answers were recorded, and follow-up questions were asked when any clarification was needed in the participants’ statements. The literature review gave a thorough background that guided the researcher in understanding trauma experienced by the participants. This was a crucial aspect of the data collection because it allowed the researcher to help identify incongruences between what the participant stated and what they seemed to be feeling or experiencing, as indicated by non-verbal communication. One potential risk factor that this researcher needed to account for, was in this type of observation, personal habits or quirks of the participant may have not been known prior to, or during the interview process.

Convenience samples and purposive sampling were utilized in selecting participants for this study. Convenience samples rely on available subjects. One disadvantage in this type of sampling is that a researcher may be interested in studying the characteristics or processes that the readily available sample cannot provide. The benefit of this type of sampling is that it can provide information on research questions quickly. In purposive sampling, a small sample is utilized that meets specific criteria established to best answer the qualitative research questions. These methods differ from quantitative research methods, where the goal is to represent the general population (Silverman, 2001). Due to qualitative research utilizing fewer participants, this bias is more likely to occur, however, this researcher feels saturation was accomplished. Berg (2001) states:
When developing a purposive (judgmental sampling) sample, researchers use their special knowledge or expertise about some group to select subjects who represent this population. In some instances, purposive samples are selected after field investigations on some group in order to ensure that certain types of individuals or individuals displaying certain attributes are included in the study. Despite some serious limitations (for instance, the lack of wide generalizability), purposive samples are occasionally used by researchers. (p. 36)

All participants were selected on a volunteer basis. All participants met certain criteria, to include: they all held a license (LPC, or LSOTP) in the state of Texas, that is in good standing with their perspective boards; they were licensed for a minimum of two years; and they were recognized as trauma informed treatment providers. Trauma Informed Treatment Providers are service providers who: (1) routinely screen for trauma exposure and related symptoms; (2) use culturally appropriate evidence-based assessment and treatment for traumatic stress and associated mental health symptoms; (3) make resources available to children, families, and providers on trauma exposure, its impact, and treatment; (4) engage in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma; (5) address parent and caregiver trauma and its impact on the family system; (6) emphasize continuity of care and collaboration across child-service systems; and (7) maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff resilience (National Child Trauma Stress Network [NCTSN], 2014).
In accordance with the Belmont Report’s section on selection of human subjects, which is devoted to fair procedures and outcomes in the selection of research subjects, all precautions were taken to ensure that individual and social justice was maintained while selecting participants and throughout the research process. Individual justice requires that all researchers exhibit fairness while selecting participants. The criteria that guided the procedure utilized in the selection of the participants met the social justice principles listed above.

**Data Collection Methods**

The number of participants interviewed was eight. The participants met the specific criteria set forth. Although a specific number of participants was not stated in Strauss and Corbin (1994), various other studies in qualitative research have utilized approximately the same number of research participants on similar topics. The researcher conducted in-depth interviewing as the means of collecting data in this study. After conducting research on the best methodology to research the information sought, this style was found to be the most beneficial for answering the research questions. The goal of this study was to provide an understanding of the participants’ perspectives on the topic. In order to accomplish this, it was important to allow the participants to discuss their experiences openly. Taylor and Bogdan (1987) explain:

Qualitative interviewing has been referred to as nondirective, unstructured, non-standardized, and open-ended interviewing. We use the phrase in-depth interviewing to refer to this qualitative research method. By in-depth qualitative interviewing, we mean repeated face to face encounters between the researcher and informant directed toward understanding
informants' perspectives on their lives, experiences, or situations as expressed in their own words. The in-depth interview is modeled after a conversation between equals rather than a formal question and answer exchange. Far from being an impersonal data collector, the interviewer, and not an interview schedule or protocol, is the research tool. The role entails not merely obtaining answers, but learning what questions to ask and how to ask them. (p. 88)

Data were collected using semi-structured, in-depth interviews. Interviews were used for data gathering because it allowed for appropriate data for this type of study. Taylor and Bogdon (1998) postulate that when investigators are interested in understanding the perceptions of participants or learning how participants come to attach certain meaning to phenomena or events, interviewing provides a useful means of access. Glesne (2011) adds that semi-structured interviews “capture the unseen” and give an understanding to how “respondents think and feel about something” (p.134). According to Berg and Lune (2012) semi-structured interviews allow more flexibility in the order questions as re asked as well as, the wording of questions.

Qualitative interviewing allows a researcher to enter into the inner world of another individual and to gain an understanding of that individual’s perspective (Patton, 1987). A strength of this data collection method was the manner by which the research questions were structured. The semistructured interview allowed the flexibility to identify the themes that emerged when participants discussed their experience with secondary traumatic stress. One weakness of this type of interview method is the themes
which emerged from the study were based on self-report by the participants, and the assumption that the participants reports were accurate to their reality (Moskowitz, 1986).

The interview questions in this study were derived from the research questions which emerged by in large from the review of literature. The interview questions that were asked during each interview were:

1. How do you feel your work with sexually abused adolescents impacts you?
2. How would you define secondary traumatic stress?
3. In what ways do you feel best addresses your experience with secondary traumatic stress?
4. Are there specific things that you do in order to manage secondary traumatic stress? Recurrences of secondary traumatic stress?
5. What secondary traumatic stress management skills did you learn in graduate school?
6. Post-graduate school?
7. Is there anything else you would like to add about your experience with or feelings regarding secondary traumatic stress?

These interview questions were based on the primary research question. The interview questions were succinct and specific as possible to assist the participant in answering the entire question. The goal was to avoid complex questions or ambiguity when the asking the participants the interview questions (Berg & Lune, 2012). The questions were set up to build on each other to allow for participant insight due to the order of the questions being a meaningful part for the study (Berg & Lune, 2012). Transitions were implemented to move between each question in order to create fluidity.
in the questions (Berg & Lune, 2012). Each participant was asked the interview questions in the same order with the same wording to ensure consistency within the data collection.

During the interview, Berg’s (2009) ten commandments of interviewing were closely followed. This includes never beginning an interview cold, remembering your purpose, presenting a natural front, demonstrating aware hearing, thinking about appearance, interviewing in a comfortable place, not being satisfied with monosyllabic answers, being respectful, practicing, and being cordial and appreciative.

**Interviews**

The initial stage of the interview focused on building rapport with the participants. Berg and Lune (2012) state that rapport is defined as “positive feelings that develop between the interviewer and the subject, it should not be understood as meaning there are no boundaries between the interviewer and the subject” (p. 137). While establishing rapport does not indicate the removal of boundaries between the participant and the researcher, it is viewed as a “precursor to building trust” (Glesne, 2011, p. 141). During the rapport building process, the participants were thanked for their participation, and the purpose and procedures that were adhered to in the interview were described.

Interviews followed the ensuing format: introduction was made, then the researcher described the purpose of the study, defined the format of the interview, disclosed the confidentiality of the interview, obtained the demographic interview information from the participant, then the permission to record the interview granted. Once these steps were accomplished, the interview began. Once the interview was
completed the researcher explained to each participant that the interview would be transcribed, and sent to them for review and clarification.

The first interview question was a generalized question regarding the participants’ ideas on the impact of secondary traumatic stress. Through asking single focused, open-ended questions, thus avoiding the creation of a multiple meaning question, more information was obtained from counselors about their experiences of secondary traumatic stress. Each interview question was asked in such a manner that, the questions were clear, and avoided “lumping questions together” which causes confusion, or potential false dichotomies with the participant (erg & Lune, 2012). When necessary, probing questions were utilized, to obtain more specific detail to allow the participant to respond to the concept more completely, and in a more in-depth manner. Probing questions are most closely related to utilizing active listening skills in counseling and may include reflection of meaning statements, reflection of feeling statements, and focusing statements. This researcher notified the participants that follow-up interviews will be scheduled as needed, however, after this researcher and a third party reviewed the information gathered, follow up interviews were not necessary, as saturation was achieved.

**Ethical Considerations**

Steps were taken to avoid any sense of ethical impropriety. All proper applications and information was submitted to the Human Subjects Review Board at Texas Tech University, and research began once approval was granted by the review board. Confidentiality was maintained through the use of pseudonyms selected by the participants, and all of the data collected is stored in a secure location.
Data Analysis, and Management

Upon approval of this study by the Human Subjects Committee of Texas Tech University, this researcher recruited participants, and subsequently set up interviews with the participants. The participants were interviewed utilizing a predetermined set of questions. These interviews were recorded and transcribed into a Microsoft Word document. Upon transcription of the interviews, this researcher sent the transcriptions to the participants who agreed to confirm their statements from the interviews. Their revision and approval was requested during this process. After the approval of these transcripts, by the participants, an open coding method was utilized to analyze the data by inspecting the transcript line by line to write notes regarding the identified emerging themes.

Initial open coding, handwritten notes and discussion with the committee were the primary means by which themes were identified. Using a computer program to analyze and process data can be helpful due to the computer program’s ability to search for information throughout the entire document, and the ability to manage data with greater ease than can be done with only handwritten transcriptions (Richards & Richards, 1987). Using computer programs “offers much assistance in managing data, and also” “in building and using theoretical categories” (Richards & Richards, 1987, p.454). In order to manage the data collected, this researcher utilized a computer program entitled NVivo 10, which is software specifically utilized for qualitative research data. NVivo 10 is software designed to allow the researcher to store and analyze data while creating and “easy to analyze” audit trail (NVivo, 2012). NVivo aides the researcher in tracking and managing large amounts of various data related to the study; however NVivo 10 does not
code the data for the researcher. Though there are potential downfalls to computer aided qualitative data software, this researcher and committee decided that utilizing software for this study would best serve the needs of this research study.

All data, printed and electronic, collected in this study were secured in a location where the data will be stored for a minimum of two years. Printed data will be destroyed by a professional document disposal company. All electronic data collected will be multiple pass and securely erased.

**Trustworthiness and Transferability**

In order to promote the validity, and trustworthiness of this study, a colleague reviewed the research data and provided feedback as to any potential problems, or themes that were not identified by the researcher. This process is known as peer review (Johnson & Christensen, 2007). The colleague that was chosen, had a familiarity with the research area; however, did not meet the criteria of the research study (as a participant) to limit bias. In addition, this researcher utilized member checking. Glesne (2009) describes member checking as sharing interview transcripts, analytical thoughts and/or drafts of the final report with research participants to make sure you are representing them and their ideas accurately. Another manner by which trustworthiness was established was through the monitoring and clarification of any researcher bias. Researcher bias that arose was identified, then clarified and discussed by the researcher throughout the course of this study.

To promote the transferability of this study, this researcher identified all methods, categories, characteristics, and groups covered in the research study, as well as utilized
standard terminology whenever possible, as well as ensured clarity as to the scope and boundaries of this study.

**Limitations**

The potential for limitations is strongly noted in research when human participants are utilized. The research findings for this study were based on LPCs, and LSOTPs who have been in practice for two or more years, in the Texas panhandle. In-depth interviews were conducted with the participants. Due to the self-report method utilized, the potential for these participants to present as more self-aware than they are was a consideration that had to be accounted for. Observational data was collected, as well as, the answers to the interview questions to help identify incongruences. This researcher is also a LPC, and could have potential bias in the outcome. To overcome this bias, the interviews were audiotaped then critiqued by a third party to identify trends observed in the interviews and shared with the researcher to diminish research bias. Member checking was also utilized to ensure accuracy of information recorded and transcribed.

**Summary**

A qualitative study was conducted utilizing in depth interviews with counselors who currently work with sexually traumatized adolescents to include LPCs, and LSOTPs. This study was unique in that the sample was restricted to treatment providers in the Texas panhandle, specifically counselors who treat sexually traumatized adolescents. This study sought to examine their skill sets and processes that were used to diminish or thwart the impact of secondary traumatic stress on them as counselors. Findings from this study provided insight into this phenomenon and information that might lead to the
development of more adequate training through professional development opportunities, counselor education programs, and supervision.
CHAPTER IV
RESULTS

Organization

This chapter will report the results from this study through the following subsections: a restatement of the problem, a description of the participants, an analysis of data which will describe the themes that emerged throughout the study, and a summary of the results.

Restatement of the Problem

Counselors and mental health professionals are at higher potential risk of experiencing secondary traumatic stress by practicing the vocation they worked so diligently to learn. This study sought to explore the presence of risk levels in the population of counselors in the panhandle of Texas who deal with sexually traumatized clients, the means by which they manage these stressors, and how effectively these management tools work to diminish the effects of the secondary traumatic stress experienced. According to the American Institute of Stress, and the National Child Trauma Stress Network, secondary traumatic stress is the least researched area of traumatology. The dearth of literature regarding counselors’ experiences with secondary traumatic stress, specifically, shows this to be an area in need of further research.

Description of Participants

The following is a list of demographic information for each of the eight participants in this study. In order to maintain confidentiality and the participants’ anonymity, the participants will be listed by the pseudonym that participants chose for themselves.
Maine. Maine is a Caucasian female, with Indian and Irish heritage. Maine is 36-40 years of age. Maine has been fully licensed for 6 years and has practiced as an LPC the extent of the time she has been licensed. Maine holds a PhD. Maine is considered to be a Trauma Informed Treatment Provider, and treats clients ranging from 15-60 years of age. Her primary theory base when conducting counseling is an Integrative Therapy approach.

Sally. Sally is a Caucasian female. Sally is 51-55 years of age. Sally has been licensed for 2 years; in addition, she worked with traumatized adolescents and children in another professional capacity prior to her LPC licensure for over 20 years. Sally holds a PhD. She is also considered to be a Trauma Informed Treatment Provider and treats clients ranging from 3-63 years of age. Her primary theory base when conducting counseling is Cognitive Behavioral Therapy.

Lacie. Lacie is a Caucasian female. Lacie is 31-35 years of age. Lacie has been fully licensed for 2.5 years, and has practiced as an LPC the extent of the time she has been licensed. Lacie holds a PhD. Lacie is considered to be a Trauma Informed Treatment Provider and treats clients ranging from 3-73 years of age. Her primary theory base when conducting counseling is Multi-Modal Therapy.

Penelope. Penelope is a Caucasian/Hispanic female. Penelope is 41-45 years of age. Penelope has been fully licensed for 3.5 years, and has practiced as an LPC the extent of the time she has been licensed. Penelope holds a PhD. Penelope is considered to be a Trauma Informed Treatment Provider and treats clients ranging from 3-60 years of age. Her primary theory base when conducting counseling is an Integrative Therapy approach.
Carlos. Carlos is a Caucasian male, with Irish, English, and Dutch heritage. Carlos is 51-55 years of age. Carlos has been fully licensed for 13 years, and has practiced as an LPC the extent of the time he has been licensed. Carlos holds a Master’s degree, and is considered ABD (completing his dissertation for PhD). He has also been licensed as a Licensed Sex Offender Treatment Provider (LSOTP) for 2 years. Carlos is considered to be a Trauma Informed Treatment Provider and treats clients ranging from 3-60 years of age. His primary theory base when conducting counseling is an Integrative Therapy approach.

AA. AA is a Caucasian female. AA is 51-55 years of age. AA has been fully licensed for 23 years and has practiced as an LPC/LSOTP the extent of the time she has been licensed. AA holds a PhD. AA is considered to be a Trauma Informed Treatment Provider and treats clients ranging from 3-90 years of age. Her primary theory base when conducting counseling is Cognitive Behavioral Therapy.

Suzie. Suzie is a Caucasian female, with Indian heritage. Suzie is 51-55 years of age. Suzie has been fully licensed for 6.5 years and has practiced as an LPC/LSOTP the extent of the time she has been licensed. Suzie holds a Master’s degree and is considered ABD (completing her dissertation for PhD). Suzie is considered to be a Trauma Informed Treatment Provider and treats clients ranging from 15-76 years of age. Her primary theory base when conducting counseling is Cognitive Behavioral Therapy, Rational Emotive Behavioral Therapy, and Choice Theory.

Doug. Doug is a Caucasian male. Doug is 51-55 years of age. Doug has been fully licensed for 21 years and has practiced as an LPC the extent of the time he has been licensed. Doug holds a PhD. Doug is considered to be a Trauma Informed Treatment
Provider and treats clients ranging from 3-60 years of age. His primary theory base when conducting counseling is Choice Theory.

**Analysis of Data**

This section will provide information about the themes that emerged from the interview questions with the participants regarding secondary traumatic stress in counselors.

**Interview Question 1**

How do you feel your work with sexually abused adolescents impacts you?

**Physically.** The first theme to emerge was the “overwhelming physical impact” secondary traumatic stress has on counselors. Figley (1995) describes the physical impact of secondary traumatic stress as a state of tension and preoccupation with traumatized clients’ where the mental health professional is re-experiencing traumatic events, avoidance of reminders, and persistent anxiety associated with the client. Symptoms are believed to include: difficulty sleeping, increased startle response, avoidance of places or things that are reminders of the event(s), obtrusive thoughts and images about the event(s), and depressed and/or anxious moods (Alkema et al., 2008).

Maine posited this in regard to the physical impact of secondary traumatic stress, as “it impacts me in several ways. It has caused me some trauma, in that it affects my sleeping patterns, how I dream, etc.” Suzie expressed this idea as well, but she also expanded this idea beyond her sleep and dream life.

**Suzie:** In the beginning, for me, I started seeing everybody as someone who could possibly be an offender. If I saw a child I would analyze who they were with, watch their interactions, etc. Initially I was hyper vigilant
and it created an increased startle response in me that could be overwhelming to manage.

Sally voiced a similar thought, “It has affected me in a lot of ways. There are some positive results and some negative results. It has impacted my ability to trust what I see… to trust, period.” She went on to say, “There were times I remember feeling like I had the flu, a weary and defeated feeling that I couldn’t shake.”

**Sally:** At times, I see a perpetrator behind every bush. I think you're just a lot more suspicious of people because you see the results of sexual abuse on these children. And so you're a lot more suspicious about people. I tend to see that. I also tend to see that there's some of those cases that have become so personal that it's hard to leave them at the office. And it can impact you…for me, it's impacted my sleep, my ability to rest and just to, you know, kind of gear down from the day, because you kind of …there's some of them that are just kind of hard to leave at the office. And you tend to take them home. And then it kind of -- that kind of negatively impacts you in a myriad of ways, your health, and even relationships at home can be impacted by what you experience at the office in those sessions.

Maine also expressed a similar idea regarding the impact on “the trauma” working with this population has caused her.

**Maine:** It has impacted me in the way in which I am aware of the depth of what is going on in today’s society. It is no longer “what you see is what you get,” instead it is unsure. I have become more hyper vigilant with the safety of my own
children, as well as mine, and that of my clients, to almost an obsessive level. Carlos stated the physical impact, for him, was typically an initial issue for him, but one that subsided with time.

Carlos: It generally tends to create a lot of stress in me initially, due to dealing with sexually abused adolescents is somewhat awkward in the early stages. I think it creates initial feelings of nervousness, and physical stress in both the client and the counselor, but subsides as the counseling relationship develops.

**Emotionally Pervasive.** A second theme that developed was the pervasive manner in which the participants were impacted on an emotional level. Alkema et al. (2008) refers to this phenomenon as a deep sense or quality of knowing, or awareness among helping professionals of the suffering of another coupled with the wish to relieve it; a deep physical, emotional, and spiritual exhaustion accompanied by acute emotional pain. Emotional symptoms tend to mirror that of Post Traumatic Stress Disorder (PTSD) from an indirect trauma perspective. These include: difficulty eating, difficulty sleeping, intrusive thoughts, feelings of helplessness, flashbacks, hyper-vigilance, irritability or outbursts of anger, and difficulty concentrating. These participants believe the emotional impact of secondary traumatic stress is pervasive in nature. AA states that initially it was difficult to buffer herself from the emotional impact but she has developed some skills over the years to manage it in a more productive manner. Lacie agrees that the emotional impact reaches beyond working with that particular client.

Lacie: It impacts the way you address people following that session – things flow from that client onto others you deal with throughout the day.
That emotion gets transposed onto other people and situations. It impacts what you take home at night; what you cover in your prayers in the morning; it amplifies any situation going on. On those days, you love on your kids a little more, spend more time with them, and on the days when it is rough, your spouse may get less conversation, as you try to deal with everything going on in your head.

Penelope likewise mentioned the emotional impact as “trying at times” and one that needs to be managed on a daily basis. Doug stated that at times “hearing these stories will bring even a strong person to tears,” to which Suzie agreed.

**Suzie:** I treat juvenile offenders, mainly, however many of them have been victimized as younger children. When they tell their stories, I can somewhat visualize what is happening in my mind and it is enough to bring you to tears. I do cry at times, not in front of my client, but later on, like at the end of the day. It’s very difficult to let that go sometimes and go on with life as if you never heard that.

**Time Matures the Effect of the Impact.** The third theme that emerged was the concept of time maturing the effect the impact of secondary traumatic stress has on these participants, especially the participants who have been practicing for six or more years. AA began this idea by stating that her work with abused adolescents has given her an awareness and understanding of the cruelty that can be perpetrated from one person to another.

**AA:** Working with this population has given me an appreciation…an awareness and understanding for the horrors that humans can perpetrate on
humans. I think this has helped to mature my skills and I think I am maturing as a human being through this. Working with these clients has also given me an appreciation for the strength of human beings, and their resilience to endure and work through traumas of this nature. It’s their story, not mine, so I don’t need to take it on; I need to be there to walk them through their journey. I’m blessed that they are sharing their story with me, that they have developed enough trust in me to see me as someone who can be on this journey with them. I just need to listen and reflect and that is my job in this. Feeling with them is not my job. Allowing them to feel what they are feeling, and be there with them in that and be safe for them. It helps me to hold my boundaries in that situation.

Penelope states that she has also matured through the process of working with these abused adolescents. Her position is similar to AA.

**Penelope:** Though it is trying at times, it is also enlightening to see such young individuals have such incredible strength. It motivates me to be equally as strong in working with them, so as to help them feel empowered, not disempowered in their situation.

Doug speaks to this as well. Doug states, “Initially, in hindsight, I felt like kind of a wreck, but over time, I have been able to learn different perspectives so I’m not impacted like I was in the early days.” Carlos, also, states the impact is shorter lived than in the early years.

**Carlos:** I do all I can do in the moment to help that client, and then I move onto the next task. It may sound harsh, but it works for me. I do my job,
have closure by making sure I have done all I can do, then I can put it to 
rest for the time being, and be good-to-go for my next client or situation I 
have to encounter.

Interview Question 2

How would you define Secondary Traumatic Stress?

Figley (1995) defines secondary traumatic stress as the experience of those who 
come into continued close contact with trauma survivors and their stories, including their 
oral and visual evidence. Secondary traumatic stress is viewed as an occupational hazard 
of providing direct services to a traumatized population. It is a natural, consequent 
behavior and emotion resulting from knowledge about a traumatizing event experienced 
by another person and it is the stress resulting from helping or wanting to help a 
traumatized or suffering person. A collective, summarized definition for secondary 
traumatic stress from the participants of this study is: pervasive stress that adheres itself 
to you and traumatizes the mind and body due to the empathy we have for our clients to 
the point of experiencing anxiety, grief, and PTSD like symptoms.

The participants in this study defined secondary traumatic stress in their own 
words. AA, Suzie, and Maine utilized personal experiences or stories to describe their 
definition of STS.

AA: I have a great example of this. In the early part of my career, I 
developed a belief that -- and every time I saw a dad in the park with his 
children, he was a perpetrator. Or a dad in Walmart with his kids and no 
mom, he was a perpetrator. I began to see all men with children as evil 
perpetrators. And, you know, I think that that was a clear example of the
traumatic stress and that it colored my entire world, not just the clinical aspect of my everyday life. There was an impact that had to be worked through to be able to say, you know, how to address that and how to buffer my own mental capacity not to go there. So defining it is, you know when you're having negative symptoms, whether it's emotional or intellectual or behavioral as a result of what you're listening to day after day after day, I think that's secondary traumatic stress.

Suzie utilizes a similar story to explain how she defines secondary traumatic stress.

**Suzie:** Well, It's, like, I know that not everyone is an offender, but it's hard because you just start thinking -- you start eyeing everybody as someone who could possibly be an offender. You can think that after hearing some stories from people you work with. It's hearing the story of someone sitting in a group that I do. I'll just give you an example. I was sitting in a group with a person who says, yeah, I was sexually abused by my mother; here's how it happened . . . And it's just, the grief, it's just overwhelming because it's easy for me to put myself in that person's shoes and I feel like I'm standing right there watching the abuse. And I can feel the effect that it's having on that person. And it just gives you cold goose bumps because you just feel sick, like you feel helpless and cannot help them, but you know that you need to.

Maine shared similar feelings of sadness and helplessness as it relates to her definition of secondary traumatic stress, along with her ability to visualize aspects of the
stories that are shared by her clients. She likened secondary traumatic stress to the concept of PTSD, by utilizing PTSD as the basis for forming her definition for secondary traumatic stress.

**Maine:** Define secondary traumatic stress? That's hard because I'm sitting here thinking, okay, what's the definition of PTSD? And, you know, I think about, okay, what's the definition? And it means that, you know, you have to have something that's a threat to you or someone you love. But I think when you're talking about secondary traumatic stress, you're talking about something that is a trauma, it's a trauma to the mind. It's something that even though it may not have specifically happened to you, there is such pain and such hurt in it that it does affect you. I think that as a counselor we have a high level of empathy for others and the ability to walk alongside someone, and so when you hear something like that and then not being able to help. I would almost describe it like watching someone get hurt or traumatized and you being tied up and not being able to do anything about it. And so then you go home with that. And then, to me, those, you know, when you hear them over and over and you have, you know, numerous victims coming in and talking to you and it's just kind of the same theme throughout, I don't know, to me, it's almost a helpless feeling.

Carlos defined secondary traumatic stress as a form of continued stress that sticks with you over time, and at times affects all aspects of his life.

**Carlos:** I would say that the continued stress that I experience from
working with different clients causes me to feel an additional stress that sticks with me and bleeds over into the rest of my personal life at times. Not all of the time, but there are times it does.

Lacie adds to Carlos’ statement by stating, “I think it’s an emotion from something dealing with that individual that adheres itself to you.” As well, Doug continues this thought utilizing a quote he heard (whose author is unknown).

**Doug:** It’s emotion from your client that is like, well let me explain it this way, from I quote I heard: working with trauma and expecting it to not impact you, is like walking in the rain expecting to not get wet. It just happens. Sometimes it is more intense than others, but it always affects you.

Penelope describes secondary traumatic stress as a settling of the information, emotion and energy on the person giving treatment.

**Penelope:** I would call secondary traumatic stress to be the residual effects that the information, emotions, and energy settle onto the individual giving the treatment. So when you're working with a victim and their stress is given to you as they portray, discuss, share their experiences, it's not just verbal but it's very emotional and there's a certain energy to it that I feel like literally transforms to the person they're speaking to when you're in the moment with them. Trauma just sticks to you a little bit, or a lot depending on what the client is sharing.

Sally concludes with her definition of secondary traumatic stress as causing a trauma that produces a heightened level of stress and anxiety in the counselor due to
hearing the stories of abused adolescents over long periods of time.

**Sally:** I feel like that you as the counselor are being traumatized by the stories and the information that you hear on a daily basis from these kids. We are…you're experiencing your own kind of trauma. It's not the same…it's not as severe as the trauma they experience. But by hearing those stories over and over again, the impact it's had on them, it's traumatizing. And it creates that level of stress and you just keep having that feeling of anxiety listening to those kids tell their stories over and over. And, to me, that's what secondary traumatic stress is, that you're traumatized just by hearing these stories over and over and over again.

**Interview Question 3**

In what ways do you feel best addresses your experience with secondary traumatic stress? Are there specific things that you do in order to manage secondary traumatic stress?

**Collaboration with peers or mentors.** The first theme that emerged in this area was collaboration with peers, or mentors. The American Counseling Association Code of Ethics (2005; 2014) discusses the manner by to which counselors are to conduct themselves at times of ethical dilemmas. Forester-Miller and Davis (1996) composed the model utilized by the American Counseling Association for resolution of ethical dilemmas and instructs collaboration with peers, mentors, and other counselors when seeking a solution for an ethical dilemma.

Most of the participants in this study stated collaborating with colleagues as their first line of defense when feeling the effects of secondary traumatic stress. AA stated that
sharing stories and hearing herself say things out loud to a trusted colleague can oftentimes diminish the feelings she is experiencing and minimize the impact of secondary traumatic stress.

**AA:** Collaboration with colleagues is one of the first things I will do. Because sometimes we have to hear ourselves out loud, what we've heard, to another person…where we are thinking and feeling in order to hear their feedback so that we can adjust where we need to be with that…. And sometimes that pulls us out of where we might have gone with that client. Some of the things we listen to are so horrendous. Processing with my spouse who is also a counselor, because, you know, he has years more experience than I do. You know he can always help me shift the way I'm looking at something and help me distance from it if I've become too invested emotionally in a situation.

Carlos added to this idea by stating, “Well, I do, in a healthy way, try to process with other therapists in the office when I appear in an initial, very stressful trauma situation or event that a client has told me about. Lacie continues by stating the importance for enlisting input from colleagues and mentors, “I have been really blessed to have good mentors along the way, that help me through issues as they arise. They do it almost intuitively, and that is helpful to not have to come and seek out help all of the time.” Maine states that talking to other counselors makes her feel less alone in her secondary traumatic experiences.

**Maine:** …just being able to be able to talk to other counselors has helped, being able to share the experiences I am having. For a long time, I
thought I was the only one that had secondary traumatic stress issues. And then I was able to kind of start opening up to some counselors and found out that, no, I'm not the only one. It's something that everybody that I've talked to that specifically deals with high trauma cases experiences.

Penelope, also, finds speaking with other counselors, and mentors helps her to maintain a balance in her work life and helps to keep work from bleeding over into her personal life.

**Penelope:** Processing with my co-workers, my fellow counselors, is incredibly important to me to help manage and sort the way that I internalize the stress that I absorb from other people. It helps me separate a personal issue I may be having with the information presented to me versus a struggle I may or may not be having on a professional level.

Suzie commented that she also collaborates with other therapists when needing to discuss issues regarding secondary traumatic stress. She adds that she likes to also speak with others who have less trauma related jobs to gain balance in her life. She states, “I like to speak to others who don’t experience daily what I do, don’t hear what I hear. It adds a balance to it all.” Sally stated a similar idea of talking to colleagues, but also to others whose idea of a normal day is a “different kind of normal”.

**Sally:** I, of course, collaborate with other therapists, colleagues and mentors, and then I just find, you know, socializing with people that aren't connected with the counseling people, the counseling field. People that have a different…I would say a different kind of normal, which kind of balances things out.
Compartmentalization and Self-Care/Wellness. The second theme that emerged in this area was the idea of compartmentalizing work life from personal life and the practice of self-care or wellness in the counselor. The American Counseling Association Code of Ethics (2005; 2014) addresses the concepts of (a) promoting the welfare of clients, and (b) avoiding the harming of clients in the process of counseling services. Meyers, Sweeney, and Wittmer (2008) posited, Professional counselors seek to encourage wellness, a positive state of well-being, through developmental, preventive, and wellness-enhancing interventions. Wellness conceptualized as the paradigm for counseling provides strength-based strategies for assessing clients, conceptualizing issues developmentally, and planning interventions to remediate dysfunction and optimize growth. (p. 482) Penelope embraces this concept by compartmentalizing her personal life from her professional life through the use of strong boundaries, and good self-care. Penelope: On my good days, I use proper diet and exercise to help channel my energy and other calming relaxation-type techniques such as deep breathing, reading, retail therapy, things like that that help me kind of decompress. And, also, spending quality time with my family and friends, because in working with trauma victims, I feel that I gain a greater appreciation for the times I have with them, and it gives me permission to maintain strong boundaries allowing me to compartmentalize my life into two parts.
AA also loves exercise, the outdoors, praying for guidance, and spending time with family. She also feels that maintaining strong boundaries is an important element in managing her secondary traumatic stress.

**AA:** Feeling with them what they're feeling is not my job. Allowing them to feel what they're feeling and be there with them in that and be safe for them. And that's really helped me to hold my boundaries in that situation. My husband also helps me to maintain these boundaries when I feel tempted to breach them. He is very good at separating work from personal life, and I really appreciate his help in that for myself as well.

Maine utilizes compartmentalization, along with prayer as one of her main wellness activities to help address her secondary traumatic stress experiences.

**Maine:** I think that as I have matured through the counseling, it's changed. I think part of it, I'm able to just kind of compartmentalize and put it in a part of my head where I just don't think about it. Once I close that folder, then it stays in that folder and I kind of visualize that; it's just staying in this folder and it's not coming home. I pray a lot for my clients. I just pray protection over them. And there have been a few cases that I've had that have been extraordinarily graphic. And those things do come back to your head over and over which is why it is so important to have those stop gaps in place to help assist you in compartmentalizing information that may be extraordinarily difficult to do otherwise. I also enjoy several hobbies and activities with my husband and children, which take us outdoors and into nature, which helps me to appreciate all of God’s
creation. It has a way of putting everything in perspective.

Carlos adds to these statements by intentionally and actively working to not personalize the information he encounters. He remains purposeful in the session so he can better keep the information shared in that moment and in that session, and prevent as much bleed over as possible.

Carlos: One thing I do to try to manage my secondary traumatic stress is I try to compartmentalize that information and not personalize it, not think about my children or grandchildren when I think about these young victims telling me about their circumstances, because that creates a lot of stress when I personalize. So I try to compartmentalize that and only think of them when they tell me about their stress or their abuse. I also enjoy walking, golfing, skiing, and spending time with my wife and children, and grandchildren. I try to implement the full scope of the wellness model that we learned about back in graduate school. It helps bring a balance. I also pray a lot…for me that is very helpful in all situations.

Doug agrees with Carlos’ statement and adds that music is a great source of calm and peace for him. He revealed that he has played a musical instrument “for as long as I can remember and it really helps me to gain a new perspective on things when nothing else can.” He continues that it has worked for a long time, and it is in some of the “toughest moments as a counselor that some of the greatest music I have written has been born.” He encourages counselors he works with to have hobbies that are completely different than work to help add a balance to their lives. He also states his family and
friends are good to keep him grounded. He stated he also prays and asks for guidance on a daily basis.

Sally, also, embraces time with family, prayer, and having a social circle of people with different work experiences to help her on her wellness journey.

**Sally:** I have several things that I do to address the secondary trauma. And first of all, I'm a person of faith. I believe that my faith and my prayer life very positively impact that, because there are, I think a lot of times with secondary stress or secondary trauma is that it's a feeling of lack of control and I can't do anything to fix this. The way I can address that is through my prayer life. And then, you know, reading and meditating on the Word of God. That impacts me more than anything else in this battle. The second thing is that every once in a while I need a grandkid fix. You know, to get around kids that are happy and healthy and have good supportive families and aren't experiencing all this trauma. I just have to do that to kind of balance out the negative side. And then I just find, you know, socializing with people that aren't connected with the counseling people. People that have a different kind of normal. That kind of balances things out.

Suzie utilizes similar strategies to address her secondary traumatic stress, including outdoor activities, family, and travel to different places for a change of scenery.

**Suzie:** I pray a lot. I talk to other therapists and my husband, of course I leave out any identifying information and a lot of the detail to preserve
him from getting secondary trauma, too…and I spend time outside, and I look up at the stars. I also realize that there is more to life than this trauma, all of the negative stuff. We have several properties we can retreat to if we want to get away, which is nice, because we have a ranch and a cabin in different states, so we can go to a different location and see different scenery. We have children and grandchildren with whom we love to spend time. We also love to golf and ski and work in the yard, do things that allow us to be outside, breathing the fresh air, etc.

Lacie agreed with the statements of the other participants as well as adds the concept of planning. Lacie plans her schedule according to the types of clients she has in that day and will manage her calendar to reflect breaks and longer lunches as necessary, especially if the likelihood of additional trauma is recurring with a client or type of situation.

**Lacie**: If we're dealing with traumatic reoccurrences and we know that that's an issue with that individual, or situation, we try not to work to back-to-back. We try and provide some breathing room and to make sure you're not working sun up to sundown that day so that you have some kind of time to decompress and compensate before you go home and try to be a part of your family. Because your clients need your 100 percent, but your family does too. It is important to do both. Also, in my world, prayer is my go-to for relieving stress. That is how I grew up and how I was trained, and it is what’s most effective for me.
**Interview Question 4**

What secondary traumatic stress management skills did you learn in graduate school? Post graduate school?

**Graduate School.** The general consensus among the participants was that most of the skills for managing secondary traumatic stress were learned post-graduate school; however, most of the participants recall the concepts of self-care and collaboration with other counselors as a conversation that transpired initially during graduate school. The manner by which these concepts were applied or responded to by each of the participants differs depending on various factors.

Maine describes her understanding of self-care from graduate school as “not overworking yourself, making sure you bucket was full, not empty, etc.” She states she never realized that counseling others would be traumatizing. She found this to be quite shocking to her as it began to happen to her and she recalls struggling with how to effectively manage the situation. She recalled a comment being made in graduate school by a professor, that counselors should have their own counselors. With that memory, she hired a counselor for herself, whom she sees to date.

**Maine:** Well, I think that what I learned about secondary traumatic stress and how to handle it in graduate school was nothing. I didn't even know that existed in graduate school. I would never even have thought you'd be traumatized by counseling someone else. I don't recall anything ever being said about that. And, of course, the work that we did in graduate school in working with other clients, it's not the kind of trauma I work with now. It’s nowhere near what I work with now. I did recall, once I
started experiencing some unsettling trauma from working with my abuse clients, that it was mentioned in graduate school for all counselors to have their own counselor, so I got one. That has been a tremendous help in the management of my secondary trauma.

Sally recalls a similar experience in graduate school and found that she was disappointed by the lack of emphasis placed on daily self-care practices. Prior to graduate school, she had worked for over 20 years in a non-counseling capacity with traumatized children and knew the need for the practice of good self-care strategies.

Sally: To be real honest, it's something that we just kind of skimmed over in classes. We didn’t really spend a lot of time really talking about self-care. But I've worked in the field with abused and neglected children for 20 years, so I've had extensive training and have been taught lots of different skills for that. When I tried to discuss it with the other students, they kind of acted like I was overreacting but I continued to talk to them about it. I kind of wonder if the professors really understood it themselves. I am not sure that they had been in private practice, or in any setting outside of academia, so I am not sure they realized how great the need could be to have self-care as it applied to clients and trauma.

Lacie attended a university where prayer for stressors was emphasized. Though this is a daily, effective skill for her, she believes more practical education could have been taught to aide in her self-care practices.

Lacie: Graduate school was always real big on self-care, self-care, self-care, but nobody ever said what self-care was. There was never an
example, there was never anything. Because I came out of a Christian organization, there was a lot of talk about prayer but not much else about self-care. They talked about self-care a lot, but they didn't really give you an idea of why you might possibly need self-care, or what would, kind of, cause your need for more self-care? They used the terminology "self-care", but they never explained what that was. So we all kind of thought, so, okay, what does that mean exactly? Professors really couldn't explain it besides you just need to pray. It's like that wasn't in their scope of experience.

AA recalls leaving graduate school with a knowledge base on how to seek out necessary resources when experiencing personal issues due to counseling others or due to the needs of your clients. She states that they spent very little time on the experience of PTSD, which she feels would have been very beneficial once she established her private practice and began experiencing those types of symptoms. She feels that self-care was emphasized, but not with the fervor that she felt, in hindsight, was or is necessary.

Penelope states a similar idea by stating, “I feel like the skills that were taught in graduate school were appropriate, but they weren't necessarily communicated with the amount of emphasis they needed.” She continued, “I know that I was directed to find positive self-care, but I don't think anybody is quite prepared for the depth of the internalization that can happen.” She concluded, “It doesn't happen with every case, but some cases hit closer to home than others, so it is vitally important to have good self-care practices in place.”

Carlos, Doug, and Suzie recall learning the wellness model in graduate school.
They also stated they were older graduate students who “had some life experience to make me realize I needed to listen to what they [the professors] were saying, especially if they repeated it more than once.” Carlos stated that he exercised prior to graduate school, which was an immediate stress reliever; however, when he was taught the wellness model over several semesters, he embraced all facets of the wellness model and began to implement them in his daily life.

**Carlos:** We had to do the wellness model for an assignment over several semesters. I saw that it forced me to schedule time for it, and it seemed to work well to balance my life, so I continued doing it. I have been doing it ever since. I break the components down into spirituality, family, finances, education, and exercise, which isn’t the exact way I was taught but it is what I have kept as my personal wellness model.

Doug reports a similar experience in graduate school, but also had a professor who shared his love for music and encouraged him to implement music into his wellness model. He stated that his professor told him, “if it works for you, then do it, just make sure to keep a balance in all you do, moderation, son, moderation is the name of the game.”

Suzie also reports a similar experience but due to a “personal tragedy” in the life of one of her professors, she embraced his directive for self-care. This experience was reinforced by other professors she had, so she recalls her graduate school experience as “impactful.”

**Suzie:** During graduate school I remember one professor saying things like, you’ve got to take care of yourself. Then one day, my primary professor walked
in and he was really sad and talked about this counselor who had committed suicide. He was like, “please, call or talk to somebody before you get to that point or you just feel overwhelmed. As counselors you hear lots of grief. People don’t usually come talk to a counselor because they are happy and everything is going well for them.” He encouraged us to have our own counselor. Having that example gave me an awareness; I think all of us [students], an awareness that sticks with you, that you were going to have to figure something out to take care of yourself. It was surprising, enlightening, and definitely got me thinking. Later on we had a professor that required us to complete wellness plans for a grade for 3 semesters in a row. I got into the habit of doing it, and I have continued doing it to this day. It is really an effective tool for me.

**Post graduate school.** The majority of the participants attribute their skill development to post-graduate school training and life experiences. As Penelope stated in an earlier comment, “though I found the training given to me in graduate school, appropriate, it needed more emphasis.” The participants stated that once they were in private practice, or another related environment, the skills they needed became apparent to them causing them to seek out skills they were in need of. The consensus of the skills acquired post-graduate school that were found to be most effective in managing their secondary traumatic stress include: collaboration with colleagues, having a personal counselor, practicing good self-care, having a good support system with mentoring-type relationships, attending trainings, and for most of the participants, prayer.

Lacie attributes acquiring her post graduate school skills to her mentors, trainings and trial and error.
Lacie: Mostly outside of graduate school, I learned through trial and error, and thankfully some very good mentors that have helped me out along the way. Since the completion of graduate school, I have taken many trainings because I feel they are definitely beneficial. I think everyone needs to continue adding skills, even if they think they have a handle on things because you never know which day you’re not going to have a handle and need different skills to use to get it back.

Penelope adds her belief is real learning takes place outside of the classroom environment, when you are in private practice, and utilizing what you have been taught and what you have read. She has utilized trial and error, realizing some things that sound good in theory, are not practical in her daily life.

Penelope: I think the real lessons and the real learning takes place when you’re actually practicing and having appropriate mentorship and supervision and a good relationship with those mentors and supervisors to help process what you’re going through most appropriately and reinforcing the skills that were discussed and taught. And finding which ones that you read in a textbook might have sounded attractive at the time and actually putting them to trial and finding out what works for you and what doesn’t. What I have found works best for me, on my good days, is proper diet and exercise to help channel my energy. I use other calming, relaxation-type techniques such as deep breathing, retail therapy, reading, and things like that to help me decompress. I also like sending time with my family and friends, because in dealing with trauma victims, I feel like I gain a greater
appreciation for the times I have with them.

Doug stated that in addition to maintaining good self-care practices, collaboration is another key to managing secondary traumatic stress. Doug asserted the ability to openly share with colleagues some of the struggles he was having with client situations he was experiencing proved to be helpful in keeping a realistic perspective on his work and role within the counselor-client relationship. He reports his support system is so vast in the community that he does not have a specific person he seeks out for “counseling, per se, but I have a lot of people I can talk to on just about any client topic. It is very nice to have that type of support system.” Doug also finds mentoring others, as he has been mentored, is rewarding in helping “the next generation not experience the intensity we older counselors did, prior to all of the resources that are now available.” Doug states attending seminars that address these types of issues are always helpful for educational and networking purposes.

Maine attributes a good support system and good mentors to her success in managing secondary traumatic stress. She discusses the ability to feel “normal” in her discussions with other counselors, when she once felt alone in her struggles with difficult client situations.

**Maine:** In the beginning I would just go home and cry. I mean, I did not know what to do with that information. But once I got my own counselor and gained the courage to open up about my struggles with what I was hearing, I think for the most part, just being able to be able to talk to other counselors has helped, being able to share that. For a long time, I thought I was the only one that had that. And then I was able to kind of start
opening up to some counselors and found out that, no, I'm not. This is something that counselors who work with high trauma cases experience.

Other counselors seem to have some of the same reactions I do which helps to normalize my feelings.

AA agrees with Doug and Maine on these points, adding that balancing the work she does, between victims and offenders, helps her to maintain a good understanding as to why people do what they do. While this may seem to be more geared toward a work-related understanding instead of a secondary traumatic stress understanding, she emphatically postulates that knowing what to look for, how to respond to what you see, and how to educate victims, as well as offenders on the impact of their actions, alleviates a great deal of potential stress due to the ability to leave the session in the session and not allow it to carry over into other parts of your life, work or personal.

Carlos and Suzie work with similar clientele as AA, and agree that her statement is a valid one, and one that they embrace as well. Carlos states in addition to these he values time with his family, weekend trips with his wife, and attending trainings that are pertinent to his work. He hosts collaborations on a weekly basis for counselors of all experience levels to gain support and insight. He also utilizes prayer as a vital part of his daily life and his overall wellness plan.

Suzie, in addition, appreciates the resources provided by her service contracts to attend “pertinent, cutting-edge trainings with all of the best of the best.” She feels that gaining knowledge from some of the pioneers in the field is helpful and allows her the opportunity to be mentored by people with experience beyond “the norm.” She participates in monthly collaborations where she is able to be a part of a “community of
counselors” where they support and encourage each other in more difficult cases.

Sally summarizes that the balance of work, exercise, family time and attending effective trainings are the manner by which she addresses secondary traumatic stress. She attributes her skill acquisition to these factors, mainly outside of the classroom, but implores classroom training on this is imperative. She continues by stating continued education on this subject is necessary to preserve the counseling community.

**Further/Future Training Sessions.** This theme emerged during the initial interview and continued throughout all interviews. All participants stated a need for further training, and requested information on future trainings on this subject. Maine, Suzie, Lacie, and Sally feel more training is necessary and would attend any training given on this topic.

**Maine:** If training was offered on this topic, it definitely would be something that I would attend. I think that it would be very helpful. Not your “compassion fatigue” type training, but one specific to this exact topic on the experience of secondary traumatic stress in counselors.

**Suzie:** More training is needed to keep people from getting overwhelmed and leaving the field. I would definitely attend a training given on this topic, as many as I could to help me be better for myself and my family and my clients.

**Lacie:** I think that this study is covering a much needed field that hasn't been covered and missed along the way that would definitely allow counselors that are dealing with this to allow them not only deal with this better, but each of their clients a little better, so a specific training in this
area is very important to the wellbeing of us as counselors and for our clients.

Sally: I think there's definitely a need for it, because even though you may have gone to two or three, twenty different trainings on this, you're going to encounter different kinds of trauma all the time. I think a lot of people don't even realize that they're going to be suffering this trauma. You know, they don't come in prepared knowing that they're going to experience that. And so it's always good to learn new ways to deal with that. And if we don't deal with it, then I feel like we become ineffective in serving our clients. Because if we can't deal with those issues then we can't be helpful to them. So I think it's something that we should continually be working on and continually looking for new ways and new strategies for helping counselors as a whole deal with and helping them to understand that it's something that will occur.

AA believes training on this topic would serve more than one purpose. She feels it would also benefit the community by building camaraderie in counselors and facilitate the development of collaborative groups by which counselors could process in a safe environment.

AA: I think trainings on this topic would serve several benefits, to include awareness of the topic, development of camaraderie within the counseling profession, and provide the opportunity to create collaborative groups for us to decompress with one another in a safe environment.
Carlos, Doug, and Penelope state they would attend additional trainings on this topic, however, would like the topics to be progressive with the current research and literature.

**Carlos:** In the past few years I have gotten kind of a saturation with the subject; however, I do think it is important and would attend training if it were offered, especially if the training offered something beyond the normal self-care type training. I am also aware that most counselors I have spoken with have not had trainings specific to this topic.

**Doug:** Trainings specific to this topic, in my opinion, cannot be done enough. We all experience things differently and as the research improves in this area, the more we can learn how to better manage this through trainings offered to us.

**Penelope:** I would consider attending training in that area. My concern would be the content of the training and the benefit and the value of my time and money spent in receiving the training, because to attend a training to be taught or reminded of everything that I learned in my initial training to become a counselor, I feel like it would be redundant and not really beneficial. So, for example, I wouldn't find it helpful to go to a training and be taught how to do deep breathing and muscle relaxation exercises that I do all day long with my clients. It would have to be more substantial and more specific to us as counselors than just general stress reduction type stuff.
Summary

Through identifying the major themes of interviews with the participants, the results hopefully offered insight into counselors’ experiences of secondary traumatic stress. This chapter presented details from the individual interviews of each of the LPCs. It also included insight from the researcher after the interviews were transcribed and the participants’ thoughts were placed into specific themes. The results identified several themes regarding the impact of secondary traumatic stress on counselors such as the impact is (a) physically overwhelming, (b) emotionally pervasive, and (c) over time the effect of the impact matures within the counselor. In regard to the participants understanding of secondary traumatic stress, the themes identified were: (a) pervasive stress that adheres itself to you, (b) trauma to the mind due to client empathy, and (c) the experience of anxiety, grief, and Post Traumatic Stress symptoms. The themes identified regarding management of secondary traumatic stress were: (a) collaboration with colleagues and mentors, (b) a support system within the community, (c) compartmentalizing your work and personal life, and (d) self-care. When reviewing secondary traumatic stress management skills acquired, the concept was divided into skills attained in graduate school, and skills attained post-graduate school. The themes that emerged from the graduate school division were: (a) minimal specific training regarding secondary traumatic stress, and (b) self-care. The themes that emerged from the postgraduate school division were: (a) collaboration and trainings, (b) support system and mentorship, and (c) prayer. A final theme that emerged was the need for more training on the topic of secondary traumatic stress in counselors. The results of this study reveal that counselors need an awareness of the impact of secondary traumatic stress on
their lives to effectively acquire the necessary skills to minimize the physical and emotional effect secondary traumatic stress can produce in them. The next chapter will present discussion of the findings, conclusion, implications and future research.
CHAPTER V

DISCUSSION

The final chapter contains analysis of the implications of this research study and includes the following: a summary of the results of the research, implications for theory and practice, recommendations, suggestions for further research, and a closing statement.

Summary

In order to ascertain the experience of secondary traumatic stress in counselors who work with sexually abused adolescents, this grounded theory study was conducted. Grounded theory was chosen due to the lack of published literature and research in the field of professional counseling regarding this topic (Berg & Lune, 2012). As a result of the literature review, the following research questions emerged: What identifiable traits are present in counselors who experience secondary trauma stress when counseling victims of sexual trauma? What particular skills do counselors who manage secondary traumatic stress utilize? What identified skills were noted as acquired in graduate school and post graduate school?

The purpose of this grounded theory study was to explain the process of counselors’ experience of secondary traumatic stress when counseling sexually traumatized adolescents. Throughout the data analysis, secondary traumatic stress was defined as the natural, consequent behavior and emotion resulting from knowledge about a traumatizing event experienced by another person and it is the stress resulting from helping or wanting to help a traumatized or suffering person (Figley, 1995). The secondary purpose of this study was to increase the knowledge base about the impact and management of secondary traumatic stress in counselors.
In order to answer the research questions, eight Licensed Professional Counselors (LPCs), three also identified Licensed Sex Offender Treatment Providers (LSOTPs). All participants self-identified as Trauma Informed Treatment Providers as defined by the National Child Trauma Stress Network, are service providers who routinely screen for trauma exposure and related symptoms; make resources available to children, families, and providers on trauma exposure, its impact, and treatment; engage in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma; address parent and caregiver trauma and its impact on the family system; maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff resilience (National Child Trauma Stress Network [NCTSN], 2014).

All participants in this study have been practicing counselors for at least two years. Six participants held PhDs, and two participants held Master’s degrees, and are currently completing the dissertation requirements to obtain their PhD. The participants consisted of six females who ranged in age from 31-55 years of age, and two males who ranged in age from 51-55 years of age. Their experience as LPCs/LSOTPs ranged from 2 to 23 years. All of the eight participants identified as Caucasian, with four of them also identifying as (1) Hispanic, (1) Irish, English and Dutch, (1) Indian, and (1) Indian and Dutch. All of the participants resided in west Texas.

“Theorizing is the act of constructing… from data an explanatory scheme that systematically integrates various concepts through statements of relationship” (Strauss & Corbin, 1998, pg. 25). Thus, utilizing grounded theory helps to gain a deeper understanding of lived experiences. During the process of data analysis of this study,
four primary categories emerged from the research questions: (1) impact of secondary traumatic stress, (2) the counselors’ understanding of secondary traumatic stress, (3) counselors’ management of secondary traumatic stress, and (4) secondary traumatic stress management skills acquisition. Further coding and analysis of the data provided themes within each category. The major themes that emerged from the data analysis were: (1) the physically overwhelming manner by which the participants were affected, (2) the pervasive emotional impact on the participants, (3) collaboration, mentorship, and support system, and (4) further training, and graduate curriculum. A brief summary of the themes that emerged from each of the research questions is provided in the following paragraphs.

The first theme depicts the physiological effect that secondary traumatic stress had on the participants. All eight participants commented regarding: difficulty sleeping, difficulty concentrating, difficulty winding down and resting, hyper vigilance, health issues, and increased stress (Figley, 1995). The second theme encompasses the pervasive emotional impact experienced. This theme identified the emotional and psychological symptoms experienced by the participants, due to client empathy, according to all eight participants. Alkema et al. (2008) refers to this as the deep sense of quality of knowing, or awareness among helping professionals of the suffering of another coupled with the wish to relieve it. Client empathy is necessary in the field of counseling however, it can also be a venue by which trauma is experienced by the counselor.

The third theme involved collaboration, mentorship and support systems with colleagues. In addition to techniques of best practice in the event of ethical dilemmas, collaboration with colleagues and mentors was described as a source of resilience for
managing secondary traumatic stress (APA, 2014; Figley, 1995). Figley (1985) lists companionship, encouragement, comfort and advice as primary aides in the management of the effects of secondary traumatic stress. All of the eight participants discussed having a support system within the community that involved counselors and other professionals was described as beneficial when working through traumatic issues. The ability to speak with others who have had similar, as well as different experiences, helped to give perspective to a situation that could otherwise prove to be overwhelming (Figley, 1995).

Within this theme the ability to compartmentalize their work and personal life could be accomplished. The participants identified the need to separate their work and personal lives in order to be fully present in both situations. Not allowing work to intrude on their personal life, and vice versa, helped them to focus on the task at hand, giving full attention to what they needed to do in the moment (Flannery & Vanterpool, 1990). Another concept influenced by collaboration, support system and mentorship was the positive change over time that occurred within the counselor as they matured in the field and as a person. This identified the impact of secondary traumatic stress lessening, or becoming less impactful over time as a counselor employed more advanced coping skills to the secondary traumatic stress they experienced. Pearlman and Saakvitne (1995) stated the idea was for counselors to work with their clients to help clients fight their battles, not fight the battles for them. This in turn will minimize or potentially alleviate the potential for secondary traumatic stress in the counselor. Counselors recognition of these processes to minimize or alleviate these symptoms can aide in their understanding of secondary traumatic stress as well as the need to manage the effects thereof (Figley, 1992; 1995).
In addition the practice of self-care was emphasized, and encouraged by all eight participants. The participants identified several aspects of self-care to include: exercise, prayer, family time, proper diet, and the enlistment of music into a self-care regimen. Myers, Sweeny and Wittmer (2000) postulate that the five life tasks include: spirituality, self-direction, work and leisure, friendship and love, which are encompassed in the participants responses regarding self-care. The participants reported when actively practicing self-care, the effect of secondary traumatic stress was minimized. Prayer was discussed by seven out of eight participants as a necessary component to their ability to manage the stressors involved with counseling sexually-traumatized adolescents. White, Peters and Schim (2011) postulate:

Spiritual self-care and theoretical clarity is needed to understand the contributions of spirituality to health and well-being. Spiritual self-care is the set of spiritually-based practices in which people engage to promote continued personal development and well-being in health and illness (pg. 1).

A fourth and final theme that emerged was the need for more training on the topic of secondary traumatic stress in counselors. All eight participants involved in this study stated a need for further training on this subject to aide in the preservation of the counseling field. Training by effective presenters, either in the community or at conferences, would be helpful in continuing the self-care and secondary traumatic stress skills acquisition for the participants. Two participants specifically stated the trainings needed to go beyond the stress reduction focus and specifically address experience and
impact of secondary traumatic stress, along with the effective management of it. Figley (1995) implores trauma workers to seek training on the topic of trauma to aide themselves, as well as the population with which they work. Figley (1995) concludes that incorporating information on secondary traumatic stress and the management of this phenomenon, as well as on the physical and psychological impact of trauma, into training programs can serve many purposes.

Several patterns also emerged across the themes to include: the need to be connected to others; the need to be supported and understood; and the need for guidance and assurance. The pattern of connectedness involves both human elements and spiritual elements and was evident through the themes of collaboration, mentorship, and prayer (Figley, 1995). Hargrave (2001) stated that the effect of warm close, connected relationships was oftentimes the most healing component for people who are grieving, or experiencing a loss. Connectedness to the spiritual realm through prayer, church attendance, etc. was important over several of the interview questions which spoke to the physical and emotional impact and management of secondary traumatic stress. This pattern was implied by all participants as a comfort in many areas.

In addition, the need for support and understanding spanned over several themes, to include: the impact of secondary traumatic stress, the management of secondary traumatic stress, and the need for further training in this area. Participants shared that involvement in a support system included others who understood and supported them in times of need. Overall, this concept was important to their sense of belonging, security and safety within the field, and in their continuing education endeavors. When participants felt that other counselors understood what they were dealing with in their
secondary traumatic stress, they were able to continue practicing at an optimal level. This pattern also suggests that participants applied appropriate self-care to meet their various stressor experiences through mentorship and support.

The last identified pattern regards the need for guidance and assurance. The need for guidance and assurance was discussed in the impact of secondary traumatic stress, the management thereof, as well as the need for further training and education. This theme went deeper into the participant’s need for affirmation of their daily work in the face of intense stress and self-doubt (Figley, 1995). In addition, guidance and assurance validated that mentorship and collaboration was a necessary component for participants (Figley, 1995). When this need was met participants felt a greater sense of normalcy, hope, and resiliency from the experience of secondary stress.

Through individual interviews, these different themes and patterns developed a clear and persuasive understanding of the experiences that are felt by counselors as they counsel sexually abused adolescents. The information obtained should assist counselors and graduate school faculty in their attention, support, and instruction of secondary traumatic stress with other counselors and counselors-in-training. The need for further research regarding this phenomenon was the catalyst for this research study. The findings from this study provide insight about the secondary traumatic stress experiences of counselors.
Figure 1  Axial coding diagram portraying the interrelationship of causal conditions, actions, contextual and intervening conditions, and consequences with the core phenomenon of the management of secondary traumatic stress.

Implications for Theory, Practice, and Research

The research participants in this study recognized and confirmed previous research that counselors’ experiences of secondary traumatic stress closely resemble that of Post Traumatic Stress Disorder (Bride et al., 2004; Figley, 1995; Pearlman & Saakvitne, 1995). Also, this study supports the idea of secondary traumatic stress as the natural, consequent emotions and behaviors resulting from knowledge about a traumatizing event experienced by another person and the stress that results from helping
a suffering person (Bride et al., 2004; Figley, 1992, 1995; Kanter, 2007). Most participants described this process when counseling all abused clients, but specifically sexually abused clients. In addition, the experience of secondary traumatic stress reported in this study endorses previous research regarding mental health professionals’ vulnerability to this phenomenon due to several factors including isolation, empathetic understanding, and the desire to help suffering persons (Gentry et al., 2004; Figley, 1992, 1995; Kanter, 2007).

Therefore, the data collected from this study indicates the need for practicing counselors as well as counselor educators teaching counselors-in-training to anticipate, and subsequently manage the impact of secondary traumatic stress.

**Theoretical Implications.** Based on this study, the potential theoretical implications include the necessity to reframe the manner by which the counselor comes alongside their client and guides them through the healing process. Particularly, the concept of utilizing cognitive reframing to separate the counselors’ cognitions and emotions from the client’s experience, while remaining physically and emotionally present in the session is key (Beck, 1999). The interviews from this study indicated that the utilization of cognitive reframing to separate oneself from the information described by the client allowed the counselor to be physically and emotionally present while not in the midst of the “trauma story” and thus avoid the subsequent feeling of powerlessness the client experiences regarding their situation. This cognitive reframing creates a necessary boundary to protect the counselor from becoming overly involved in the process of healing with the client and feeling the sense of powerlessness felt by the client. As mentioned previously in the results section, AA stated that:
It’s their story, not mine, so I don’t need to take it on; I need to be there to walk them through their journey. I’m blessed that they are sharing their story with me, that they have developed enough trust in me to see me as someone who can be on this journey with them. I just need to listen and reflect and that is my job in this. Feeling with them is not my job.

Allowing them to feel what they are feeling, and be there with them in that and be safe for them. It helps me to hold my boundaries in that situation.

Much like other counselors she is reframing her experience into a role of support and guidance, instead of experiencing along with the client in order to maintain appropriate boundaries for herself and her client. Through this, counselor experiences in dealing with secondary traumatic stress would help them to develop the tools and abilities to maintain appropriate boundaries while meeting the needs of their clients (Figley, 1995).

Therefore, the above described implications for the utilization of cognitive behavioral theory techniques.

**Research Implications.** The purpose of this study was to explore the impact and management of secondary traumatic stress in counselors who work with sexually abused adolescents. Further, this grounded theory study explored the skills counselors utilize to manage secondary traumatic stress, as well as, the manner in which these participants acquired these skills. While insight was gained into counselors’ experience with secondary traumatic stress, several avenues for further inquiry are suggested. First, given the limited scope of the study with only interviewing LPCs/LSOTPs, others with equivalent licensures could be interviewed to gain understanding into their experiences. Research could also be conducted in other parts of the country in order to expand the
literature on counselors’ experience of secondary traumatic stress. In addition, the participants in this study met specific educational requirements (doctoral level studies) with at least two years of licensed experience. Further research could be conducted on helping professionals at various levels of experience to include: LPC – Interns, LPCs with more than five years of experience; Licensed Master’s Social Workers; Clinical Psychologists, and so on. Further research could also be conducted in a variety of settings such as clinical settings, hospital settings, correctional institutions, shelters, etc.

In addition, research regarding the distinction between the experience of compassion fatigue and secondary traumatic stress in counselors is recommended. In this study, several participants indicated a distinction between the two but did not clarify the distinction. Considering these two terms, secondary traumatic stress and compassion fatigue, which are often used interchangeably, it would be helpful to query counselors’ identification and experience with both secondary traumatic stress and compassion fatigue delineating specific distinctions between them, if such distinction exist.

**Practice Implications.** This research study focused on the impact, experience, and management of secondary traumatic stress in counselors. In so doing, this study begins to help counselors recognize the symptoms of secondary traumatic stress and to employ acquired coping skills to manage secondary traumatic stress effectively. The practice of self-care is emphasized by the findings in this study, thus encourages counselors to actively practice good self-care regimens in their daily lives.

**Recommendations**

In this section, five recommendations are made for counselors and Counselor Educators. The first recommendation is to increase counselor awareness
regarding the existence of secondary traumatic stress and the impact it has on counselors. The second recommendation is to educate counselors on effective coping skills to help manage secondary traumatic stress symptoms. The third recommendation is to develop secondary traumatic stress training programs for counselors at the community, state, and national level. The fourth recommendation is to develop secondary traumatic stress training programs for Counselor Educators to utilize in graduate programs. The fifth and final recommendation involves advocacy for counselors regarding self-care, and training.

**Recommendation 1: Increase counselor awareness regarding the existence of secondary traumatic stress and its impact on counselors.**

As a result of the interviews conducted, it was discovered that the concept of the existence and impact of secondary traumatic stress was somewhat foreign to the participants in the early years of their practices. Educating counselors on the existence and impact secondary traumatic stress can have on counselors will not only increase awareness within counselors, but with others in the helping professions as well. It is important that counselors are aware of their own vulnerabilities and are able to identify symptoms and subsequently employ effective strategies to safeguard themselves and their clients in situations where secondary traumatic stress arises (Bride et al., 2004; Figley, 1995; Pearlman & Saakvitne, 1995).

**Recommendation 2: Educate counselors on effective coping skills to help manage secondary traumatic stress symptoms.**

Education and knowledge regarding not only the existence of secondary traumatic stress, but also the impact it can have on a counselor is paramount in the effective management of secondary traumatic stress (Bride et al., 2004; Figley, 1995; Pearlman &
Saakvitne, 1995). Once counselors are educated on the subject, the effectiveness of mentoring relationships and collaborative groups will increase in effectiveness, as counselors learn and develop the necessary skills to manage secondary traumatic stress in a safe, open environment. Learning to utilize self-care strategies beyond the concept of “thwarting burnout” and employing these strategies as a daily practice will increase counselor mental health and well being, thus fulfilling the American Counseling Association’s charge of beneficence and non-maleficence, as well as, the Code of Ethics admonition to (a) promote the welfare of clients, and (b) avoid the harming of clients in the process of counseling services (ACA, 2014).

**Recommendation 3: Development of secondary traumatic stress training programs for counselors at the community, state, and national level.**

Educating counselors on a personal, individual level regarding the existence, impact, and management of secondary traumatic stress is vitally important. However, unless training programs are developed to educate counselors on a larger scale, awareness will rely on “word of mouth” or happenstance. The concept of secondary traumatic stress is becoming somewhat epidemic in counselors, and implementing effective training on this topic is essential to the overall management of secondary traumatic stress. One of the participants in this study stated:

I would attend a training in this area, as it is a needed thing, however, I wouldn't find it helpful to go to another training to be taught how to do deep breathing and muscle relaxation exercises that I do all day long with my clients. It would have to be more substantial and more specific to us as counselors than just general stress reduction type stuff.
Programs developed to train counselors in the full scope of secondary traumatic stress will need to include: a working definition of counselors understanding of what secondary traumatic stress is; the emotional and physical impact secondary traumatic stress has on a counselor; and ways to identify the onset of symptoms and employ effective management skills to include collaboration, mentorship, and self-care (Figley, 1995).

**Recommendation 4: Develop secondary traumatic stress curriculum for Counselor Educators to utilize in graduate programs.**

As mentioned above, the development of specific secondary traumatic stress training programs is essential for the counseling field (Figley, 1995). The development of curriculum specific to secondary traumatic stress in graduate programs is also essential. The challenge will be implementing the curriculum to a population that has likely not yet been impacted by a traumatic experience in the counseling setting. As mentioned by one of the participants, the lack of knowing what to expect regarding the experience of secondary traumatic stress could potentially lessen the adherence of knowledge of this topic; however, the goal would be to implement curriculum that could be taught and then if necessary looked back upon when needed.

One effective manner in which to teach students this concept would be to have trauma-informed counselors speak to the students regarding some of the traumatic experiences they have had to help them to engage in the information more readily. Once the “trauma story” is shared by the counselor, the Counselor Educator can poll the students to measure the impact the trauma story had on them, utilizing a teaching moment by which to educate them on secondary traumatic stress. Counselor Educators could
implement curriculum in various classes, to include: child and adolescent counseling, play therapy, family therapy, group counseling, practicum and internship.

**Recommendation 5: Advocate for counselors to receive and utilize time and resources for self-care and training.** When speaking with the participants involved in this study the need for time, resources, and training was prevalent. A secondary factor to this was the assumption it would be necessary to gain permission from the agencies or employers to receive and utilize time, resources, and training to help manage the affects of secondary traumatic stress. Though this was not stated specifically by the participants, advocacy seemed to be potentially important to the overall concept of the management of secondary traumatic stress. Counselors are bound by the Code of Ethics (ACA, 2014), in section C.2.g:

> Counselors monitor themselves for signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when impaired. They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until it is determined that they may safely resume their work. Counselors assist colleagues or supervisors in recognizing their own professional impairment and provide consultation and assistance when warranted with colleagues or supervisors showing signs of impairment and intervene as appropriate to prevent imminent harm to clients. (pg. 9)

Advocacy for counselors and graduate students in the management of secondary traumatic stress is important especially when working with agencies who employ several
types of occupations with the helping field. Advocacy can be accomplished in several ways through utilizing the Advocacy Competencies endorsed by the American Counseling Association (Lewis, Arnold, House & Toporek, 2003). These include: empowerment; advocacy; collaboration; systems advocacy; public information; and social/political advocacy. Through empowerment, graduate students, and counselors will recognize the need to develop self-advocacy skills, and implement action plans to advocate for the counseling profession. Through graduate student, and counselor advocacy, necessary services are identified, especially when vulnerabilities are present and negotiate relevant services and education to minimize the impact of the issues presented. When utilizing the concept of community collaboration and systems advocacy, the counselor advocate becomes an ally to the community of counselors by identifying recurring themes, and responding to the difficulties present in the counseling community. This, in effect, can alter the “status quo (pg.2)” and serve as a preventative measure to issues that are prevalent on an ongoing basis. Through the use of public information and social/political advocacy, counselor advocates educate, and act as “change agents (pg. 3)” in the current systems in place that are failing to meet the needs of the counseling community.

Unanticipated Conclusions and Implications

In this study, the information reported in the literature review was confirmed; however, the literature review did not encompass all of the information gleaned from the interviews. One major topic discussed in the interviews, but not adequately covered in the literature review was the physically overwhelming nature by which secondary traumatic stress impacted counselors, as reported by the participants. Though secondary
traumatic stress has been researched regarding other helping professions, the physically overwhelming manner it impacts counselors was not specifically covered. The participants referred to several pre-identified feelings that are common in others experiences of secondary traumatic stress, but added “feeling like I had the flu, a weary and defeated feeling that I couldn’t shake….”

A second and related topic discussed in the interviews, but not fully covered in the literature review was the depth and emotionally pervasive manner by which secondary traumatic stress impacted the participants. Many emotional symptoms have been identified as a result of secondary traumatic stress in professionals in the helping field, to include: sleep difficulties, difficulty concentrating, intrusive memories, flashbacks, hyper-vigilance, etc. While the participants commented on these experiences, there were several expansions to these that had not been reported in the literature review. The inability to “shake off what I have heard, which goes with me into each session and then home with me, at times” was present in participants with less experience in the field. The more seasoned participants reported ways they learned to manage this, however, reported feeling this way when initially in the field (within the first “few years”). In addition, the ability for the experiences of secondary traumatic stress to mature was not addressed in the literature.

The third major topic not addressed in the literature review was the lack of secondary traumatic stress knowledge gained in formal settings. There was little to no information shared in the literature regarding secondary traumatic stress training, or curriculum in formal or academic settings. The Figley Institute offers training to professionals in the helping field; however, in the literature review there was no mention
of graduate curriculum available for counselors. Much of the information reported by the participants was related to self-care in a general sense. Self-care training and curriculum specific to the experience of secondary traumatic stress would benefit counselors-in-training, as well as counselors, post graduate school.

Summary

Due to the dearth of literature regarding the experience of secondary traumatic stress in counselors, this study added information regarding the experience of secondary traumatic stress in counselors who work with sexually abused adolescents. Specifically, the impact and management of secondary traumatic stress was identified as well as themes counselors identified based on their experience with secondary traumatic stress. This information is useful to counselors and Counselor Educators, and if recommendations are applied, impacts clients through a healthier therapeutic relationship. This chapter described a summary of the results provided, implications for counselors and Counselor Educators, as well as recommendations for further research.
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Appendix A

Email Script Asking for Participation in the Study

Dear Counselor,

My name is Sara Lynn Jennings; I am a doctoral candidate in Counselor Education at Texas Tech University. I am currently recruiting counselors to participate in my dissertation study. I obtained your email address through the Board website. I would like to meet with you to discuss secondary traumatic stress if you meet the following criteria:

• You currently hold a LPC, or LSOTP license that is in good standing in the state of Texas.
• You have been licensed for at least two years
• You are considered to be a Trauma-Informed Treatment Provider

In this study, I am exploring counselors’ experiences of secondary traumatic stress when counseling sexually abused adolescents.

This meeting with me will consist of one interview 45-60 minutes in length. I will schedule meetings with you at a time that is convenient for you. I would like to record this interview in order to be able to visit with you without having to take notes. Audiotaping your interview will help me ensure accuracy and completeness of information. Your research participation is completely voluntary, confidential, and great care will be taken to maintain your anonymity in the final study report. Upon completion of the study, please contact me if you would like a copy of the findings of the research study. Records will be maintained in a secure storage location, behind two locked doors,
as well as in a locked cabinet, for 2 years following the study, and will be shredded by a professional document shredding service after 2 years.

This research study has been approved by the Texas Tech Institutional Review Board. This board protects the rights of individuals who participate in research. You can ask them questions at 806-742-2064. This study is being supervised by Dr. Janet Froeschle-Hicks in the Texas Tech University College of Education. She can be reached at 806-834-3611 or janet.froeschle@ttu.edu.

I would like to meet with you before December 31, 2014. If you are interested in participating or have questions about the study or participation, please contact Lynn Jennings at lynn.jennings@ttu.edu or 806-282-1137.

Thank you for your consideration,

Sara Lynn Jennings, MA, LPCS
Counselor Education Doctoral Candidate
College of Education | Texas Tech University
Lubbock, Texas 79409
806-282-1137
Email: lynn.jennings@ttu.edu
Appendix B

Information Sheet

What is this project studying?
This research project is a study focusing on counselors’ experiences with secondary traumatic stress when working with sexually abused adolescents. This study hopes to add information that may later assist counselors in better managing their experiences of secondary traumatic stress.

What would I do if I participate?
The interview will take approximately 45-60 minutes to complete. Meetings can be scheduled at a convenient time for you. Your participation is completely voluntary. Questions may be skipped, and the participant can stop the interview at anytime. You will be asked if you wish to review the transcript to provide feedback. If yes, then I will ask you to write your email address. You will be asked if you can be audiotaped during the interview, and audiotapes will be electronically stored on the researcher’s external hard drive. Transcripts will then be uploaded on a software program that will help the researcher develop a theory from the themes described. The information will be uploaded with a pseudonym, and upon the completion of the research, the original audio will be deleted. In addition, after the research has been completed, identifying information such as email addresses, will be deleted.

May I withdraw participation if I become uncomfortable?
Yes, absolutely. Dr. Janet Froeschle-Hicks and the Protection Board have reviewed the questions and find them to be suitable. However, you can stop answering the questions at any time. You can leave any time you wish. Participating is your choice.
How long will participation take?
The interview will take about 45-60 minutes.

How will I benefit from participating?
You will be contributing to the growth and development of the counseling community through participation in this research. If you are interested in the findings of the study, please contact me and I will give you a copy of the findings of the study or a copy of the study should you desire to receive this information.

If I have some questions about this study, to whom may I address my concerns?

• The study is being conducted by Dr. Janet Froeschle-Hicks from the Counselor Education program at Texas Tech University. If you have questions, you can call her at 806-834-1366 or email janet.froeschle@ttu.edu.

• Lynn Jennings 806-282-1137.

• TTU also has a Board that protects the rights of people who participate in research. You can ask them questions at 806-742-2064.
Appendix C

Script to Read to Participants Prior to Interview

My name is Sara Lynn Jennings, and I am a doctoral candidate in the Counselor Education Program at Texas Tech University. I am delighted that you have decided to participate in this research study. Thank you for your participation. This study focuses on counselors’ experiences with secondary traumatic stress. Currently, there is little information regarding counselors’ experiences with secondary traumatic stress and your participation will help us learn more about helping counselors to manage their experiences. This interview will begin with you reading the information sheet and asking me any questions that you have regarding the information sheet. Next, I will ask you to filling out a short demographic survey. Then I will request your permission to record the interview, and upon your consent to record, I will begin asking you interview questions about your work and how it impacts you. Please feel free to skip any questions at anytime.

Thank you again for the time you are taking out of your busy schedule to participate in this study. Do you have any questions before we move on to the information sheet?
Appendix D

Prior to us beginning the interview, please fill out the below demographic information.

Please feel free to skip any questions at anytime. Please do not list your name. No identifying information will be asked of you throughout this study.

Demographic Information Form

Chosen Pseudonym:

__________________________________________________

Age Range (circle one): 20-25 26-30 31-35 36-40 41-45

46-50 51-55 56-60 61-65 66-70 70+

Gender:

Ethnicity:

How long have you been a counselor?

Are you considered to be a Trauma Informed Counselor?

What is the age range of the clients you treat?
Appendix E

Interview Protocol

Interviewer: _______________________________              Date: _________________
Interviewee (pseudonym):  ________________________________

1. I will describe the research purpose to the participant, i.e. secondary traumatic stress experienced when treating sexually traumatized adolescents.

2. I will cover the IRB statements for participants.

3. I will ask the participants the following questions:
   a. How are you today? (icebreaker question/rapport building)
   b. How do you feel your work with sexually abused adolescents impacts you?
   c. How would you define secondary traumatic stress?
   d. In what ways do you feel best addresses your experience with secondary traumatic stress?
   e. Are there specific things that you do in order to manage secondary traumatic stress? Recurrences of secondary traumatic stress?
   f. What secondary traumatic stress management skills did you learn in graduate school?
   g. Post-graduate school?
   h. Is there anything else you would like to add about your experience with or feelings regarding secondary traumatic stress?

After the questions are finished, the interviewer will ask the participant of any other counselors (that meet the research criteria) who would be willing to provide
insight into how they manage secondary traumatic stress. Please thank the participant for their time and insight into their perceptions. Also, remind the participant that you will be in contact with them shortly to confirm the themes that have emerged from the data provided.