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Mental Health Counselors and Vicarious Trauma

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Clinical Mental Health Counselors and Vicarious Trauma

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Abstract

Although there are a handful of evidence-based treatment interventions for clients seeking treatment for trauma related concerns, limited evidence-based treatment interventions exist for the professionals treating survivors of trauma that are experiencing symptoms of vicarious trauma. Mental health counselors are potentially at-risk for developing vicarious trauma or secondary traumatic stress while working with clients seeking treatment for traumatic experiences. Signs and symptoms of vicarious trauma include emotional and physical symptoms similar to those of posttraumatic stress disorder. Risk factors include childhood or personal trauma, work-place organization, lack of supportive clinical supervision, and lack of self-care. Screening tools utilized to measure and assess vicarious trauma amongst mental health counselors include: The Vicarious Resilience Scale, the Professional Quality of Life Protocol, the Coping Strategies Inventory, the Differentiation of Self Inventory, and the Modified Stroop. Preventative efforts against developing vicarious trauma include attending regular clinical supervision and consultation groups, practicing healthy self-care, and participating in continuing education. Treatment interventions associated with vicarious trauma include self-care, mindfulness-centered therapeutic approaches, additional supervision, and cognitive behavioral techniques. Additional research is needed to quantify further evidence-based treatment interventions for treating mental health counselors experiencing vicarious trauma.

Keywords: Vicarious Trauma; Mental Health Counselors; Evidence-Based Practice

Contents

Clinical Mental Health Counseling and Vicarious Trauma

There will always be a need for workers in the helping fields such as therapists, child welfare workers, police officers, nurses, emergency response teams, paramedics, and emergency room staff (Killian, Hernandez-Wolfe, Engstrom, & Gangsei, 2017). These careers work with victims of traumatic or abusive events. The collectively gathered research specifically examines vicarious trauma as it relates to mental health counselors. Specifically identified are possible precursors to developing vicarious trauma such as the impact of personal history of trauma or abuse, organizational work settings and supervision, measurement tools for screening for vicarious trauma symptoms amongst mental health counselors, as well as ways in which counselors can try to prevent or overcome vicarious trauma (Killian, 2017; Williams, Helm, & Clemens, 2012; McCann & Pearlman, 1990).

Traumatic events occur daily that cause individuals to seek counseling concerning the life changing events they have encountered. Given the amount of traumatic experiences that mental health counselors are secondarily exposed to puts them at-risk for developing vicarious trauma, or secondary trauma. Williams, Helm, and Clemens (2012) reported, "the incidence of trauma in the United States has become immense and pervasive, [and] mental health counselors are inevitably exposed to demoralizing stories of trauma, disempowerment, and abuse" (p. 133). Frequently working with individuals experiencing undue turmoil in their lives can negatively affect counselors that are not adequately engaged in self-care practices and techniques. McCann and Pearlman (1990) observed that, "persons who work with victims may experience profound psychological effects that can be disruptive and painful for the helper and can persist for months or years after working with traumatized persons" (p. 133). It is imperative for mental health

clinicians to continually monitor and engage in self-care practices, to promote client welfare, non-maleficence, and to maintain their own health.

Review of Literature

Positively or negatively, counselors working with survivors of traumatic events can expect to be affected in one way or another. In some circumstances, therapists may be affected in such a manner from the trauma spoken about by their client that they themselves may start to suffer symptoms resembling those that their client has presented (McCann & Pearlman, 1990). This is known as vicarious trauma. As defined, "vicarious trauma (VT) involves affective distress and shifts in cognitive schemas following secondary exposure to traumatic material" (Aparicio, Michalopoulos, & Unick, 2013, p. 199). When experiencing vicarious trauma, counselors experience negative effects and changes occur in their thought processes that develop subsequent to hearing about the traumatic event encountered by the client.

If the mental health counselor does not experience or develop vicarious trauma, then the counselor is said to have gained positive effects or vicarious resistance (Pearlman & Saakvitne, 1995). Posttraumatic growth is also a synonym for vicarious resilience (Killian, Hernandez-Wolfe, Engstrom, & Gangsei, 2016). Therapists may be affected either in a positive or negative manner while providing trauma related services. Neutral responses from therapists providing trauma services were not elaborated in the research. Hernandez, Gangsei, and Engstrom (2007), defined vicarious resilience as, "a process characterized by a unique and positive effect that transforms therapists in response to client trauma survivors' own resiliency" (p. 237). Vicarious resilience occurs when a therapist gains insight and learns from watching their client grow and gain self-efficacy while bouncing back and resisting defeat of their experienced traumatic

hardship (Hernandez, Gangsei, & Engstrom, 2007). When it comes to, "manifesting vicarious resilience," (Hernandez, Engstrom, & Gangsei, 2010, p. 72) trauma counselors have reported obtaining new perspectives and insight while observing clients succeed throughout treatment; this prompted an increase in self-efficacy of the counselors providing the trauma therapy (Hernandez, Engstrom, & Gangsei, 2010).

Examples of self-reported changes amongst counselors included:

> (1) reflecting on human beings' capacity to heal; (2) reaffirming the value of therapy; (3) regaining hope; (4) reassessing the dimensions of one's own problems; (5) understanding and valuing spiritual dimensions of healing; (6) discovering the power of community healing; and (7) making the professional and lay public aware of the impact and multiple dimensions of violence by writing and participating in public speaking forums (Hernandez, Engstrom, & Gangsei, 2010, p. 72-73).

While vicarious trauma has negative or detrimental effects, vicarious resilience can have positive and beneficial effects for the counselor (Hernandez, Engstrom, & Gangsei, 2010). With conscious awareness of possibly encountering vicarious trauma or vicarious resilience, it is important to be mindful about the known risk factors.

Signs and Symptoms of Vicarious Trauma

As with PTSD, there are emotional, physical, and somatic responses to vicarious trauma (Killian, 2008; Cohen & Collens, 2013). In addition to emotional or somatic responses to vicarious trauma, a counselor may end up brining stress home with them instead of leaving it at the office (Cohen & Collens, 2013). Symptoms of vicarious trauma are similar to symptoms of

PTSD (Killian, 2008) such as, "…re-experiencing of the traumatic event, avoidance of stimuli related to the event, increased arousal, and cognitive intrusions" (Ivicic & Motta, 2017, p. 200). Killian (2008) concluded that, "…all of these bodily symptoms [described] are diagnostic criteria for PTSD and are initial evidence that therapists who work with severely traumatized clients do run the risk of developing secondary traumatic stress" (p. 37). Behavioral patterns have also been identified as possible symptoms of vicarious trauma amongst mental health counselors. According to Killian, Hernandez-Wolfe, Engstrom and Gangsei (2017), "Common behavioral patterns that signify impairment include social isolation, neglecting meal breaks, and putting clients' needs first; Impairment can lead to poor clinical judgment, increased risk of ethical breaches, boundary violations, and inappropriate emotional involvement with clients" (p. 25). It is essential for counselors to monitor their own well-being while simultaneously monitoring the client (Killian, Hernandez-Wolfe, Engstrom, & Gangsei, 2017). Supervisors should also continue to monitor their supervisees for possible impairment.

Emotional Symptoms. Emotional symptoms displayed by counselors exhibiting vicarious trauma may appear similar to symptoms of major depressive disorder where despair, anhedonia, and lack of motivation and drive are present (Killian, 2008). Ability to manage time effectively may decrease while experiencing symptoms of vicarious trauma (Killian, 2008). Additionally, it may be challenging for therapists to, "…switch off after sessions," leading them to experience rumination of the session's content (Spelvins et al., 2010, as cited in Cohen & Collens, 2013, p. 572). Emotional dysregulation, feelings of disgrace, and shortened temperament may also be signs of emotional symptoms of vicarious trauma (Adams & Riggs, 2008; Cohen & Collens, 2013). Cemans (2004) acknowledged that detachment is also a common emotional symptom of vicarious trauma (as cited in Cohen & Collens, 2013). Adams

and Riggs (2008) hypothesized that, "when new therapists encounter symptoms of vicarious traumatization, they may experience anxiety, shame, and absence of competence, and consequently not seek adequate supervision and support" (Neumann & Gamble, 1995; Pearlman & Mac Ian, 1995, as cited in Adams & Riggs, 208, p. 27). It is essential for mental health counselors to seek additional supervision if they begin to experience emotional symptoms of vicarious trauma and countertransference.

Physical Symptoms. Physical signs and symptoms of vicarious trauma include, but are not limited to, '…muscle tension, headaches, and lack of energy" (Killian, 2008, p. 572). Difficulty remaining asleep or falling asleep may prompt an increase in fatigue experienced by the counselor (Killian, 2008). Emotional symptoms such as intrusive thoughts may ultimately affect physical symptoms (Killian, 2008). Killian (2008) identified intrusive thoughts during intimate moments with your partner as an emotional symptom of vicarious trauma. Killian (2008) reported. "…having conversations with clients about negative sexual experiences can really skew your thoughts about sex unless you are able to be honest and talk about your feelings with your partner" (Killian, 2008, p. 35). The ability to have open conversations with your partner is also challenging due to confidentiality and privacy rights. Therapists may be embarrassed to discuss the affects that providing counseling is having on their sexual relationship with their partner and may be reluctant to bring up the countertransference that they are experiencing during supervision.

Somatic Responses. Somatic responses to vicarious trauma include, but are not limited to, "numbness and nausea" (life, & Steed, 2000; as cited in Cohen & Colleens, 2013, p. 572); "insomnia" (Splevins et al., 2010; Stteed & Downing, 1998, as cited in Cohen & Collens, 2013, p. 572), "muscle tension, headaches, and lack of energy" (Killian, 2008, p. 35), and feelings of, "

detachment" (Cemans, 2004, as cited in Cohen & Collens, 2013, p. 572); experiencing, "cognitive intrusions"; avoidance of related material; engaging in flight or fight reactions; and flashbacks (Ivicic & Motta, 2017, p. 200). Somatic responses are present for more than a week following the session (Shamai & Ron, 2009; as cited in Cohen & Collens, 2013).

Risk Factors

Childhood or Personal Trauma. One possible risk factor mentioned in multiple research studies concluded that counselors whom have experienced or witnessed childhood or personal trauma may be more at-risk than counselors who have not experienced traumatic events (Williams, Helm, & Clemens, 2012; Baird & Kracen, 2006; Nelson-Gardell & Harris, 2003; Srang, Clark, & Whitt-Woosley, 2007, as cited in Miller & Sprang, 2017). Counselors who have suffered childhood or personal trauma or abuse in their past may become triggered when listening to their clients speak about traumatic events they have experienced (Williams, Helm, & Clemens, 2012). According to Williams, Helm, and Clemens (2012), counselors should have:

> Awareness of the potential impact of their own history of trauma [and how they] will enable [themselves as] therapists to recognize when emotions and memories related to their own experiences have been triggered and seek help to manage shifting beliefs about the goodness of self, others, and the world associated with VT [vicarious trauma] (p. 147).

Although most of the research pointed to childhood and personal trauma as being risk factors for vicarious trauma, there were also a couple of studies that produced results indicating that counselors with childhood trauma or personal trauma were not at an increased risk for vicarious trauma (Williams, Helm, & Clemens, 2012). While there appears to be more counselors with a

trauma history reporting symptom of vicarious trauma, there are still counselors that do not have a history of trauma that report having experienced symptoms of vicarious trauma from their work with clients (Miller & Sprang, 2017). More research will need to be completed to determine whether previous trauma in the therapist's life increases their risk for vicarious trauma and the intensity of the risk.

Organizational Factors. Besides having a history of childhood or personal trauma, organizational factors and work-related supervision were found to be factors in the development of vicarious trauma (Trippany et al., 2004). Trippany et al., (2004), reported that vicarious trauma that is experienced by mental health counselors, "…has been described as an occupational hazard and a normal counselor adaptation to recurrent client-presented traumatic material" (p. 32). It is no secret that counselors expect to deal with challenging situations or clients at times and therefore it is essential to have adequate supervision available to help counselors make decisions as well as to debrief and consult when needed. Additional organizational risk factors include the variation of clients seen and the size of caseloads (Molnar et al., 2017).

Assessment and Screening Tools

There are many screening tools that assess the various symptoms associated with vicarious trauma and vicarious resilience. Some of the screening tools available include the Vicarious Resilience Scale (VRS) (Killian, Hernandez-Wolfe, Engstrom, & Gangsei, 2017); the Professional Quality of Life Scale (Ivicic & Motta, 2017); The Modified Stroop (Ivicic & Motta, 2017); The Coping Strategies Inventory (Bober, Rogehr, & Zhou, 2005); The Differentiation of Self Inventory (DSI) (Skowron & Schmitt, 2003, as cited in Halevi & Idisis, 2017) ; The TSI

Belief Scale (Pearlman, 1996; Halevi & Idisis, 2017); and the Secondary Trauma Scale (Motta, Hafeez, Sciancaleore, & Diaz, 2001, as cited in Ivicic & Motta, 2017). Many of these screeners rely on self-reported data.

The Vicarious Resilience Scale (VRS). The Vicarious Resilience Scale (VRS) (Killian, Hernandez-Wolfe, Engstrom, & Gangsei, 2017) stands out from other screeners described in this section, as it was designed to quantify posttraumatic growth amongst therapists providing counseling services to trauma survivors. The VRS focuses on the positive effects that counselors may retain from facilitating trauma work, rather than screening for negative side effects such as vicarious trauma.

Professional Quality of Life Protocol. Unlike the Vicarious Resilience Scale (VRS) by Killian, Hernandez-Wolfe, and Gangsei (2017), that only measured the possible posttraumatic growth amongst counselors, the Professional Quality of Life Protocol (Stamm, 2002; Stamm, 2003; Stamm & Figley, 2009, as cited in Killian, Hernanez-Wolfe, Engstrom, & Gangsei, 2017) measured both the positive and negative possible side-effects of providing trauma counseling; thus, compassion fatigue and compassion satisfaction are variables examined in the Professional Quality of Life Protocol (Stamm, 2002; Stamm, 2003; Stamm & Figley, 2009, as cited in Killian, Hernandez-Wolfe, Engstrom, & Gangsei, 2017).

The Coping Strategies Inventory. While the Vicarious Resilience Scale and the Professional Quality of Life Protocol measured the possible side-effects of providing trauma services, The Coping Strategies Inventory (Bober, Rogehr, & Zhou, 2005) measured the effectiveness of coping skills amongst counselors. The Coping Strategies Inventory (Bober, Rogehr, & Zhou, 2005) measured assumptions regarding which coping behaviors would be

associated with the lowest levels of distress regarding vicarious trauma. Conclusions drawn from utilizing The Coping Strategies Inventory (Bober, Rogehr, & Zhou, 2005), concluded that, "…leisure, self-care, supervision, and research and development were most beneficial (p. 79). Bober, Rogehr, and Zhou (2005) identified discrepancies between therapist's perceptions of the importance of self-care activities and the amount of time that the counselors spent engaging in self-care and coping strategies.

The Differentiation of Self Inventory. While assessing therapists' use of coping strategies is important, it is also imperative to assess the therapists' interpersonal and intrapersonal styles (Halevi & Idisis, 2017). The Differentiation of Self Inventory assesses the therapists' self-identity, boundaries, affect, and ability to respond or react to the emotions of others (Halevi & Idisis, 2017). The Differentiation of Self Inventory (DSI) (Skowron & Schmitt, 2003, as cited in Halevi & Idisis, 2017) appraises the therapists, "sense of self," "emotional reactivity" "emotional cutoff" and "Fusion with Others" to assess their susceptibility to vicarious trauma (as cited in Halevi & Idisis, 2017, p. 3) The Differentiation of Self Inventory (DSI) may be helpful in assessing the counselor's ability to function in a professional and ethical manner.

The Modified Stroop. In contrast to the previously mentioned assessment tools, The Modified Stroop (Ivicic & Motta, 2017) is a not an assessment based on self-reported data. The Modified Stroop has often been used to assess symptoms of PTSD (Ivicic & Motta, 2017). In addition to the Modified Stroop (Ivicic & Motta, 2017) not being a self-report measure, it is also harder for participants to malinger or to provide false answers (Ivicic & Motta, 2017). Given the amount of self-report assessments for screening for symptoms of vicarious trauma, it may be helpful to utilize a couple different screeners to collect a more accurate overall base-line.

When assessing clinicians for possible symptoms of vicarious trauma, it may also be useful to utilize screeners associated with job satisfaction and supervision (Ivicic & Motta, 2017). Ivicic and Motta (2017) reported that, "Currently, there is no empirically validated measure to assess the quality of supervision, specifically among mental health professionals" (p. 201). To assess supervision, Ivicic and Motta (2017) recommend utilizing the Supervision Scale, which was established to, "…assess the availability and quality of [the] supervision offered…" as well as the, "…supervisors availability to help, [provide] support, [and] encouragement, [as well as provide] assistance, [support clinician's] concern[s], and [provide] empathy…" (p. 199). Assessing clinicians' in-regards to overall risk factors will provide a more accurate screening for possible symptoms of vicarious trauma.

Prevention

Self-Care. As self-care and wellness were briefly mentioned as being important factors within the work environment, it is crucial that mental health therapists engage in self-care and wellness in all aspects of their lives (Williams, Helm, & Clemens, 2012). If the counselor is not modeling self-care and wellness, the client may be negatively affected which would then be deemed as unethical practice (Williams, Helm, & Clemens, 2012). If therapists are not taking care of themselves they will not be able to do their job ethically which will ultimately affect their clients and those that come in contact with their clients and therefore they are also ultimately affecting society.

Mindfulness. Mindfulness is defined as, "…present focused attending… ongoing shifts in [the] mind, body, and the surrounding world, integrated into daily life… to develop enhanced patience, presence, and compassion…to maximize and enrich every moment and interaction with

heightened attention and loving acceptance" (Harrison & Westwood, 2009, p. 209-210). Utilizing mindfulness may assist counselors in maintaining appropriate boundaries (Harrison & Westwood, 2009). Mindfulness also helps professionals differentiate between their personal and professional lives (Harrison & Westwood, 2009). Mindfulness promotes, counselors' abilities to be mindful of personal and professional limits, scope of practice, and their efforts to promote change (Harrison & Westwood, 2009). Although technology is not necessary to practice mindfulness, there are computer apps, phone apps, and smart-watches and fitness trackers that now have mindfulness activities programed into the technology to promote daily mindfulness engagement.

Wellness. Earlier in the risk-factor section of this research paper, childhood trauma was mentioned as a possible risk-factor. Williams, Helm, and Clemens (2012) discovered positive effects of self-care and wellness as they found that, "personal wellness partially mediated the relationship between childhood trauma and VT" (p. 144). This indicates that self-care and wellness are important and relevant to not only prevent vicarious trauma, but to also help relieve vicarious trauma after symptoms have developed (Williams, Helm, & Clemens, 2012). Also discovered by Williams, Helm, and Clemens (2012) was that engaging in, "regular participation in wellness activities had a significant negative correlation to VT, which suggests that counselors who engage in wellness practices more often experienced fewer cognitive distortions related to VT" (p. 148). Evidence shows that participation in self-care and wellness is essential for everyone including counselors and clients and is one example that counselors can model effectively for their clients in order to improve overall wellness for their clients and themselves (Williams, Helm, & Clemens, 2012). As part of overall wellness, counselors should have a positive support group within their work setting as well as in their personal life (Killian, 2008).

Having positive support groups in both their personal and professional lives may help promote healthy boundaries as well as overall wellness.

Supervision. Regularly engaging in supervision and consultation with colleagues and supervisors are tools within workplace settings to help provide support. Killian (2008) reported that, "Talking with supervisors, consultants, and colleges may represent a basic, effective practice that can ward off secondary traumatization, but this must be investigated further" (p. 42). It was discovered by Hernandez, Engstrom, and Gangsei (2010) that, "addressing the potential negative impact of trauma work in training and supervision is essential to help therapists become aware of their own vulnerabilities, attend to self-care issues, and establish personal and organizational support networks" (p. 68). Training and preparing therapists for possible vicarious trauma, promoting self-care and wellness, and providing approachable and supportive supervision are ways to increase positive outcomes amongst the wellness of treatment teams as well as to decrease the likelihood of therapists experiencing effects of secondary trauma (Hernandez, Engstrom, & Gangsei, 2010). Not only will effective supervision, support, and wellness have a positive impact on vicarious trauma, but it will also have a positive impact on vicarious resilience (Borja, Callahan, & Long, 2006). Efficient supervision can help enable supervisors to more accurately identify vicarious trauma in their employees and may request for their employees to complete a self-assessment (National Child Traumatic Stress network, Secondary Traumatic Stress Committee, 2011). Although supervision may often be required by agencies, there are positive effects related to self-care in regard to actively engaging in supervision sessions.

Continued Education and Training. Continued education and training will allow therapists to take time to learn new skills and stay up-to-date or refresh their therapeutic

techniques. Continued education and training also allows therapists to review ethical principles, consult with other professionals in the field, learn and try new techniques, and restore self-care. Ling, Hunter, and Maple (2014) concluded that counselors continued to desire to work in trauma counseling due to, "engaging in professional development; having flexibility in the[ir] career path; and organizational factors that promoted the sense of autonomy, value, and support" (p. 305). Providing supportive supervision and consultation, promoting self-care, and providing continued education and professional development is essential to decreasing vicarious trauma amongst trauma counselors while increasing vicarious resilience (Ling, Hunter, & Maple, 2014).

Treatment Interventions

While exposure-based therapy has been used to treat survivors of trauma, it is also how mental health counselors are exposed to the trauma that may lead to experiencing vicarious trauma. Although evidence has indicated that more trauma counselors are experiencing vicarious trauma than previously thought, there are few evidence-based treatments crafted explicitly for treating counselors experiencing vicarious trauma (Figley, 2002; Mathieu, 2012, as cited in Miller & Sprang, 2017). According to Miller and Sprang (2017), "There is little in the practice literature that specifies how, or if, the empathic encounter should be altered to allow for maximum therapeutic benefit to the client and still offer protection from harm for the therapist" (p.154). The current recommendation for trauma therapists, "…focuses primarily on self-care strategies to protect the clinician from the deleterious effects of empathic engagement" (Figley, 2002; Mathieu, 2012; Pearlman & Saakvitne, 1995; van Dernoot Lipsky, 2009, as cited in Miller and Sprang, 2017, p. 154.) There are evidence-based practices such as eye movement desensitization and reprocessing (EMDR)and trauma-focused cognitive behavior therapy (TF-CBT) that have been developed and designed to treat trauma related disorders (Miller & Sprang,

2017). Evidence-based treatments such as EMDR and TF-CBT, "…aim to desensitize a client to provocative stimuli and to reduce emotional dysregulation" (Miller & Sprang, 2017, p. 154). Miller and Sprang (2017), reported that, "Curiously, interventions for compassion fatigue in trauma treatment providers have largely ignored the effectiveness of these approaches in favor of an emphasis on self-care after secondary trauma exposure" (Miller & Sprang, 2017, p. 154). Despite the efficiency in utilizing EMDR and TF-CBT approaches for clients, these methodologies are not widely discussed as options for treating counselors with vicarious trauma (Miller & Sprang, 2017). To continue to provide care that is in the best interest of the client, additional research is needed to ensure that therapists may be treated for vicarious trauma in an effective and safe manner to continue to meet the needs of the client and to keep clinicians healthy.

Self-Care. Just like providing therapy, counselors should use self-care as an "intentional" skill on a "personal and professional" level (Daughhetee, 2014, p. 4). Engaging in self-care practices is a highly recommended strategy for counselors to use to promote their own emotional regulation (Cohen & Collens, 2013). Harrison and Westwood (2009) described self-care as, "…protective practices that mitigate the risks of VT" [vicarious trauma] (p. 207). The "Nine Major Themes of Self-Care" as identified by Harrison and Westwood (2009) include, "…countering isolation (in professional, personal and spiritual realms); developing mindful self-awareness; consciously expanding perspective to embrace complexity; achieve optimism; holistic self-care; maintaining clear boundaries and honoring limits; exquisite empathy; professional satisfaction; and creating meaning" (p. 207). Examples of self-care include exercising, meditation, mindfulness, healthy nutrition, healthy sleep regimen, personal hygiene, spending time in nature, utilizing meal breaks at work, spirituality, supervision, and having a

positive support circle (Hunter & Schofield, 2006; Illiffe & Seed, 2000; Naturale, 2007; Pistorius et al., 2008; Spleviins et al., 2010; Steed & Downing, 1998, as cited in Cohen & Collens, 2013; Killian, 2008).

Increased Supervision. If a counselor suspects that they may be experiencing vicarious trauma, it is essential that they seek out additional supervision and consultation, for the protection and wellbeing of their clients and themselves. Supervision and consultation are vital within the counseling profession. Harrison and Westwood (2009) describe supervision as, "relational healing" (p. 207). Engaging in supervision may aid in promoting a sense of balance by allowing counselors to reflect on their own feelings regarding the size of their workload and stress levels regarding current cases (Harrison & Westwood, 2009). There are many potential benefits to participating in supervision as described by Harrison and Westwood (2009):

> …Supervision helps decrease their isolation and some said supervision helps diminish feelings of shame about VT [vicarious trauma] symptoms. Most [counselors] attend at least one peer supervision group [per week]. This practice enhances their self-awareness and ability to 'self-monitor,' and reinforces their commitment to implement self-care practices, as needed (p. 207).

Not only does supervision assist in providing additional clinical insight into different cases and possible treatment interventions, but it also provides feedback to counselors regarding their own personal insight and self-care (Harrison & Westwood, 2009).

Due to levels of confidentiality and privacy, a supervisor or colleague may be the only persons that a counselor may be able to talk to regarding their workload and current stressors

regarding work (Killian, 2008). If a counselor is not receiving enough weekly supervision per week they should request additional time to meet with their supervisor.

Cognitive Behavioral Therapy. Psychoeducation has been used to treat counselors whom are experiencing vicarious trauma (Molnar et al., 2017). Psychoeducation provided as continuing education has been deemed as a way for individual counselors to increase one's awareness, acceptance, and self-efficacy regarding recognizing and handling personal symptoms of vicarious trauma (Gentry, Bggerly & Baranowsky, 2004; Gentry et al., 2004, as cited in Molnar et al., 2017). In addition to psychoeducation, "self-regulation, intentionality, perceptual maturation/self-validation, connection, and self-care" were also techniques that were used to treat counselors with vicarious trauma under the realm of cognitive behavioral therapy (Molnar et al., 2007).

Employee Assistance Programs (EAP). In addition to increased self-care, wellness, and supervision, counselors exhibiting symptoms of vicarious trauma may benefit from assistance from an Employee Assistance Program (EAP) (National Child Traumatic Stress Network, Secondary Traumatic Stress Committee, 2011; Killian, 2008; Cohen & Collens, 2013).

Reduction of Client Caseload. Reduction in the number of clients that the therapist is seeing may be clinically and ethically necessary in order to protect clients from harm and to provide care to clients that have the client's best interest in mind (National Child Traumatic Stress Network, Secondary Traumatic Stress Committee, 2011.) A leave of absence is also an option if deemed necessary (National Child Traumatic Stress Network, Secondary Traumatic Stress Committee, 2011).

Components for Enhancing Clinician Engagement and Reducing Trauma Model.

The Components for Enhancing Clinician Engagement and Reducing Trauma (CE-CERT) model was developed by Miller and Sprang (2017) to promote effective treatment strategies and approaches for counselors experiencing vicarious trauma. The CE-CERT model is made up of five practice elements that include skills from other evidence-based interventions (Miller & Sprang, 2017). The five elements of the CE-CERT model include: (1) "experiential engagement," (2) "regulating rumination," (3) "intentional narrative," (4) "reducing emotional labor," and (5) "parasympathetic recovery" (Miller & Sprang, 2017, p. 154). Miller and Sprang (2017) acknowledged that therapists whom attempt to avoid or divert from engaging in the trauma experience throughout sessions are more likely to develop vicarious trauma or burnout versus trauma therapists whom work though the trauma experience with the client (Cushway & Tyler, 1996; Duquette, Kerouac, Sandhu, & Beaudet, 1994; Maslach & Leiter, 2008, as cited in Miller & Sprang, 2017). The CE-CERT model focuses on the therapist experiencing the emotions of the sessions and acknowledging their own responses to the session while engaging in distress tolerance (Miller & Sprang, 2017). Miller and Sprang (2017) reported that, "…the most important ability therapists must develop [an ability] to deal with the intensity of trauma work is to engage with the experience fully and to allow it to be experienced through to completion" (Miller & Sprang, 2017, p. 155). The CE-CERT model has a similar, "core component" of, "experiencing and tolerating distressing feelings" as do other, "…evidence-based psychotherapies such as dialectical behavior therapy (DBT), mindfulness-based cognitive-behavioral therapy, prolonged exposure therapy, and acceptance and commitment therapy (ACT)" (Miller & Sprang, 2017, p. 155). The CE-CERT model incorporates utilizing cognitive behavioral and narrative strategies including, behavioral activation, mindfulness, deep breathing

and relaxation techniques, and trauma narratives (Miller & Sprang, 2017). Since the CE-CERT model is a recent development, more research will need to be completed to determine the validity and reliability of utilizing the CE-CERT model (Miller & Sprang, 2017).

Discussion

Unfortunately, in today's society, experiencing trauma is not an uncommon finding. Most individuals seeking mental health counseling or treatment have experienced some sort of trauma within their lifetime that is related to their reasons for seeking treatment (Hernandez, Engstrom, & Gangsei, 2010). It is important to have skillfully trained counselors that can assist individuals suffering from trauma related concerns to help them adjust and promote healing and resilience. If counselors are not practicing healthy self-care, lack supportive supervisors or work experiences, or do not engage in trainings and continued education, they are at a higher risk for experiencing vicarious trauma (Pearlman & Saakvitne, 1995; Hernandez, Engstrom, & Gangsei, 2010; Cohen & Collens, 2013). Counselors that experience vicarious trauma, but do not seek supervision or extra support, are providing unethical services to clients. Counselors that are not healthy themselves, may not provide services that are in the best interest of their clients. If a counselor is not able to put their client's best interest first and are not able to remove themselves from the client's situation after the session has ended, they must seek supervision to ensure ethical treatment for their clients to ensure non-maleficence.

In most cases, counselors who had experienced childhood trauma were deemed to be more at-risk for developing vicarious trauma than counselors who had not experienced childhood trauma in their personal lives (Williams, Helm, & Clemens, 2012). Research results discovered that counselors who had personal history of childhood trauma were able to decrease their level of risk for experiencing vicarious trauma at a statistically significant rate by participating in self-

care and wellness-related activities (Williams, Helm, & Clemens, 2012). Self-care and wellness were shown to decrease a counselor's risk of developing vicarious trauma, but also increased their likelihood of gaining vicarious resilience (Hernandez, Engstrom & Gangsei, 2010). Though vicarious resilience, counselors gain insight and new perspectives by witnessing their client strive past barriers endured due to traumatic events (Hernandez, Engstrom, & Gangsei, 2010).

Work environments that prosper supportive supervision, offer continuing education and training, and promote self-care and wellness of employees have shown to have positive effects on counselors including a decreased risk for experiencing vicarious trauma (Borja, Callahan, & Long, 2006). Supportive supervision that encourages counselors to decompress may also help promote healthy boundaries and aid counselors and supervisors detect signs or symptoms of vicarious trauma (Cohen & Collens, 2013; Molnar et al., 2017; Ivicic & Motta, 2017). There are screening tools, self-assessment tools, and measurements to assess counselors for symptoms of vicarious trauma. Utilization of these assessment and screening tools may be helpful if implemented into agency policies and procedures.

Possible interventions that have shown to be effective with counselors experiencing vicarious trauma include utilizing cognitive behavioral techniques as well as utilizing mindfulness techniques (National Child Traumatic Stress Network, Secondary Traumatic Stress Committee, 2011.) Additional research and efforts to develop evidence-based interventions for treating counselors experiencing vicarious trauma are necessary to continue to provide ethical care to clients and to promote overall wellness of clients and counseling practitioners.

Conclusion

In conclusion, it is essential for clients to be consciously aware of their emotional states and to seek supervision, continued education and trainings, as well as to engage in regular self-care and wellness to continue to work in a stressful environment that keeps the client's best interest in mind (Pearlman & Saakvitne, 1995; Hernandez, Engstrom, & Gangsei, 2010).

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