The Development of the Trauma Therapist: A Qualitative Study of the Child Therapist’s Perspectives and Experiences

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Although there is increasing literature on secondary traumatic stress, little is known about the therapist’s perspective and experience in working with traumatized children. This qualitative study utilized an interpretivist paradigm to understand therapists’ experiences in working with such children. Interviews suggest that therapists perceive common issues related to treatment, impact of the therapeutic work, and the importance of making personal meaning of their work. Most importantly, becoming a trauma specialist is a developmental process requiring careful examination, willingness to be changed, and a program of self-care, as therapists work to help children who have been witness to and often victims of horrors many find unspeakable. Implications for training, supervision, community support, and self-care are discussed. [Brief Treatment and Crisis Intervention 4:353–366 (2004)]

KEY WORD: trauma therapist development.

Sometimes when people ask us, “How can you do this work?” we think, “How could we not?” How could we have the ability to contribute to a journey of hope and healing and not use it? There is no other work that we would find this meaningful, challenging, and rewarding. What other work would allow us to engage fully—our minds, our hearts, our spirits? How could we choose not to do something that demands our creativity, all of our intellectual capacity, all of our feelings, and our whole humanity? (Pearlman & Saakvitne, 1995, p. 400)

This study explored a developmental model for understanding how trauma therapists made meaning of their experience in working with traumatized children—specifically, how participants understood their work, how the work impacted them, and how they retained hope and persisted in this career despite its difficulty. Understanding these experiences is important, as this knowledge can contribute to...
improved training, supervision, therapist retention, and ultimately, enhanced services for children.

Research on the impact of therapists working with trauma confirms that those who work with traumatized clients can be profoundly affected by their experiences (e.g., Cerney, 1995; McCammon, 1995; McCann & Pearlman, 1990; McCann, Sakheim, & Abrahamson, 1988; Yassen, 1995). This impact has been referred to as contact victimization (Courtois, 1988), secondary traumatic stress or compassion fatigue (Figley, 1995), and vicarious traumatization (Rosenbloom, Pratt, & Pearlman, 1995).

Many factors influence the development of the trauma therapist, including a personal history of trauma, length of time working in the field, percentage of trauma survivors on one’s caseload, work setting, availability of supervision, and level of trauma-specific training. While these factors affect therapists in various ways, the findings remain mixed (Follette, Polusny, & Milbeck, 1994; Pearlman & MacIan, 1995; Schauben & Frazier, 1995). Therapists with trauma histories, those working in a clinic setting, those with less training, and those dealing with the impact of their work in personal therapy all showed an increased level of disrupted schemas. However, more experienced therapists, even those with a trauma history, showed less disrupted schemas. Therefore, it is critical to identify aspects of increased experience that may mitigate the negative effects of conducting trauma work.

Greater effort is being made to understand the effects of conducting trauma work on therapists and the amelioration of these effects (Cerney, 1995; Chu, 1988; Pearlman & Saakvitne, 1998; Valent, 1995). The interpretivist qualitative perspective used in this research stresses consultation with the experts—therapists who specialize in psychological treatment of traumatized children—in order to understand their experience and to further inform the direction of future research in this important area. The interpretivist research paradigm holds that access to meaning is not had through a process of empathic identification, but rather “understanding unfolds as one looks over one’s respondent’s shoulder at what they are doing to figure out what the devil they think they’re up to” (Schwandt, 1994, p. 123).

Method and Participants

Purposive sampling and the “snowball” technique (Bogdan & Biklen, 1992) were used to obtain the 8 therapists who were included in this study. Professional contacts of the authors provided names of potential participants, and several participants supplied names of other therapists who would qualify for the study.

Telephone screenings with potential participants were conducted to determine whether they met eligibility criteria, which included having a graduate degree in a mental health field, working 5 or more years in the field, and viewing themselves as specialists in child trauma work. Semistructured interviews were conducted lasting from 45 to 75 minutes. The nine interview questions were developed through a review of the professional literature and consultation with key informants who were psychological consultants in child trauma cases. The questions inquired into how participants became involved in working with traumatized children, what they found effective in their work, what their challenges and successes were, what the impact of the work upon them was, how they stayed hopeful in the face of working with trauma, and what the significant influences upon their work were.

Interviews were audiotaped and transcribed. Follow-up discussions lasting from 10 to 30 minutes were conducted with participants in order to explore perceptions and request further elaboration. Field notes were recorded.
as an ongoing and crucial supplement to interviewing, as suggested by Bogdan and Biklen (1992).

The interviews were read numerous times to identify initial themes. A computer software program (QSR NUD.iST 4.0, 1997) was used to format and organize the data. Themes were identified using open coding, which involves the examination of small pieces of data (Strauss & Corbin, 1990). The broad, general themes helped create an organizing principle, or "situated meaning structure" (Miles & Huberman, 1994), which is a framework with which to understand the data. The second step of coding, "pattern coding" (Miles & Huberman, 1994), involved the formulation of hierarchically structured trees. This hierarchy allowed the researchers to assign an initial relationship between themes, going from general to specific to create a meaningful understanding of participants' narratives. Definitions were created for each of the coding terms according to their meanings in context. Other sources of information included field notes.

After coding was complete, a summary narrative was created for each interview and reviewed with the participant. As suggested by Miles and Huberman (1994), a summary of the broader themes from the data was prepared, combining previously summarized information from each case. This summary compared commonalities and differences between interviews. Listing common events in two or more of the interviews created this cross-group summary.

Glaser (1978) and Strauss and Corbin (1990) note that effective coding is enhanced by theoretical sensitivity. Related to this, both trauma theory and constructivist theory were lenses through which the researchers viewed the data.

Guidelines for assessing the quality, or trustworthiness, of naturalistic research are discussed by Lincoln and Guba (1985). To improve trustworthiness, the second coauthor read transcripts and independently developed initial, or "first level" (Miles & Huberman, 1994), coding schemes. Subsequent to this, both researchers reviewed all decisions about analysis and interpretation and reviewed final summaries. A third colleague, a psychologist familiar with trauma theory, provided feedback on conclusions drawn by the researchers. Another consideration in developing a trustworthy study is transferability, in which the researcher provides a thick description of the data so that others can decide whether findings might apply to other situations. Thick description included a detailed account of the informants' views, as indicated in the use of quotations as well as the field notes and memos that provide information regarding the researcher's thought and decision-making processes.

The 8 participants worked in a variety of settings, including urban and rural areas, hospitals, private practice, and community mental health centers. Seven females and one male participated; all were white. The mean age was 42.71 years (range, 32–50). Two had master's degrees in counseling or social work; the remainder held doctoral degrees and were psychologists. Each had practiced specifically as trauma therapists from 8 to 22 years, with a mean of 13 years. At least half the caseloads were focused on trauma work, but most estimated that 75–100% of their clients were dealing with trauma. Theoretical orientations included play therapy and humanistic, cognitive-behavioral, and psychodynamic approaches. Most of the participants had extensive postdoctoral training in trauma work, through ongoing conferences and workshops. Several participants are trainers in the field and serve regularly as expert witnesses in the courtroom. Pseudonyms were used to protect anonymity.

Throughout the interviews all informants described their perspectives and the meaning
they made of therapeutic experiences within a developmental context. Thus, we utilized a developmental model, described below, as an organization for the themes that emerged. In addition to the three developmental stages, the coding themes were collapsed into three domains: view of therapy, self-care, and view of self. The supervision literature was examined to search for existing models anchored in a theoretical framework, which could be adapted to the specific development of trauma therapists. Stoltenberg and Delworth’s (1987) model of counselor development is ideal for viewing the development of trauma therapists.

**Developmental Model of Clinical Supervision**

Stoltenberg and Delworth’s (1987) Integrated Developmental Model (IDM) describes stages that all counselors in training pass through. The model examines therapist growth in specific domains of functioning over three developmental stages (beginning of the journey, trial and tribulation, and challenge and growth). Within each stage there are three specific overriding structures: self- and other awareness, motivation, and autonomy. Changes in the three structures were identified across stages, which implied various levels of functioning and readiness to operate autonomously. This general model is very useful for understanding development for all therapists, and the current study explores differences specific to trauma therapist development.

**Application of the Integrated Developmental Model to Trauma Therapists**

While it is assumed that trauma therapists have gone through similar developmental stages as have therapists in general, there are unique, work-specific aspects of their growth. Thus, based on the interviews and the use of the IDM as a lens for viewing participants’ experiences, a model for exploring the development of trauma therapists was devised. Table I illustrates the adaptation of IDM to the development of trauma therapists.

**TABLE I. Three Developmental Stages of Trauma Therapists Across Three Overriding Categories**

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<thead>
<tr>
<th>Stages</th>
<th>Developmental Domains</th>
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<td></td>
<td>View of Therapy</td>
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<tr>
<td>Beginning of the journey</td>
<td>Dependent on views imposed in training</td>
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<tr>
<td>Trial and tribulation</td>
<td>Self-doubt, questioning, developing own views</td>
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<td>Challenge and growth</td>
<td>Theory and practice integrated</td>
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<td>Self-Care Issues</td>
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<td></td>
<td>Unaware, underdeveloped</td>
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<td>Entering awareness, developing methods</td>
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<td>Aware, practicing methods</td>
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<td></td>
<td>View of Self</td>
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<tr>
<td></td>
<td>Savior, view of self limited</td>
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<tr>
<td></td>
<td>Vulnerable, awareness of distress</td>
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<td></td>
<td>Human, view that vulnerability positive</td>
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Although we have kept the three distinct developmental stages discussed by Stoltenberg and Delworth (1987), our data suggest a different set of categories to reflect the major themes of trauma therapist development: (1) view of therapy, (2) self-care issues, and (3) view of self.

Trauma therapists undergo many changes, both personal and professional, as they gain experience. Oftentimes these transformations occur due to the meanings they make of those experiences. These changes form the foundation of the developmental stages discussed here, beginning with therapists’ first exposure to and involvement in trauma work and continuing.
throughout their careers. Development is not strictly linear. Therapists may be in different developmental stages in particular areas. For example, a therapist whose practice is well integrated with theory but who has few or poor coping strategies would function in the challenge and growth stage in the view-of-therapy category while performing in the less advanced trial and tribulation stage in the self-care category. There may be movement between stages depending on stressors such as caseload, financial difficulties, and life circumstances.

**Development Stages**

As noted previously, the developmental stages in this study were: beginning of the journey, trial and tribulation, and challenge and growth. The major themes were: view of therapy, self-care issues, and view of self. Quotes from informants illustrate the salient themes and subthemes.

**Beginning of the Journey.** This first stage in the development of trauma therapists characterizes the later stages of their general clinical training, as one might expect of advanced graduate students or therapists in the early period of their careers. Here, the therapists tended to be rigid in their beliefs, particularly that there was “one right way” to conduct therapy. While developing an understanding of their role as therapists, they still had a naïve sense of the therapeutic process and potential for change. This naïveté resulted in an inflated view of self as change agent and the assumption that the therapist was responsible for change, healing, and control of the session.

Well, initially, I would feel a lot of guilt and ambivalence and “Oh, gosh, why can’t I be it all, do it all?!” So I used to cry when kids would leave [terminate therapy]. I would say goodbye, give them a graduation present, go through the whole thing and be in the office crying because it was hard. You never knew what was going to happen and you wanted to know.

Participants brought varied backgrounds and motivations into the trauma field. Mary’s journey as a trauma therapist began with her disappointment in other careers:

I studied psychology as an undergraduate, and then when I graduated I had to pay back my student loans, so I ended up working as an accountant. Later, I worked on an in-patient adolescent unit. That was really a turning point. Years later my work was not very challenging. You do everything else trying to make a living, but you don’t find anything you love so you go back into it [trauma work]. . . . So, if I’ve done other things [besides work in psychology], it’s been incidental or not really planned.

Linda intentionally chose a career in counseling, but “fell” into trauma work:

I decided that I wanted to go into counseling with kids. I wanted to work with kids with divorce issues. . . . Anyhow, I got out of school and landed this job at a huge mental health center. On the first day, . . . they said, “Now the sexual abuse treatment team is going to meet.” And I thought, “Oh my God, is that what we’re doing?!?” I just kind of landed in it. . . . I got to work with kids and 90 percent were sexual abuse victims and some physical abuse. I really got incredible training and peer supervision. So, I just kind of fell into it.

**Trial and Tribulation.** This stage was marked by therapists’ growing awareness of the need
to develop self-care strategies and address the limitations of their role as therapists, as they gained experience. This increased awareness was distressing, as therapists found cracks in their previous theoretical foundations. Through experience, they discovered the enormous challenges inherent in working with traumatized children. Although all stages are integral, this stage was a turning point. How participants reacted to and coped with struggles influenced their continuation with trauma work. Therapists who did not find a way to transition through these stages tended to leave the field, due to lack of hope. Two participants did so, then subsequently returned, having tried other careers. Other therapists engaged in self-exploration and pursued further training. This stage was marked by meaning making—the therapists’ effort to organize what they had learned from experience. From a constructivist point of view, participants were engaged in the process of making their implicit assumptions and beliefs explicit (McCann & Pearlman, 1990). Susan illustrated the importance of engaging in the trial and tribulation stage and finding her own way of looking at therapy:

It’s the most hopeful work I think you can do, rather than the most unhopeful. I think that people leave early on if they don’t get that sense. I think you find that people who have been doing trauma work for a long time... have a sort of eternal hope. There are other people who can’t find that and leave. It’s self-limiting.

**Challenge and Growth.** Finally, as Stoltenberg and Delworth (1987) aptly stated: “Level three is best summarized as ‘the calm after the storm’” (p. 93). This level of integration described participants’ development in all areas of functioning, including their view of therapy, their view of themselves, and coping. At this level, increased awareness and an enhanced ability to make meaning of experiences became tools to use to work more effectively and help therapists keep their lives in balance, to enhance their maturity and understanding of their role as therapists.

During this stage, participants began doing things differently. This included becoming less rigid in the application of theory and actively struggling with ambiguity and the lack of the one right answer. Mary described her development:

Mostly now I follow the child. Occasionally I used to say something, or I’d think, “I need to be doing this technique” or something... There’s a notion that there’s something specific you need to do, but I’m always wrong. Some of my most successful work has been where I have not had a clue to this day what worked.

Views on how to conduct therapy changed too. Jan reflected on her naiveté during the first stage, and was later struck by the harsh reality of this work: “I thought that traumatized kids had so much potential because they started out typical, so I can just undo it. I don’t think I had any idea how damageable kids were.” However, in working through trials and tribulations and moving into the third stage, she created new meaning: “In terms of the trauma, once I realized that horrible things happen, I also think about the good. I like to go back to Hamlet: ‘What a piece of work is man.’”

Following is a discussion of therapists’ development in the three main categories: view of therapy, view of self, and self-care. Also included are the subthemes that emerged across the interviews with the 8 participants, including: directiveness, interpretation, termination issues and goals, relationship, negative and positive effects on the therapist, and coping.
Results

View of Therapy

At the beginning of the journey, participants held rigid views of what therapy should look like. As they acquired more experience and knowledge through trial and tribulation, they became increasingly aware that they needed to integrate clinical training and theory into their own belief systems and personalities. Mary described her development in this area:

Initially I think I heard, “Here’s how you do play therapy,” and then I would think, “Well, we really need to work on this or that,” and I got these grandiose ideas. No matter how I tried to manage the game, it wouldn’t work. Really the only thing I could control was my reaction to the children.

In addition to participants’ views on conducting therapy, there were changes in the way they thought therapy should work:

A lot of times I’ll have kids who are playing something and I don’t know what it means, but we’ll play it over and over again. I don’t know whether it’s just distracting to them or whether it has some meaning. . . . I usually don’t think about what the play means. I was taught to have the extra sense, to think about what’s going on and being in there, and now I don’t think I do that. I think I just play. (Jan)

Directiveness and Interpretation. While each participant had been trained in a variety of theoretical foundations and techniques, they all thought it was important to include play therapy in their work with children. One of the common early beliefs expressed was that they could and should control the direction of the therapy, despite the fact that much of play therapy is nondirective. At the challenge and growth stage, therapists achieved a more complex understanding of directiveness: “Oh yeah, just try to lead a child in play, especially a traumatized child. . . . I use what they’re doing in play and try to change a little bit, the nuances.” She concluded: “I have had no success in actually getting a kid to play what I want them to play, directing them that way.”

In general the therapists in later stages had developed a sense of faith and trust in the process of therapy. It became a more collaborative event, where they provided less directiveness and more acceptance.

Termination and Goals. Another important subtheme for all participants in their view of therapy was the critical nature of termination. Termination was complicated by the growing influence of managed care. Mandates on the length of treatment often enforced rules for termination that may have little to do with the goals of therapy. Participants expressed frustration with the limitations imposed by managed care. Susan did not believe that time-limited therapy was effective for children, stating, “Number one is allowing for long-term treatment. I don’t think you can say, ‘Well, we’re gonna give this child six sessions and that’s gonna be great, and we’re gonna rationalize that short-term therapy is the answer.’” Other than the restrictions imposed by the dictates of managed care, they also noted such factors as interference by the legal system and the family system. An instance of the former includes courts removing therapists from cases and questioning their interpretations (often due to incomplete or poor understanding of the therapeutic process and of trauma theory). As for the latter, “crazy-making” situations included work with children living in temporary foster-care settings as well as chaotic and unsupportive family environments. As Jan noted:
As a matter of fact, I just won’t take foster kids in treatment any longer. I’ve finally reached that realization, that point ... where I see it’s just such an uphill battle to try to do treatment when kids are in situations that are so unstable ... they can be taken out of the situation at any time, there’s no predictability and they are retraumatized over and over again by the system. An hour or whatever it is a week with me just can’t overcome all that.

In the early stage of their development, participants’ view of therapy was that termination would occur when the goal of therapy was met. Their early perspective was that the goal was to provide a cure or to fix what was wrong with the clients. This certain yet naive view was transformed during the trial and tribulation stage, as therapists came to terms with the far more ambiguous nature of therapeutic work. While there were signs that a client had made progress, therapists came to understand healing as a process, as opposed to a destination. Susan commented, “Not everyone walks out of here 100 percent cured. I think healing is a process just like life is, so it’s like getting them back on track.”

**Relationship.** Participants’ perspectives were strikingly similar on the importance of the therapeutic relationship. Whereas most acknowledged having been taught in training that the therapeutic relationship was an essential factor for successful therapy, they initially considered it only a minor factor, to be used along with the techniques that “really” made up the therapy. During the course of their work, this view changed, and the significance of the relationship was seen as not only a necessary, but also a sufficient condition for healing (Rogers, 1961). Jean said: “It [the relationship] is everything. I think my understanding of the importance of the relationship is probably a lot stronger than when I first started out. Maybe I didn’t realize how important that was.”

Beyond understanding the value of the relationship, there was also deeper understanding of its complexity. During the early developmental stages, participants viewed their role more ambitiously, as being more powerful, than they later did. Over time they developed the skills to create a delicate balance between being present for the client while at the same time not being “it” for the client. Susan noted, “You can’t be there for every child forever. You know, that’s not my role. So, I’m separating from them, and that separation is sometimes extremely painful.”

While it is clear that the relational aspect in trauma work is crucial, it is also fraught with difficulties. Because trauma results in disrupted schemas (Pearlman & MacIan, 1995; Schauben & Frazier, 1995) and shakes core beliefs, the ability to trust, and the expectation of reasonable safety, relationships are very often more problematic for trauma survivors than for other individuals. This was certainly reflected in the therapists’ points of views. They described relationships with traumatized children as slow to build, “taking longer than you could ever think possible” (Mary).

**Therapist Self-Care/View of Self**

The two categories labeled self-care and view of self were examined together because of their interrelatedness. While they were two distinct categories with their own themes, they were interdependent in terms of development. Self-care implied behaviors on the part of the therapists, but before there could be a change in behaviors related to caring for themselves, they first developed awareness of distress, which involved the growing awareness of self.

Self-care included an examination of the impact of conducting trauma therapy and
how therapists took care of themselves in the face of distressing work. The impact included both negative and positive effects. Generally speaking, self-care was an area that had received little focus in training, and therapists felt unprepared to manage the effects of this work. Susan said: “I think we don’t talk enough in graduate school and training about the experience of working with people in pain and the feeling that sometimes you can’t be helpful.” Susan made it clear that important others in her life made a difference in helping her to gain perspective: “During the worst time of my career, two people were instrumental. The DA [district attorney] called to remind me that I was not God and I couldn’t control the world, and a professor told me, ‘It’s not happening to you.’”

**Negative Effects.** Participants discussed the painful effects of their work and reflected on changes in their awareness and interpretation of events over time. Early in their work they construed their sadness, grief, and pain as weakness, as evidence that they were not fit to be therapists. Over time, acknowledgment of these feelings was helpful, even though occasionally difficult. Expressing feelings became both a way to recognize the need for an adjustment (such as accepting less traumatic cases in their workload, taking a vacation, or discussing intense material with trusted colleagues) and a coping tool.

Therapists described their experiences with secondary stress, which included a growing recognition of symptoms of stress and the importance of developing coping tools.

Susan and Mary illustrate the development of distorted schemas and overgeneralization, as identified in the literature on vicarious trauma (Courtois, 1997; McCann & Pearlman, 1990). Susan said: “I went through a stage. When I worked at the mental health center, I had a colleague who said to me, ‘Not every kid in the waiting room is being sexually abused as we speak.’” Early in her development as a trauma therapist, Susan overgeneralized the existence of abuse, which is a risk related to vicarious traumatization. She then later recognized this response as a stage, and had developed increased awareness of it.

Mary discussed how her views became distorted, “I think you can always lose sight of what you’re doing, and I can get really jaded. It seemed like every situation had abuse involved. Sometimes there is no abuse. I’m trying to keep my objectivity about it.” She emphasized the importance of increased awareness of stress symptoms and ameliorating them. In their early work, participants recalled, they were particularly distressed because they had not yet figured out how to deal with feelings. Susan provided a powerful statement regarding the effects of conducting trauma therapy with children:

Last week I did a [review of a] homicide of a 17 month old and . . . the days I worked on it, it didn’t hit me. It hit me hard later and then it was just like, “Hey, you’re a person too!” Years ago, I would think that I was a bad person because I couldn’t handle it. I should be out of this profession. But now it’s just like, “Oh, crap.” Now, I talk to somebody about it. Sometimes doing clinical notes helps to clean out some of that. I read something. I change my activity level. I’ll go to aerobics more just to get rid of that awful feeling. It’s overpowering. The other thing is that you begin to think that all kids are being hurt. It is frightening. My work has made my parenting different. It’s made me different as a person, it’s made me a lot more wary, it’s made me more knowledgeable about things I just would choose not to know. The difference is that I’m real clear that, at times, I can’t go there: “I’m too vulnerable right now” or “No more homicide cases!” I notice that
usually when I’m starting to have no feeling is when I know I’m in trouble. It took me years and years. Lots of reading too.

**Positive Effects.** While there are negative effects in conducting trauma work, therapists also spoke of the benefits. Interestingly, it emerged that over time therapists reinterpreted some of their negative experiences as positive. Once they became aware of their painful feelings and the potentially devastating trauma stories (the existence of incredible suffering and the capacity of people for cruelty), they could no longer use denial (ignoring the existence of evil in the world) as a defense against that reality. The desire to create meaning of their painful experiences, particularly the need to find meaning in suffering, made sense from an existential point of view (Frankl, 1984).

Therapists were not asked specifically what they viewed as the positive effects of their work, yet all participants discussed the profound impact their work had on their lives, both professionally and personally, and their views of the world. Being significantly impacted by their work was not something that they had expected early on, and like many transformative experiences, change did not come without struggle. The learning process included recognizing the positive changes that were taking place: ”You have to focus a lot on success, or you get mired in the things that don’t work” (Jean). Informants also spoke about positive views of self: ”I feel like, my God, at least I’m doing something about it. I’m not just closing my eyes to it. So that makes me feel good” (Linda). Susan saw her role as that of an “intervener” who helps the child and then moves on:

[Y]ou know, sort of like the fairy godmother who comes and makes the pumpkin into a coach, but then she’s doesn’t stay. It’s up to the princess to figure out the rest of it. You can’t be there for every child forever. You know, that’s not my role.

**Coping.** Most of the participants developed a number of coping strategies to mitigate the negative effects of conducting therapy. One was to educate themselves about secondary traumatic stress, as Susan indicated: ”I read a lot about secondary traumatic stress, which normalizes the process incredibly for me. It gives me a sense of hope.” She also noted the importance of focusing on her experience and creating a distinction between herself and her clients. She said it was important to remind herself, “It’s real and it’s there, and it’s not me and it’s not my children.” Supervision was very helpful in debriefing, or discussing cases and the emotional toll they took on participants. Mark described not having become numb to the work, but not being ”blind-sided” any longer either. He described this as having taken time and experience and learning how to use debriefing with another therapist who “understood the set.” It was clear to participants that therapy and supervision for conducting trauma work does indeed differ from general clinical supervision, in terms of the need for the supervisor both to be familiar with trauma theory and practice and to understand the particular risks involved for the supervisee. Other self-care techniques included consultation, regular exercise, vacations or taking a break from the work, developing other interests outside of work, setting limits around talking about the work, developing other interests outside of work, setting limits around talking about the work, limiting the number of particularly difficult cases, having sufficient monetary reward for work, and working as part of a multidisciplinary team.

**Discussion**

This study provided insight into the unique path of development of the trauma therapist
and implications for training future therapists. Because the process of creating and altering meaning structures is essential to the development of individuals in general, and to therapists in particular (Rosen, 1988), understanding this process was a critical component to this research. Trauma therapists are at particular risk for distortion of their schemas. Such distortions are harmful for therapists in their personal lives due to the potential harm to their own relationships and ability to function well. It also makes therapy difficult. The therapists must be able to keep clear in order to guide the client in the process of healing. If therapists are suffering from similar distorted views as their clients, they cannot reasonably provide that guidance (Pearlman & Maclan, 1995; Schauben & Frazier, 1995). As reflected in other studies (Brady, Guy, Poelstra, & Brokaw, 1999; Pearlman & Maclan, 1995), this study found that trauma therapists were certain about the positive benefits of conducting trauma therapy. The Brady et al. (1999) study of vicarious traumatization reported the unexpected result that clinicians seeing higher numbers of sexual abuse survivors actually had greater spiritual well-being. While Brady et al. hypothesized that therapists with greater current and cumulative exposure to graphic sexual trauma depictions would have significantly lower scores on the Spiritual Well-Being Scale (Ellison, 1983), the opposite was found to be true. General positive effects of conducting therapy, as well as trauma therapists’ responses regarding the benefits of their work included accelerated psychological development; a feeling of privileged participation in witnessing courage and resourcefulness, and the satisfaction of being an agent of positive change (Mahoney, 1991; Schauben & Frazier, 1995). The present study added to this knowledge base in two important ways. First, it revealed information related to benefits from the therapists’ points of view, specific to trauma work. Second, it helped to provide a rationale for why these benefits exist.

**Implications**

Implications for future research suggested by this study are in the areas of training, supervision, community support, and therapist self-care.

**Training.** Of particular emphasis are trauma therapists’ training and development issues. Graduate programs have lacked a specific focus on trauma work and have not sufficiently addressed the effects of therapy on therapists (Alpert & Paulson, 1990; Mahoney, 1998; O’Halloran & O’Halloran, 2001; Pope & Feldman-Summers, 1992). As Yassen (1995) noted, a theoretical framework not only informs interventions, but also offers the therapist intellectual containment. Therefore, a key concern is how to best teach this material. To address this, it was necessary to better understand issues and stages of trauma therapist development, which this study provided. Additionally, several participants suggested that knowledge of secondary traumatic stress was key in assisting them to understand their predicaments and learn new ways of coping. While didactic material can be incorporated into coursework, it is less clear how to address the issues related to therapist-specific variables. There is a need to investigate how this material can be integrated into clinical and practicum-based classes.

**Supervision.** This study indicated that in addition to training therapists, there was a need to address the training of supervisors, consistent with the recommendations of Figley (1995) and Pearlman and Saakvitne (1998) to provide trauma-specific supervision. Effective supervision necessitates an understanding of trauma therapists’ development and how best to...
support their growth. This study suggested an initial developmental framework from which to view trauma therapists. Some of the difficulties in developing such a trauma-specific supervision model could include the almost synergistic manner in which clients and trauma therapists are impacted by the trauma. As Chu (1988) pointed out, trauma therapists are at particular risk for falling into traps. These 10 traps include the assumption of the presence of trust, distancing, failure to set boundaries, failure to set limits, responsibility, control, denial, projection, idealization, and motivation. Supervision may be a challenge due to the possibility of distorted schemas pertaining to relationships, such as trust, boundaries, and power. It is important for supervisors to provide education on such traps to trainees, to reduce anxiety and potential barriers in supervision. As Chu noted, awareness of these potential barriers to treatment can prevent therapists from becoming immobilized and anxious. Due to the potential in supervision for “parallel process” (Clarkson, 1998), potential barriers to treatment also become potential barriers to effective supervision.

Thus, providing supervision from a developmental perspective requires that supervisors assess the developmental level and readiness for growth of the therapists, assist trainees to be aware of any negative effects of their work, and provide the education and support necessary to promote activities to create effective meanings associated with conducting trauma work. The participants identified important issues for supervision, including an examination of the view of self, view of therapy, and self-care activities. Supervision might include encouraging trainees to engage in their own therapy, if indicated.

Community Support

This study acknowledges that in addition to graduate training, there is a need for programs like the Community Crisis Response Team (CCRT) at Cambridge Hospital in Massachusetts, which provides services for the prevention of compassion fatigue in professional caregivers (Yassen, 1995). The community workshops, consultations, and debriefings support the interdependence of the personal and the environmental. The participants in this study indicated that consultation and both peer and formal supervision helped them to cope with their work. When help was not available, they experienced greater distress and isolation. It would also stand to reason that services such as those provided by the CCRT could be helpful for therapists, since debriefing has proven helpful with trauma survivors (Beaton & Murphy, 1995; Cerney, 1995; Janoff-Bulman, 1985). Further research on the value of community services with trauma therapists is indicated. Research might also explore what the positive effects of trauma work are, as indicated by this present study.

Therapist Self-Care

Due to shrinking resources and the restrictions of managed care, the pressure on trauma therapists to conduct work briefly will increase in the future. As has been indicated (Mahoney, 1997; Mahoney, 1998; McCann & Pearlman, 1993; O’Halloran & O’Halloran, 2001), research and training on self-care for therapists is underdeveloped, and this topic is important to expand upon. Trauma therapists are charged with the task of balancing their own well-being with their ability to be present with clients’ painful experiences. While techniques varied, each participant discussed the importance of her or his self-care program.

This study included only one male, and while he did mention self-care strategies when asked, he did not emphasize it compared with the other participants. Future studies could examine possible gender differences in how trauma therapists cope and make meaning of their
experiences. Another complementary study could include contacting former trauma therapists who have left the field to understand what led to that decision. It is important to consider the factors that facilitate the development of positive coping tools, skills, and knowledge that increase the likelihood of staying in the field and being effective as trauma therapists.

Summary

This study provided an exploration of trauma therapists’ development. This included an examination of how participants who were trauma therapists working with children made meaning of their experiences and how they viewed themselves and their work. The participants were able to recognize a number of factors that helped them stay hopeful and effective. An important factor in the therapists’ being successful was insight regarding the effects of the work on them, and their subsequent ability to make new meaning of their experience with traumatized clients within a personal and theoretical framework. Both a developmental and a constructivist model were used to aid in this understanding, as well as to point to future directions for inquiry.

References


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