VICARIOUS HEALING:

INTEGRATION OF FAITH AND PRACTICE

by

Yolanda R. Montgomery

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

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APPROVED BY:

Kelly Orr, Ph.D., ABPP, Committee Chair

Jennifer Roberts Ed.D., Committee Member

ABSTRACT

Several studies have evaluated the emotional burden added to therapists who are treating traumatized individuals. However, little research has been done to determine how to mitigate the secondary trauma in clinicians within the therapeutic environment during counseling sessions. An exploration of change theory can be applied to understand why secular therapists experience resilience and growth at different times or not at all. However, this intersection lacks a spiritual component that is present for Christian therapists to heal from this trauma during in-person sessions. The present study aims to explore this intersection of change theory with posttraumatic growth and vicarious resilience. The study also discusses the possible differences between secular therapist growth and Christian therapist vicarious healing. Vicarious healing (VH) in psychotherapy takes place when the therapist (a) is transformed through the Holy Spirit; (b) experiences insight and the sharing of sacred space; (c) experiences the integration of growth through mind, body, and spirit engagement; (d) encounters permanent change; and (e) views self as an agent of healing for the client. Where posttraumatic growth involves psychological growth, vicarious healing encompasses the soul and spirit of the therapist. Qualitative data were collected through in-depth semi-structured interviews with 26 self-identified trauma therapists. The data were transcribed verbatim and were then analyzed using a grounded theory methodology. This finding expands the human understanding of the occupational benefits of the helping profession by revealing another dimension of clinicians' lives—that of the soul or spirit--which may be affected by their therapeutic work with trauma survivors. Implications for practice emphasize the need for the addition of spiritual guidance during the collegiate training of Christian therapists.

Keywords: traumatization, trauma therapy, PTSD, vicarious trauma, vicarious healing, spirituality

Dedication

This study is dedicated to the clinical therapists, pastoral counselors, and mental health practitioners who have dedicated their lives to helping others. Placing yourselves at risk for the occupational hazards of Vicarious Trauma and Compassion Fatigue, my hope is that your hearts and souls will feel hope and healing within your therapeutic sessions.

For Heather Kellum, my therapist, who was a conduit of healing for me in my personal and painful journey as I conducted this research. You welcomed the active engagement of the Holy Spirit, bringing biblical truth and God's unconditional love to my life in such a unique and powerful way.

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List of Abbreviations

Constructivist Self-Development Theory (CSDT)

Disorder of Extreme Stress Not Otherwise Specified (DESNOS)

Eye Movement Desensitization and Reprocessing (EMDR)

Posttraumatic Growth (PTG)

Post-Traumatic Stress Disorder (PTSD)

Secondary Traumatic Stress (STS)

Vicarious Healing (VH)

Vicarious Resilience (VR)

Vicarious Trauma (VT)

CHAPTER ONE: INTRODUCTION

Overview

Vicarious trauma is a deleterious effect on the helping professional working with traumatized clients (Mollner et al., 2017). McCann and Pearlman (1990) coined the term *vicarious trauma* (VT), which they conceptualized within the constructivist self-development theory (CSDT), to describe the deleterious effects trauma work can have on those in the counseling profession (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995a, 1995b). CSDT provided a developmental framework for interpreting the experiences of trauma survivors by combining self-psychology, object-relations, and social cognition theories. CSDT regards individuals' responses to trauma as intersections of their individual personalities (defensive styles, psychological needs, coping styles) and prominent aspects of the traumatic events, taking into consideration any social or cultural dynamics that form psychological responses. A holistic solution to preventing the prevalent issue of vicarious trauma experienced by trauma clinicians has not been found. The current study fills in this gap through the conceptual framework of vicarious healing.

Background

Secondary Traumatic Stress (STS) has been used as another name for VT. STS is an occupational hazard among trauma service providers and often carries emotional burdens for therapists who work with trauma survivors (Rasmussen, 2005). This trauma may result in the professional experiencing intrusive and disturbing thoughts about their clients' traumatic life experiences while changing their perceptions of themselves and the world. This may lead to professionals questioning their beliefs about intimacy, safety, trust, and self-worth (McCann & Pearlman, 1990; Pross, 2006). There are certain characteristics of a clinician that might impact

vicarious traumatization including personal history, the meaning of traumatic life events to the therapist, psychological and interpersonal styles, professional development, daily stress levels, and support network. Dynamics of trauma work that may increase vicarious traumatization include the type of clientele, the material discussed in session, troubling behaviors of clients, workplace setting, and social-cultural context (Pearlman & Mac Ian, 1995).

Interest in the impact of this trauma potential in the workplace has captured the increased attention of researchers, therapists, organizational leaders, and policymakers across a variety of service systems. The physical, cognitive, and psychological ramifications of providing therapeutic services to survivors have been researched over the past several years (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995; Salston & Figley, 2003). These consequences can create VT for helping professionals providing direct services to survivors. In fact, the job-related dangers of delivering services to a traumatized population have been deemed a public health issue threatening the stability of the workforce (Mollner et al., 2017). There must be responsibility taken for lessening the likelihood of VT in the workplace by agencies or organizations whose staff members serve a significant number of trauma survivors.

The physical, psychological, emotional, and spiritual well-being of the mental health therapist is significantly impacted by the work environment (Sabo, 2008). Engaging with trauma therapy can affect clinicians negatively in a manner that differs from those practicing general psychotherapy. Vicarious traumatization is defined as the “transformation that occurs within the trauma worker due to empathic engagement with clients' traumatic experiences and their sequelae” (Sabo, 2008, p. 3). This level of engagement includes hearing details about devastating events, bearing witness to human beings' ruthlessness toward each other, and re-playing traumatic reenactments with the client (Pearlman & Saakvitne, 1995a, 1995b). Vicarious

traumatization is a known hazard in the profession of trauma therapy. VT bears no reflection of clinician pathology nor does it indicate intentionality on the part of the client (Pearlman & Saakvitne, 1995a, 1995b).

Personal stress may be a key element in understanding VT. Stress has been defined as "a state of biological activation triggered by the person interacting with external agents that force her or his capacity to adapt" (Selye, 1950, p. 5). Stress is also defined as "a disruption of the individuals' equilibrium that provokes a stress response, which is the body's natural defense to deal with the distress" (Lazarus, 1993, p. 11). Stress can be labeled as acute (the body's automatic response to distress) or chronic (the state caused by a continuous stressor stimulus over a period of months), in cases such as childhood sexual abuse (Hellhammer et al., 2010). Chronic stress is obtained when one's body is unable to cope with the stress and a state of equilibrium is unattainable. The acute stress response allows an individual to become alert and regulate physiological and immunological functions to counteract the effects of the stressor. This allows the individual to obtain a regenerated state of adaptation and survival (Arza et al., 2019). Inevitably, the activation of stress response triggers changes in hormonal response and in the autonomous nervous system, as well as behavioral changes and a decrease in cognitive function (Arza et al., 2019). Thus, this stress response during a session with a trauma client may be a key area of focus to prevent VT from occurring.

There is an axiom that every living organism innately holds automatic stress responses and that, regardless of what causes the stress, the basic reaction pattern is consistently the same (Selye, 1950). This stress response pattern is referred to as the General Adaptation Syndrome (GAS). The derailments caused by stress are the diseases of that adaptation. This may explain, in part, why some therapists experience vicarious trauma and others do not. It is noted in research

that GAS is a useful and normal physiological response to stress, but that exposure to a stressor (or hearing about traumatic events) can be expected to produce diseases only when an inadequate defense reaction is present (Selye, 1950). This suggests that a defense mechanism is required so the reaction to this stress is adequate to protect the therapist from VT. This may occur through projective identification, wherein the therapist metabolizes the trauma alongside the client. However, there still begs the question, how does the clinician control the tension and strain experienced due to the stress of the therapeutic relationship with one who holds a traumatic history? Strain and stress are related to cognitive, emotional, physical, and mental tension (Selye, 1950) that may occur between therapist and client in the bi-personal field. The bi-personal field is a metaphor describing an unconscious dynamic and dialectical bi-personal entity, generated in the relational space of the therapeutic encounter (Loeb, 1977). While informed by the reciprocally interacting subjectivity of client and clinician, it is not the product of either, but rather an ambiguous co-creation that transcends the contribution of both participants (Loeb, 1977).

Trauma research suggests that interpersonal relationships, particularly the dynamics of empathy and emotional energy, which are considered vital elements of the therapeutic relationship, may be key to the development of Compassion Fatigue (CF) or VT (Sabo, 2008). In helping those who experience pain, suffering, or trauma, the clinician may experience severe adverse effects similar to that of the clients (Figley, 2002). Further, psychological, emotional, and physical stressors make clinicians vulnerable due to holding space with their clients over an extended period (Sabo, 2008). These various reactions are responses to the meaning of an encounter, relative to the interpersonal relationship. This could be further described as a person's

sense of the harms and benefits in a particular person-environment relationship. Considering injuries and advantages alludes to cognitive as well as motivational processes (Lazarus, 1993).

As a result of VT, therapists may experience PTSD symptoms such as horror, fear, and hopelessness (Lerias & Byrne, 2003). The sense of self can be disrupted and permanently altered. PTSD experiences may include intrusive imagery, loss of ability to trust, lack of independence, diminished capacity for intimacy, and loss of control (Pearlman & Saakvitne, 1995a, 1995b). While VT may lead to physical and mental health difficulties, it may also impact a person spiritually. Addressing and pressing into the spirituality of therapists as human beings may lead to abundantly more than overcoming a mental health diagnosis. Rather, it can heighten a person's purpose, understanding of God, and the meaning-making of their life's work.

VT may also lead to burnout, with simultaneous, varied experiences including exhaustion, reduced professional effectiveness, and cynicism that can result from discontentment with the organizational context of the job position. Burnout can be described as "resulting from working with difficult clients and is the consequence of frustration, powerlessness and inability to achieve work goals" (Figley, 2002, p. 19). There are multiple symptoms associated with burnout, such as diminished performance at work, anger, irritability, incompetence, inadequacy, sleeplessness, exhaustion, powerlessness, rumination about one's ineffectiveness, feeling weak, and/or feeling like a failure. In addition, feelings of apathy, hopelessness, melancholy, forgetfulness, a disconnected, uncompassionate, or cynical attitude toward clients, rapid exhaustion, a sense of disillusionment, and a tendency to blame oneself are often dynamics associated with burnout (Figley, 2002; Pross, 2006).

Self-care is crucial if clinicians are to continue being effective in their roles and prevent burnout. Sadly, many clinicians do not habitually employ the techniques they suggest to clients

in their own lives. The role of a clinician involves regular disclosure of instances of painful emotions, heartbreaking situations, and human suffering that increase the risk of burnout due to the saturation of the clients' pain (Coaston, 2017). VT and burnout are often confused. Unlike burnout, VT is associated with a swift onset of pervasive symptoms, often with no warning. Burnout, unlike VT, does not impact the therapist's issues of intimacy and trust, safety concerns, or intrusive imagery (Jordan, 2010). However, similarities between VT and burnout include a lack of concern for clients and a deterioration in the quality of care for clients. Both VT and burnout are believed to be affiliated with diminished social support from peers (Salston & Figley, 2003).

While VT is a job-related hazard confronting trauma therapists, not all clinicians suffer from VT. People respond differently to traumatic life events. Hence, there are contrasting individual elements that lead to VT in the clinician. A survey of approximately 200 trauma therapists found that less experienced mental health clinicians reported more somatic symptoms, depression, and anxiety than did their more experienced counterparts (Pearlman & Mac Ian, 1995). In addition, the clinician's personal history and current life situations determined which therapists were more likely to suffer invasions of clients' traumatic imagery (Rasmussen, 2005). This traumatization occurring for new professionals indicates that research is needed to understand how to prevent vicarious trauma from the very beginning of their work. There is also a need to understand what differentiates traumatized people from their non-traumatized counterparts. An ample body of research exists describing a broad variety of variables that may predict the ability to interpose the effects and the occurrence of symptoms in those vicariously traumatized due to exposure to a traumatic event. The common factors that are frequently found

in the research include previous trauma history, age, socio-economic status, psychological well-being, gender, education, social supports, and coping styles (Lerias & Byrne, 2003).

Clinicians who have dysfunctional coping styles due to persistent stress may experience interruptions in their professional lives because of dysfunctional adaptations. Alcoholism or substance abuse, for example, may be used to cope with the challenges of one's life, resulting in ineffective implementation and utilization of one's professional skills and clinical training, risking the well-being of clients served daily (Barnett et al., 2007). Pearlman and Mac Ian (1995) asserted that certain dependent variables exist that may serve as predictors of VT and independent variables that may forecast VT in trauma therapists and clinical graduate students. These variables included the relationship between the dynamics of trauma therapy, the therapist as an individual, and the therapist's current psychological function.

Pearlman and Mac Ian's (1995) findings revealed that those with a traumatic history displayed increased cognitive disruption. The clinicians lacking experience had elevated scores, which were amplified when the participants had no supervision. For example, female therapists who engage more with sexually abused clients or assist a higher number of survivors during their careers have an increased likelihood of displaying trauma symptoms themselves. This may be because a significant number of clinicians working with victims of childhood sexual abuse or sexual violence reported that they had suffered sexual violence, ill-treatment, victimization, and/or childhood sexual abuse themselves (Chouliara et al., 2009). Therefore, both clinical training and practice need to address prevention and coping skills.

These self-care strategies used to prevent and cope with VT are vital not only for the well-being of the clinician but also for the quality of service they give their clientele (Brady et al., 1999). Establishing a physically safe, emotionally supportive, and consistently respectful

workplace is particularly fundamental when trauma-related issues give rise to interpersonal and intrapersonal stress. According to Brady et al. (1999), there are several ways to decrease the chance of VT. First, addressing trauma-related issues in staff meetings should be a priority as well as regularly examining systemic concerns that may heighten VT. In addition, maintaining adequate opportunities for therapists to obtain consultation and continuing education is vital. Next, offering competent trauma therapy supervision to strengthen therapeutic skills and mitigate the effects of VT and promoting ongoing professional education in trauma are helpful steps for prevention.

Additionally, Regehr et al. (2004) investigated possible predictors of vicarious trauma in professional helpers. They underscored the importance of individual differences and cognitive schemas in making predictions regarding who will acquire and who will be shielded from the encounter with traumatization. As outlined by McCann and Pearlman (1990) in their constructivist self-development theory, Regher et al. (2004) discussed power and control as important schemas when determining self-efficacy in managing trauma, similar to the schemas in adapting to trauma. In other words, an individual's confidence has a direct effect on their levels of trauma symptoms; as confidence within one's environment increases, trauma levels decrease, and the inverse effect occurs when confidence decreases. Regehr et al. (2004) also proved supportive relationships following trauma are contingent on the self-schemas of safety and trust. Schemas can be disrupted if helping professionals are frequently exposed to their clients' experiences of betrayal and unsafety in the face of trauma (McCann & Pearlman, 1990; Regehr et al., 2004). A clinician may also find themself feeling helpless when a client's traumatic material disturbs their schema of authority or control (McCann & Pearlman 1990; Regehr et al. 2004). Decreased levels of VT were linked with a shorter length of time working with survivors

and the use of positive coping strategies, as professionals who cope better may tend to remain longer in the field and may be less affected by this type of work (Chouliara et al., 2009). It is vital to gain the mastery of distress as a therapist who works with traumatized individuals (Figley, 2002), indicating a need for preventing VT before it occurs.

There are several factors that may determine if or how severely the clinician is affected, including (a) high caseloads, (b) complexity of the traumatic material, (c) personal history of trauma, (d) if the clinician feels there has been adequate training for working with complex trauma, (e) absence or presence of clinical support or supervision, (f) social support, (g) self-care practices, (h) resiliency and stress buffers, and (i) years of experience (Michalopoulos, & Aparicio, 2012). The practice of self-care is the only factor that is solely determined by the therapist daily. While there is substantial research regarding the risks of VT, the therapists' protection and sustenance are essential for the professional care of traumatized individuals. When a clinician continues working, despite suffering from the damaging effects of VT, both the client and clinician experience disservice and the community's health is in danger. Furthermore, there is a tremendous loss of resources and potential when helping professionals abandon the field because of the overbearing effects on their mental health. On ethical grounds, therefore, attention to these damaging effects is crucial for the sake of providing professional, competent care to both the traumatized client and the clinician (Harrison & Westwood, 2009).

Thus, in light of the research, it is critical that all clinicians understand their susceptibility to stressors within their professional field. Subsequently, all clinicians should administer regular self-appraisals and engage in a continuous preventive self-care program. Self-assessments should be an ongoing aspect of their daily work and should include awareness of personal risk factors and attentiveness to warning signs. Particular types of clients and personal health and mental

health challenges could be risk factors. Warning signs may include increased boredom, lack of focus, hope for canceled appointments, fatigue, decreased motivation, decreased fulfillment from one's work, and feelings of frustration, impatience, or anger toward clients (Barnett et al., 2007). Clinicians must also avoid the use of maladaptive coping strategies that may further intensify their challenges. These coping strategies include self-medicating with various substances such as alcohol, drugs, and food, soliciting emotional support or gratification from clients, and engaging in denial, minimization, or rationalization (Barnett et al., 2007).

While crisis events may cause distress, they also afford opportunities for growth and positive change (Regehr et al., 2004), which may be referred to as healing. The term "healing" has become pronounced in the psychotherapy world, noted widely in self-help literature. Pastoral counseling can no longer lay special claim to the word even though the healing metaphor denotes for many people the association with a spiritual or religious context (Vankatwyk, 1997). Research supports the notion of healing through findings that a greater number of those who suffered exposure to the most horrific human experiences have more faith in a brighter future than others. For those who endured the Holocaust, an extremely traumatic event, the notion of some survivors might be that the worst had already happened and the future could only be better (Carmil & Breznitz, 1991). Spirituality may also play a role as Holocaust survivors and their children expressed greater belief in God and more hope than those that did not directly experience the Holocaust (Carmil & Breznitz, 1991).

While many people may perceive the holocaust as an indication of a Godless world, the results of one study found that the survivors did not (Carmil & Breznitz, 1991). Many believe their survival was credited to the power of God. When encountering a collapsing world, staying alive was considered a miracle, one that could have happened only by the intervention of

something so powerful as God. People who experienced devastation in war have also communicated a greater belief in God (Carmil & Breznitz, 1991). While death from war is unacceptable and unreasonable, in the Holocaust—staying alive was a miracle. It is plausible that when confronted with questions such as "why me?" or when faced with unexplainable phenomena, more people tend to turn to God (Carmil & Breznitz, 1991). Similarly, spiritual self-care practice can create a private, individual sanctuary (Linder et al., 2000) that can offer refuge for a counselor when overwhelmed by personal or professional adversity (Sori et al., 2006).

This research shows that spiritual beliefs can develop in the aftermath of traumatic events. Further, spiritual beliefs can be beneficial to those in psychological recovery, personal development, and emotional growth following trauma. For some, pre-existing spiritual beliefs may be ravaged by the traumatic experience. Conversely, for many, spirituality can yield a comprehensive life philosophy and serves as a steadying force that offers a framework for interpreting life's challenges and provides a tenable conclusion to such concerns as suffering, injustice, and trauma (Shaw & Joseph, 2007). In order to advance the growth and development in therapists in theory and practice, additional work must be completed to deal with the constellation of factors involved with the phenomenon of the interface between body, mind, and spirit (Stebnicki, 2007).

Religion and spirituality are essential components in many clients' lives. To attend completely and appropriately to clients' spiritual or religious needs, clinicians should also tend to their own needs (Coaston, 2017). While the Holocaust is an extreme example of trauma and spirituality, it shows that there is always room for healing and that God is centered within it. Abuse survivors may serve as an impetus for a clinician's personal spiritual growth. The

exposure to traumatic material may produce a temporary crisis and cognitive dissonance, but the result may be a stronger, more robust sense of spiritual well-being (Brady et al., 1999). Thus, clinicians must cultivate this healing within themselves by engaging in appropriate training, incorporating dynamics of trauma-informed supervision that involves the discussion of individual and work-related challenges and dangers to professionals who perform trauma work (Rasmussen, 2005) in addition to an awareness of their spirituality with guidance on healing and preventing VT. Spirituality and religion have been found useful relative to assessment and intervention according to research (Barker, 2013). Prayer can be a powerful practice for many to engage a higher power; this act of worship is an essential component in various spiritual traditions and has been associated with several improvements in health and well-being. Self-care often includes spending time in communion with a higher power when integrated into a regular routine (Coaston, 2017). Relatively little attention has been given to the function of religion and spirituality in the life of the professional helper and the consequent impact that it has on the context of practice (Barker, 2013). A counselor's spiritual livelihood can impact the therapeutic relationship in multiple ways. Impacts may include: increased awareness of the client's spiritual concerns, decreased acknowledgment of the client's spiritual values, or disregard about how the client's spirituality may be a therapeutic resource or contributing factor to distress (Coaston, 2017).

As expressed previously, spirituality may improve after a trauma. Therapists may be compelled to confront their personal constructs of spiritual meaning and faith traditions. This heightened focus within the therapist may strengthen their own spirituality. Confronted with the dynamics of meaning, hope, and spiritual knowledge, a therapist's own faith may surface even stronger and more resilient. Such exposure enhances well-being and highlights spiritual

development, which then explains the connection between traumatic material and spirituality. (Brady et al., 1999):

> Participants further described experiencing a sense of connection to a spiritual realm or a sense of larger meaning that transcends individual boundaries and reason. This sense of interconnectedness with the mysterious transcendent (e.g., "this other realm… the *mystery* stuff"), which is tacitly known and cannot be clearly articulated through words or otherwise captured, is sustaining therapists' professional efforts and personal well-being because it helps counter isolation and despair (p. 27).

These clinicians find comfort in the belief of their meaningful and purposeful existence alongside other clinicians with similar experiences. This felt sense of spiritual interconnection reinforces the clinicians' positive dispositions and renews several convictions, including the resiliency and healing capacity of human beings and the fact that growth can occur in the wake of trauma. Further, clinicians' spirituality reinforces that life is about more than suffering and that their clinical efforts are meaningful. Finally, clinicians are aware they are not solely responsible in their efforts to heal trauma. Often, spiritual connection inspires therapists to persevere despite the challenges within their profession. Most described time spent in nature as an important aspect of this sense of spiritual connection (Harrison & Westwood, 2009).

Situation of Self

As a nurse and founder of an anti-human trafficking nonprofit, the author has a deep understanding of the adverse outcomes associated with vicarious trauma and the need for self-care. As a therapy client, the author is uniquely positioned as an insider relative to her participants. A researcher often intentionally aligns their own self-interests with the research and is considered an insider due to positionality (Berkovic et al., 2020). As a human service provider,

the author is also an outsider in terms of positionality. As a Christian woman, Yolanda strongly believes in the power of Christ, which has shaped her understanding of healing for those who suffer from complex trauma. The researcher acts as the data collection instrument in qualitative research (Bourke, 2014). The researcher's spiritual beliefs, worldview, and cultural background (gender, race, class, socioeconomic status, educational background) are noteworthy variables that may determine the findings in the research process (Merriam et al., 2001). Researchers' experiences are framed in social-cultural contexts, as are those of the participants (Bourke, 2014).

Problem Statement

Standard trauma mental health interventions such as Eye movement desensitization and reprocessing (EMDR), cognitive behavioral therapy, and prolonged exposure, have been the mainstream practice of care, but do not offer a holistic solution to treating this trauma. Two aspects remain a challenge: (a) In order to support resilience, mental health modalities must consider a person’s mind, body, and spirit to support resilience and long-term well-being and (b) addressing VT and STS for therapists since a large portion of clinicians who serve trauma survivors are survivors themselves of related types of traumatic experiences. This makes trauma-related outcomes even more pertinent (Dutton et al., 2017). Research supports that this missing spirituality piece is important. Failure to acknowledge spirituality as an important element of the human condition can generate possible boundary limitations (Sori et al., 2006). Further, a therapist's insight into the client may be diminished due to a lack of examination surrounding beliefs steeped in one's own spiritual background. Further, it may give rise to difficulty with regulating the unstable emotions and psychological pain of clients because of the clinician's own struggles with faith. Therefore, engaging in reflection, exploration, or regular

spiritual practice can benefit both the counselor and the client. Finally, these therapists recognize the importance of their ability to create or perceive meaning, regardless of whether through belief in an ultimate universal goodness or a sense of interconnection with the efforts of others in continuity over time. This last finding relates back to the notion of countering isolation in the spiritual domain of life. Furthermore, it parallels the work of Briere and Jordan (2004) and van der Kolk and McFarlane (1996), who assert that the process of making meaning beyond concrete events helps to contextualize and reduce the threat of trauma (Harrison & Westwood, 2009).

Researchers have identified the need for integrating useful self-care practices that offer trauma therapists supportive resources for personal and professional growth (Coaston, 2017). Several researchers have recommended self-care practices to manage the stress vicariously experienced by therapists working with traumatized populations, including maintenance of physical health, balanced diet, adequate sleep, regular exercise, or engaging in recreational activities (Harrison & Westwood, 2009). According to McCann and Pearlman (1990), clinicians must acknowledge, express, and work through painful experiences in a supportive environment. They suggested that weekly case conferences and other groups for clinicians who work with traumatized clients can counter professional isolation and provide emotional support by helping to normalize and elucidate therapist reactions to client trauma. Furthermore, they recommended that clinicians receive regular supervision, balance caseloads with victim and non-victim clients, balance clinical work with other professional responsibilities, and maintain a balance between personal and professional life. They identified other coping strategies, including advocacy, enjoyment, realistic expectations of self in the work, and a realistic worldview (that includes the darker sides of humanity).

Purpose Statement

The purpose of this grounded theory study was to address a gap in the literature relative to vicarious healing. This study aimed to further develop the conceptualization of vicarious healing through semi-structured interviews with trauma-based clinicians to understand if and how they experience vicarious healing in their practice. This aim is to understand the construct more holistically so that it can be a tool utilized by trauma-based therapists during their trauma-based counseling sessions to protect them from VT. At the beginning of the research, the author conceptualized vicarious healing as a spiritual construct generally defined as an understanding of how a person's spirituality within themselves (sense of God and purpose in life) shapes their experiences as service providers who are dealing with trauma. Moreover, the author conceptualized vicarious healings as an avenue for them to grow spiritually through connection to their higher ideals and values. While there is an existing theory of vicarious healing, the present study inductively built a new theoretical understanding of this healing.

Significance of the Study

While the previously discussed recommendations are tools to protect clinicians from STS and VT, the self-care activities in which one may engage tend to occur outside the therapeutic environment. This study explored the role of vicarious healing (VH), which may be present inside a therapy session, while the client is still with the clinician. VH is a benefit inherent to the counseling session itself and engages the clinician in "real time." The additional recommendations given by McCann and Pearlman (1990) included recognizing the ways in which trauma work enhanced lives (of others and their own), perpetuating a sense of hopeful enthusiasm and a conviction in the capacity of individuals to withstand and transcend pain, using

it as a measure for growth. While this sounds altruistic, the question is whether it is practical or possible.

The development of clearly defined constructs is a key priority of research. The concept of vicarious healing is complex. Vicarious healing's measurement requires a diversified approach that has not yet been accomplished in the current literature. Important future directions for the progression of vicarious healing include describing and outlining a measure of spiritual engagement within the bi-personal field and continuing to find ways of qualifying the many elements that may contribute to or mitigate vicarious healing (Pearlman & Saakvitne, 1995a, 1995b). This author asserts that VH is the answer to preventing and coping with vicarious trauma. Although VT is known to be an occupational hazard, more research is needed regarding how the evidence for, training/skills needed for, and influence of VT among professionals who work with victims of trauma may be identified and minimized (Chouliara et al., 2009). This paper aimed to expand on the current literature on VH and examine if it is a viable method to minimize VT and its deleterious effects for clinicians with a hypothesis that real-time, in-session strategies that promote resilience, healing, and other psychological resources will contribute to problem reduction and prevention of VT, CF, and burnout.

Research Questions

The current study aimed to build on the underdeveloped conceptualization of vicarious healing. While vicarious healing has been explored in the literature, the present study sought to advance the evolution of this concept to shift from a passive event to an actionable tool that can be used by trauma clinicians to combat vicarious trauma and burnout. This reconceptualization of VH calls for a grounded theory to create and explore this new multifaceted holistic

understanding of VH. The current study explored how this new construct of VH applies to trauma-based mental health professions through 3 research questions:

RQ1: How does vicarious healing occur for trauma-based mental health professionals?

RQ2: How does spirituality impact how trauma-based mental health professionals experience vicarious healing?

RQ3: How can vicarious healing be harnessed so that it can be shared with all trauma-based mental health professionals?

Definitions

Bi-personal Field: "An explanation of the complex dynamics within specific individual and group settings. Determined by the following elements: the space and time of the setting and the nonconscious fantasy that emerges in the field of the therapeutic relationship" (Baranger & Baranger, 2011, p. 797).

Intersubjectivity: Intersubjectivity is a complex process that is ever-present as a mutual exchange between clinician and client who influence each other on emotional and psychological levels. Within this context, there exists a dialectical interchange between conscious and unconscious types of relatedness—involving the exchange of contact, connection, and ruptures (Cornell & Hargaden, 2005).

Burnout: The inability to achieve work goals as a result of powerlessness and frustration characterized by certain psychophysiological arousal symptoms. These symptoms may include sleep disturbance, physical or mental exhaustion, headaches, irritability, or aggression. Other symptoms include callousness, pessimism, difficulties in work relationships, cynicism, and decreased work performance (Pross, 2006).

Compassion Fatigue: Now known as *secondary traumatic stress*; “The practitioner’s reduced capacity to be empathic or bear the suffering of clients” (Figley, 2002).

Countertransference: “The unconscious attunement to and absorption of victims' stressors and traumas. The latter are often expressed nonverbally, through gestures and enactments. These are ways in which one may transfer particularly difficult emotional material not readily expressible in words” **(**Barreto & Matos, 2018, p. 429).

Secondary Traumatic Stress: Previously known as *compassion fatigue*; The natural repercussion of compassion between two individuals, one of whom has been originally traumatized and the other who is affected by the first's traumatic experiences; a syndrome of symptoms nearly identical to those of PTSD that can develop following just one incident. Symptoms include intrusion, avoidance, and arousal (Figley & Kleber, 1995).

Vicarious Trauma: The "cumulative transformative effect upon the trauma therapist of working with survivors of traumatic life events" (Pearlman & Saakvitne, 1995, p. 31).

Vicarious Healing: Conceptualized by the author as an understanding of how engagement with the Holy Spirit creates the sacred space for Christian therapists to experience healing and growth while navigating through trauma with their client, thus allowing the therapist to have a more profound understanding of and a deeper connection to the *imago Dei* to acquire a transcendence in the spiritual realm that brings personal safety and peace in the physical realm. Vicarious healing (VH) in psychotherapy takes place when the therapist (a) is transformed through the Holy Spirit, (b) experiences insight and the sharing of sacred space (c) experiences the integration of growth through mind, body, and spirit engagement, (d) encounters permanent change and (e) views self as an agent of healing for the client.

Summary

Vicarious traumatization is a vocational threat among trauma-based mental health professionals. There are numerous adverse outcomes associated with VT, such as burnout (McCann & Pearlman, 1990; Pross, 2006). Due to the prevalent nature of VT, employers should ensure that they are providing appropriate training and trauma-informed supervision for these clinicians. Supervision should address the individual and organizational-related risks and demands of therapists who serve trauma survivors (Rasmussen, 2005). Research has indicated the necessity for including helpful self-care routines that allow clinicians supportive measures for professional and personal growth (Coaston, 2017). McCann and Pearlman (1990), argued that therapists must recognize, communicate and work to resolve painful experiences in a supportive milieu, strengthening the argument for improved training and supervision.

While these recommendations are tools to protect clinicians from STS and VT, they can only be utilized after sessions—not during. This paper argued that VH is a tool that can be used during sessions to combat VT. McCann and Pearlman (1990) provided a rationale for this conceptualization in their recommendations that acknowledged the ways that working with trauma survivors could enrich lives through sustaining hope and belief in the capacity of people to endure pain and build resilience. This study asserted that VH is the answer to harnessing this enrichment. Minimal holistic research exists on how VT among those who work with victims of trauma may be identified and reduced (Chouliara et al., 2009). This author suggested VH as a way to minimize VT and its deleterious effects for clinicians.

CHAPTER TWO: LITERATURE REVIEW

Overview

Engaging with clients in an empathic relationship to identify with and understand how their traumatic experience impacts the therapist emotionally and spiritually, both consciously and subconsciously. Literature has indicated that vicarious trauma (VT) is part and parcel of the therapeutic work with individuals who have trauma histories (Bell et al., 2003; Molnar et al., 2017; Pross, 2006). VT is defined as "the transformation that occurs within the therapist (or other trauma workers) as a result of empathic engagement with client's trauma experiences and their sequelae" (Pearlman & MacIan, 1995, p. 558). VT is considered an occupational hazard, with signs and symptoms of VT remarkably similar to symptoms experienced by trauma survivors (Kadambi & Ennis, 2004; Rasmussen, 2005). The VT construct denotes the negative impact of clinical trauma work on therapists (Canfield, 2005; McCann & Perlman, 1990). VT negatively affects the therapist's sense of self, other people, and perceptions of the world. VT emphasizes the way in which the professional's perception of the self is affected relative to identity, spirituality, self-abilities, psychological needs, worldview, and the sensory system (Pearlman & MacIan, 1995). Research has demonstrated that it is critical to create and integrate effective coping mechanisms and support systems to mitigate the effects of exposure to the traumatic material of survivors and Secondary Traumatic Stress (STS; Salston & Figley, 2003). Even though there is a general recognition of these coping mechanisms and systems of support, the present study sought to go beyond that by exploring this new construct of VH that may be used to cope with VT and STS within the therapeutic process.

The elements that create the theoretical framework for vicarious healing are intersubjectivity, bi-personal field, and sacred space. Currently, there is no existing research on

the intersection of these three elements, although extensive research exists relative to the need for self-care to decrease vicarious trauma, compassion fatigue, and burnout. Further, change theory is often incorporated in an effort to elicit positive behavior and even to change thought processes, but historical and current theories miss the holistic view of the therapist-self, which includes body, mind, and spirit. In the field of psychotherapy, it is amenable to discuss a change in behavior, thoughts, and feelings, but the construct of vicarious healing explores a substantive change within the core of the therapist. This core change alters who the person is at the deepest level. When a therapist experiences vicarious trauma, it is not simply a matter of change in thoughts, feelings, or behavior (in the form of PTSD symptoms, as is commonly noted in the literature). Rather, vicarious trauma changes the core of the person, affecting the body, mind, and spirit. Thus, vicarious healing must take place on the same levels, incorporating the whole living being in its entirety. This newly developing construct of vicarious healing reorients the process to address the therapist's personhood, rather than alleviating or avoiding symptomatology that is associated with burnout, compassion fatigue, and vicarious traumatization. Vicarious healing is a reversal of the process of vicarious traumatization and introduces an orientation rather than simply addressing an existing methodology. To the author's knowledge, this has not been addressed previously, leaving a gap in the literature. The following theoretical framework discusses change theories, highlighting the lack of a holistic view of the therapist-self, addressing behavior and cognitive changes only. In addition, the elements of intersubjectivity, the bi-personal field, and sacred spaces are discussed as necessary elements for vicarious healing to materialize.

Theoretical Framework

Lewin's Change Theory

Kurt Lewin (1951) introduced Change Theory as a three-step model, asserting that behavior can be perceived as opposing forces creating a dynamic balance. Lewin's first step in the process of change is to cease engaging in the current status quo, considered to be the state of equilibrium (Lippitt et al., 1958). This unfreezing can be attained by using one of three practices. The first practice is to enlarge the compelling forces that steer behavior away from the status quo. The second practice is to diminish the suppressing forces that negatively impact the movement from the existing status quo. The last practice is to find a combination of the two previously mentioned methods. Lewin's second step in the process of changing behavior is a movement where the target system must be moved to a new level of equilibrium. There are three actions that can help with this movement step. The first is persuading individuals to understand that the status quo is not helpful and encourages them to perceive it through another lens. The second action is to work together on a mission to gain fresh information, relevant to the desired change. The final action includes connecting the perceptions of the group to highly esteemed, influential individuals that also support the change. The final step of Lewin's change model is refreezing. This should occur after the change has been implemented, over time, for it to be sustainable. It is probable that individuals will regress back to the old behaviors (or equilibrium) if this step is not incorporated into the process. The purpose here is to preserve the new behaviors that are produced from change by balancing the driving and the restraining forces. Lewin's theory promotes the concept that opposing forces combat change while driving forces stimulate change.

Most of the change theory literature, including Lewin's theory, focuses on organizational change or "systems thinking" rather than on the deep, profound, and personal factors of the individual to elicit change in their lives. This is the focus of clients in therapy, and the trauma presented therein which may induce VT for the clinician cannot be addressed by organizational or systems theory. The three-step process introduced by Lewin, even on the level of organizational change, was seen to be lacking by researchers and a new theory was refined by Lippitt, Watson, and Westley a few years later.

Lippitt's Phases of Change Theory

Lewin's Three-Step Change Theory was enhanced by Lippitt et al. (1958) through the creation of a seven-step theory. This refined iteration of change theory is built on Lewin's theory of change by focusing on the agent of change's role and responsibility rather than on the progression of change itself, and where there is a constant exchange of information throughout the process. The seven steps include (a) diagnosing the problem; (b) assessing the motivation and capacity for change; (c) assessing the resources for change, power, and stamina; (d) choosing progressive change objects; (e) acceptance that the role of the change agents should be chosen and clearly understood by all parties so expectations are clear; (f) maintaining the motivation of the change agent, which includes the change agent's commitment to change; and (g) gradually terminating from the helping relationship.

An aspect that this iteration seems to lack is spirituality. The focus rests on cognitive and behavioral elements in the physical and psychological realms but does not address the need for the core of the person to change relative to their soul, which is where the deepest level of change occurs in an individual. In C.S. Lewis's (2012) book, *Screwtape Letters*, Uncle Screwtape reprimands the apprentice demon, Wormwood, for allowing his patient to become a Christian.

Even so, he declares that discouragement is not necessary and that hundreds of adult converts have returned to the dark side after a brief visit to the enemy's camp and are once again enslaved to evil. Uncle Screwtape expressed delight in the knowledge that the mental and physical habits still play in their favor. The mental and physical habits that have been learned and incorporated by individuals, both therapist and client, for a length of time will require the power of the Holy Spirit to permanently change. Wormwood acknowledges the reality that soul change is a true and permanent change. The nature of the human body acts as an agent of active tendencies to evil or negative actions as well as moral, positive, and socially acceptable actions (Willard, 1998). To discuss change only on the levels of mind and behavior, dismissing an individual's soul and spirit, is a disservice to those whose lives are impacted and altered by trauma. As a Christian therapist, one believes the biblical references to the mind, body, heart, and soul because they embody the human personality as it really is, and as if they have a definite meaning of essential importance to the comprehension of Christ's life (Willard, 1998). This theory did not allow for relapse and a non-linear explanation of change for individuals, but decades later, Prochaska and DiClemente (1992) created a change theory that was broader and included less specificity.

Prochaska and DiClemente's Change Theory

Prochaska and Diclemente (1992) created non-linear stages of change theory that encompass different paths to change. They proposed that individuals move through stages of change, which include precontemplation, contemplation, preparation, action, and maintenance. Movement through these stages tends to be cyclical rather than linear. Often, individuals relapse in their effort to change and are not successfully maintaining their gains the first time. Precontemplation occurs when a person is unaware or unwilling to acknowledge difficulties without incorporating any change process tasks. These individuals may defend their behavior as

normal and have no desire to change. The contemplation stage occurs when a person recognizes the issue, they are actively considering changing the behavior but remain non-committal to the process. The next stage is a preparation which occurs when a person is willing to change their actions and intends to do so in the next two weeks. In order for this to occur, the individual may be in therapy. However, often they are actively engaging in some type of social interaction or support, or actively seeking assistance with problem solving. The action stage takes place shortly thereafter and is characterized by increased coping coupled with behavioral change. Maintenance is the final stage in this theory when actions taken to reinforce change are taken. In addition, there is the establishment of new behavioral changes in the individual's lifestyle and normal functioning. This may last six months or up to the lifespan of the individual. Therapy to avoid relapses is crucial to assist in long-term and permanent change. Individuals have the option to exit at any time if they decide they do not want to change, and they may revisit the contemplation stage, preparing for future action steps, if desired. Prochaska and DiClemente (1992) purported that productive self-change depends on performing the correct actions (processes) at the correct time (stages). Further, it involves the ability to include the right people or supports and having the circumstances lined up to support the prospective change. The need to modify the Prochaska and DiClemente model of change (and others previously mentioned) may benefit clinicians working with traumatized populations. While the Prochaska and DiClemente model is a compelling process, more is needed relative to spirituality in an effort to mitigate the soul-changing, deleterious effects of trauma work. This addition reflects the necessity to account for clients' experiences and therapists both in and out of the therapeutic space and to further exemplify the change process to include the mind, body, and spirit.

Related Literature

Complex PTSD in Clients

The diagnostic idea of posttraumatic stress disorder (PTSD) was originally introduced into the *Diagnostic and Statistical Manual of Diagnostic Disorders* (DSM-III) in the mid-1970s, representing a major forward motion in the defining and comprehension of psychiatric conditions (American Psychiatric Association, 1980). This was birthed out of the need for diagnostic classification by which to interpret the adverse reactions experienced by military troops returning from Vietnam (Courtois, 2004). Since then, multiple adaptations have been introduced, such as Acute Stress Disorder (ASD) or Disorders of Extreme Stress, Not Otherwise Specified (DESNOS), for the purpose of increasing precise identification of etiological issues and targeting early, effective interventions (DSM-V, American Psychiatric Association, 2013).

Characteristics of DESNOS include trauma that constitutes interpersonal victimization, multiple traumatic events, or events of prolonged duration. These six areas of disturbance are required for the diagnosis of DESNOS: (a) affect regulation and impulse control, (b) attention or consciousness, (c) self-perception, (d) relationships with others, (e) somatization, and (f) systems of meaning (DSM-V, American Psychiatric Association, 2013). The topic of trauma has resonated throughout this culture's awareness, particularly in the context of how it affects mental health clinicians (Harrison & Westwood, 2009; Lerias & Byrne, 2003; Luxenberg et al., 2001). Complex PTSD (CPTSD) is defined by the following elements: The person must (a) have experienced an event in which the life, physical safety, or physical integrity of the client or another person was threatened or actually damaged, (b) have experienced intense fear, helplessness, or horror in response, (c) re-experienced the traumatic event after it is over, (d) sought to avoid reminders of the event, and (e) exhibit signs of persistent arousal (American

Psychiatric Association [APA], 2013). Clinicians that work with these traumatized individuals engage as helpers in trauma-informed therapy to assist their clientele, often at their own expense (Benuto et al., 2018). One crucial component in ascertaining the psychopathology results is the developmental level at which the trauma occurs and whether it occurs within an interpersonal context, as with a caregiver or intimate partner (Luxenberg et al., 2001). Trauma carries the most impact when its inception transpires during early childhood or adolescence (Luxenberg et al., 2001). Further, interpersonal trauma may have ubiquitous effects on social development and personality. This may result in chronic affect dysregulation, self-aggression, dissociation, somatization, aggression toward others, and character pathology (Luxenberg et al., 2001).

Complex PTSD is also conceptually similar to Disorder of Extreme Stress Not Otherwise Specified (DESNOS). In addition to PTSD symptoms, DESNOS is often described as experiencing alterations in self-identity, chaotic relationships, and self-directed harm (Herman, 1992). These alterations may include the spiritual aspect of self-identity, such as rejecting their previous religion (no longer identifying as a Christian) or suddenly clinging to a religion if they previously did not identify as spiritual or religious. In an adverse sense, some trauma survivors deny faith in God or halt their religious attendance (Walker et al., 2009). For these individuals, a lower score is observed in particular dimensions, including reason for living, feeling productive, and experiencing peace after surviving a trauma (Sansone et al., 2013). Not surprisingly, research indicates that religious and spiritual beliefs tend to decrease after a traumatic experience (Van Dyke et al., 2009). The recommended approach relative to trauma assessment is to include it within the typical psychosocial assessment conducted at the onset of treatment (Courtois, 2004), including questions relative to potential trauma in the client's past and current life, as well as post-traumatic and/or dissociative symptoms. However, although the therapist may inquire

during intake, there is no guarantee of full disclosure from the individual (Wastell, 2002). Many people with trauma histories are unable or unwilling to share early in the process, as it can be painful and difficult in the early phase of therapy (Greenberg & Stone, 1992; Pennebaker et al., 1988; Wastell, 2002).

Vicarious Trauma

For decades, multiple researchers have asserted that a unique characteristic of some mental health clinicians' work is trauma exposure through their role as practitioners to clients' telling of and reactions to trauma and that these dynamics may indirectly cause emotional distress and secondary trauma to the clinician (Benetar, 2000; Briner, 2000; Cornille & Meyers, 1999; Sabin-Farrel et al., 2003). This phenomenon has been labeled "vicarious traumatization" (VT) and is, along with its mitigation, the foundation of this study. Vicarious traumatization (VT) has been defined as the transformation that occurs in the inner experience of the therapist that comes about as a result of empathic engagement with clients' traumatic material (Pearlman & Saakvitne, 1995a, 1995b). McCann and Pearlman (1990) coined the term "vicarious traumatization" and assert that it is a normal response to the stresses of working with clients with traumatic histories. Research has clearly indicated that mental health therapists may experience PTSD symptoms due to exposure to the horrific narratives of the clients they choose to serve (Jirek, 2015; van Dernoot-Lipsky & Burk, 2009). Figley (1998) referred to this as "costs of caring" (Figley, 1998), defined by others as a result of mental health clinicians holding space with the individual's traumatic history to discern how to most efficiently assist with treatment (Baird & Jenkins, 2003). These stories often include detailed accounts of a traumatic encounter, sometimes with reports of human-induced abuse and cruelty that elicit overwhelming emotional

responses from the clients (Figley, 1999; Pearlman & Saakvitne, 1995a; Resick & Calhoun, 2001).

Compassion fatigue is differentiated from burnout, secondary traumatization, and vicarious traumatization. Galek et al. (2011) reported that they are reinforcements to each other: Burnout equates to emotional exhaustion, compassion fatigue equates to a loss of self, vicarious trauma is identified by an alteration in the cognitive schema, and secondary trauma has symptoms similar to posttraumatic stress disorder. The symptoms of compassion fatigue for the mental health therapist can be extensive, indicated by Harr (2013), to include decreased self-esteem, rigidity, apathy, perfectionism, difficulty concentrating, preoccupation with trauma, or, in extreme cases, thoughts of self-harm or harming others. Figley and Kleber (1995) defined compassion fatigue as a "state of exhaustion and dysfunction (biologically, psychologically, and socially) as a result of prolonged exposure to compassion stress" (p. 35). In other words, compassion fatigue diminishes professional clinicians' compassion and motivation to care for their clients. Work factors including organizational dynamics (setting, colleagues, caseload, and supervision), social and professional climate, and financial environment of the agency may contribute to VT, which are not exclusive to trauma therapy (Sabin-Farrell & Turpin, 2003). Pearlman & Saakvatine (1995a) proposed that there are particular aspects of the individual and their work environment that serve as contributing factors to VT, including coping mechanisms, personal history, as well as current professional and personal life circumstances. Other researchers purport that regular supervision and scheduled time and space to react to the trauma histories of their clients may mitigate the effects of VT (Richardson, 1999).

Effects of VT

Pearlman and McCann (1990) found that mental health practitioners negatively reacted when their client's traumatic stories provoked a triggering response within themselves. Therapists experienced cognitive and emotional disruption in their personal identity, intimacy, and sense of safety (Brady et al., 1999; Cunningham, 2003; Meyers & Cornille, 2002). These disturbances can significantly affect one's work with clients as well as one's personal life (Pearlman & Saakvatine, 1995). When considering the physiology of stress and the neurobiology of trauma, there are specific disruptive elements that often create physical problems including, but not limited to, depression of the immune system, feeling overwhelmed emotionally, experiencing an uncontrollable startle response, and a reduction of ability to manage reactions. These behavioral and physical responses due to VT impact the whole of a person, including emotions, cognitions, behaviors, feelings, reactions, and somatic responses that a physical body holds. Fear of physical danger may become overwhelming when one's sense of safety is affected (Sabin-Farrell & Turpin, 2003). Intimacy depth disruption may be caused by intrusive thoughts of negative experiences told by clients, leading to a lack of fulfillment in physical intimacy for the clinician (Benetar, 2000; Knight, 1997).

These effects of VT, STS, and CF create not only an impact on individuals but also on the mental health field as a whole. There is a negative impact due to burnout in the workforce as a result of absenteeism, which often results in the premature loss of professionals in the mental health field. Professionals working with traumatized individuals often experience burnout, depression, and anxiety, influencing staff retention and turnover (White, 2006). These hidden costs of caring may include increasing sick time costs and declining satisfaction indicators related to performance (Sabin-Farrel et al., 2003). If the mental health field can drive down the

costs of caring by exploring the variable of VH that helps mitigate VT in therapists, there may be economic benefits for first responders and the general industry at large. For instance, people impacted by a fatal automobile accident due to a 5-car pileup may render first responders, police, and bystanders vicariously traumatized, leaving them unable to return to the workplace. Organizational costs escalate when symptoms of CF are present systemically. High turnover rates, spiraling Worker's Compensation Claims, and chronic absenteeism are just a few of the associated costs (Smith, 2009). When left unaddressed, stress levels rise and employees can feel helpless and eventually hopeless, leading to resentment, hostility, and blame. In turn, these behaviors, ignited by the flourishing symptoms of individual CF, give rise to rampant rumors, gossip, and unhealthy competition between employees (Smith, 2009).

The combined deleterious effects of VT on clinicians may lead to a disruption in the therapist's spirituality (Dutton et al., 2017). Feeling or believing that a loving, omniscient, all-powerful God would allow such heinous acts between human beings may change the internal core values of the therapist listening to inhumane and abusive acts expressed by clients (Jirek, 2015; Peres, 2007). Some people retain some sort of spiritual belief or religious practices, many of whom are fervent in their faith (Barnett & Johnson, 2011). Therefore, it is reasonable to assume religious or spiritual concerns may often perform an essential role in both the psychotherapy process and outcome of treatment (Peres, 2007). It is vital to recognize that accessing clients' spiritual beliefs and religious traditions throughout treatment may provide a source of strength and support (Barnett & Johnson, 2011; Plante, 2007). Although many clients will not expect their therapist to share the same beliefs (Hathaway & Ripley, 2009), there exists evidence-based incentives for using the positive aspects of a client's faith for support, hope, and encouragement (Griffith & Griffith, 2002; Pargament, 1997; Plante, 2009). Spirituality can

provide a framework for an enriched quality of life as therapists work within challenging contexts due to traumatic histories. Transcendental ideals can promote purpose and bring meaning to the vocations and daily lives of individuals (Newmeyer et al., 2014).

Spirituality

Many Christian students are drawn to therapeutic professions because of an inclination to live out biblical mandates that necessitate a commitment to serve others (Barker, 2013). They soon learn that this gives rise to unique ethical challenges that arise when prominent spiritual issues are apparent at the outset of psychotherapy (Barnett & Johnson, 2011). Ethical issues within the framework of standards must be addressed at the onset and throughout the course of psychotherapy. The American Counseling Association's Code of Ethics (American Counseling Association, 2014) underscores that its overall objective is to promote "client growth and development in ways that foster the interest and welfare of clients" and that "counselors actively attempt to understand the diverse cultural backgrounds of the clients they serve" (p. 4). There must exist a sensitivity to the desires of the client within the therapeutic milieu to create and maintain a professional, safe, and helpful environment between the therapist and the client.

Sacred Space

The condition of the relationship between the clinician and the client has long been presumed to be the essence of the psychotherapeutic method (Freud, 1912; Rogers, 1957) and an essential element promoting positive psychotherapeutic outcomes (Asay & Lambert, 1999; Martin et al., 2000). In the literature, attempts to define and operationalize the therapeutic alliance have predominantly explored the interface between clinician, client, and therapy factors determined by the therapist to contribute to the therapeutic bond (Bordin, 1979; Hunter, 2012). Orlinsky and Howard (1987) described three factors that create the therapeutic bond: Empathic

resonance (linked to the client's perception of being understood by the therapist), role investment (associated with the client's emotional investment in the therapy process), and mutual affirmation (linked to the client's impression that therapy was being held in an atmosphere of respect, mutual liking, and acceptance). Role investment and mutual affirmation were considered prominent predictors of therapy session outcomes for individuals. Empathic resonance, conversely, was regarded as more significant regarding eventual treatment effectiveness than the outcome of an individual session (Saunders, 2000). These three elements of the therapeutic alliance are universally accepted as crucial components of good therapeutic practice (Hunter, 2012; Saunders, 2000). Clinicians have only in the recent past begun to discuss reciprocity in the therapeutic alliance (Andrews, 2001; Kottler & Smart, 2006; Sandmaier, 2003). Counselors interviewed in one study replied positively to a sense of mutual acceptance within the therapeutic alliance. These therapists earnestly affirmed their clients but also experienced affirmation in the encounter (Norcross, 2002). The client's commitment to role investment and the clinician's ability to identify with the client seemed to intensify the satisfaction and personal gratification that the clinician experienced. Since counseling is a relational transaction that requires responsiveness from the clinician (Norcross, 2002), this serves to encourage both the therapist and the client.

There exists a movement toward integrating spirituality into psychotherapy sessions (Griffith & Griffith, 2002; Linehan, 1993; Walsh & Shapiro, 2006; Williams et al., 2007). In their book, *Encountering the Sacred in Psychotherapy*, Griffith and Griffith (2002) discussed their "therapeutic conversations" with clients as "sacred encounters" (p. ix). Mindfulness practices, as utilized in psychotherapy, aim to assist clinicians and clients become fully present, actively listening in deep silence and vulnerability, with honesty to themselves, each other, as well as to

the wisdom that exists “in the universe” and can be cultivated in daily lives (Lord, 2008). For the Christian therapist, the truth is not found in the universe, but in the Word of God (Holy Bible), through prayer as a result of conviction and a quickening within the person’s spirit to know and accept truth (2 Timothy 3:16; John 17:17). Christians accept the Holy Spirit “will guide them into all truth” (John 14:26, 16:13), which includes psychological truth (Tan & Gregg, 1997). Christians know that the Holy Spirit inspired God’s Word, with assurance the Holy Spirit and scripture will not contradict one another when interpreted properly (Tan & Gregg, 1997). So, for Christian therapists who have surrendered to the Holy Spirit, they can be assured the Holy Spirit will empower their service to be morally and ethically consistent with aspects of biblical teaching (Tan & Gregg, 1997).

There are times when a traumatized client may feel unworthy, unlovable, or unable to regulate emotionally (Ford & Russo, 2006; Jirek, 2015). When the clinician understands, appreciates, and communicates to the client that there is level ground in some regard, it may build the client’s self-worth and hope. As a Christian, the author asserts that there is level ground at the foot of the Cross (Genesis 1:27; Philippians 2:3). Every human being is valuable and precious in the sight of our Creator God (John 3:16; Romans 2:11). When a clinician holds the client in high esteem, placing themself on common ground, there exists a possibility of seeking direction, wisdom, and guidance from a divine and loving God, rather than being advised solely by the clinician’s training or expertise. This is invaluable because God alone knows the heart, mind, and past of the client (Hebrews 4:12) and wants their best (Jeremiah 29:11). Further, the principle of self-efficacy applies, first developed by Albert Bandura. He believed that human beings hold an ability to shape their worlds as they learn to master thoughts, motivations, emotions, and decisions (Bandura, 1995). As an expansion of Bandura’s theory, the author

asserts that the most effective way to master thoughts is to incorporate truth—the Ultimate truth: A triune God, who desires to be intimately involved in our motivations, emotions, and decisions. God desires for people to walk in truth and love (Ephesians 4:15) and He will not withhold those blessings when individuals earnestly seek Him out (James 1:5), regardless of their status or occupation (James 2). Recognizing their own humanity and frailty (Psalms 103:15), the clinician is in a unique position to relate to the client and holds the capability to open themself up as a vessel of divine and perfect guidance (John 14:26; Romans 8:26; John 16:13). Once the therapist holds space with a depressed, traumatized, or anxious client and the Holy Spirit intervenes to bring joy, peace, and wholeness, a duplicatable and self-efficacy dynamic occurs. God is no respecter of persons (Romans 2:11), so He will address each issue and provide provision for each area that is dedicated to Him in that space, with the clinician as a conduit. The therapist, then, growing in the assurance that God will intervene and bring healing, will grow more attentive to the Holy Spirit in every session. There is an interface here between Biblical truth and positive psychology's pro-self-efficacy approach. According to Bandura (2008), individuals can exercise control over their imperfections and deficiencies, choosing to make healthier or better choices. According to the Bible, humans can submit their wills, surrender their minds, and dedicate their bodies to the lordship of Christ, resulting in peace and joy.

Another aspect of equal footing between clinician and client is the recognition of the clinician's own sinful human nature, which serves as personal self-awareness for the therapist (1 John 1:8; Galatians 5:17). This aspect of self-awareness, past mistakes (Romans 3:23) and God's love and truth (2 Peter 3:9; James 1:17; Galatians 5:22) create the environment for sacred space—created by grace. To live a grace-filled life means the Christian therapist acknowledges one's whole life story, the light side and the dark (Willard, 1988). Clients seeking mental health

therapy often feel guilty or ashamed, expecting criticism, so it is remarkable to them when they are validated as human beings, which is therapeutic (Kraemer, 2006). Ideally, the therapist would be always self-reflective. Then, neutrality is a more stringent discipline in which one becomes aware of one's bias and prejudice when attending to the client (Kraemer, 2006). Neutrality may be one of the most misconceived concepts in psychotherapy. Novice therapists may feel that their opinions and reactions must be suppressed and that they must dutifully follow the method. However, a therapist who holds no particular view is useless (Kraemer, 2006). Clients seek help because, while desiring their own point of view to be validated, they desire their clinicians to introduce another viewpoint that will make a difference in their lives (Kramer, 2006). However, the greatest influencing factor in the lives of individuals is the revelation and acceptance of ultimate truth, which comes from God rather than the therapist, another human being. That therapist, however human and innately sinful, can act as a conduit of truth and love to the client.

The third dimension in which there is equal ground between the client and the therapist is that humans have been given God in their souls (1 John 4:12), Christ in their flesh (Colossians 1:27), and the Holy Spirit to actively lead and guide them as clinicians in and out of sessions. One cannot add a single inch to one's spiritual, emotional, or psychological stature on their own, but must submit themselves daily to His instruction (Psalms 103:1-22). He does not cease leading when one sits in the therapist's chair. By the very nature with which God created humanity—in His image—humanity is appropriately fitted to be the conduit of God's likeness, where dust (the therapist) and divinity (Holy Spirit) are set in place (Willard, 1998). Thus, the connectivity of the sacred space is available to all Christian therapists, even if the client does not proclaim Christianity. "The human body itself then is part of the *imago Dei*, for it is the vehicle through which we can effectively acquire the limited self-subsistent power we must have to be

truly in the image and likeness of God" (Willard, 1998, p. 53). Since Christians are created in God's image, those who surrender daily to the Holy Spirit and allow Jesus in them to flow out of their core into their actions and speech, the sacred space will bring power to discern, change and heal. In John 14:26 (ESV), Jesus states, "But the Helper, the Holy Spirit, whom the Father will send in my name, he will teach you all the things and bring to your remembrance all that I have said to you."

Any Christian, therapists included, can be filled with the presence and wisdom of the Holy Spirit (Titus 3:5). The person must first dedicate themselves to Christ, recognizing their need for salvation, asking for forgiveness of sins, and then accepting Him as Lord of their life (Romans 10:9; Acts 16:31). The next necessary step is to completely submit to the authority and leading of the Holy Spirit (Acts 5:32). The Holy Spirit is the One who lives inside and directs believers, also convicting of sin. People could not live a holy life without His power (Romans 8:14). People cannot experience His power without completely submitting to Him. From the moment of spiritual birth, the Holy Spirit lives in every believer (John 14:17). In order to be controlled by the Holy Spirit, believers must, as an act of their wills, completely surrender their lives in obedience to Jesus, listening and being attentive to the leading of the Holy Spirit. This does not mean a Christian therapist must be sinless or perfect, only that they understand the need for grace and ask for forgiveness, characterized by obedience to God and love for others. Love is demonstrated through behaviors and words (John 13:35), and is motivated to move others toward change and growth. Ideally, the Christian therapist will live surrendered to the Holy Spirit, which produces the fruit of the Spirit, including "love, joy, peace, patience, kindness, goodness, faithfulness, gentleness, and self-control" (Galatians 5:22–23). When the Spirit is involved in

Christian therapy, one can expect that the clinician will demonstrate godly behavior toward clients and that the outcome of therapy will be an individual demonstrating more Christlike fruit.

Though words serve as agents of change in therapeutic space, change can develop outside of conversation and often outside awareness. The purpose of the change is not always new knowledge, but an alternate mindset. This different frame of mind may be the shift that occurs within therapists when they actively submit their training and expertise to make room for the all-knowing, all-encompassing Creator to give them His thoughts on the discussion, troubled relationships, or problematic symptomatology. This parallels the concept of mindfulness in psychotherapy. The discussion moves to what mindfulness may entail for a Christian therapist.

Mindfulness has been described as the condition of bringing attention to the present moment of one's experience, free of judgment or expectation of outcome (Kabat-Zinn, 1990). The most frequently practiced method of creating mindfulness is meditation. The key to mindfulness meditation (MM) is to purposefully be cognizant of the present experience while maintaining an accepting and nonjudgmental attitude (Shapiro et al., 2006). Practicing nonattachment or expectations of outcomes can relieve suffering or anxiety caused by grasping at specific desired outcomes (Garland et al., 2015). The main goal of the discipline of MM is the materialization of attentiveness to impermanence, an idea that is central to Buddhism, as constant change (Shapiro et al., 2006). This coincides with decreased emotional stress and the development of positive emotions (Germer & Neff, 2013). Christian therapists are also aware of the reality of constant change in the world and can utilize the truths of God's Word. God promises that He will be present with us on a personal and daily basis as those changes occur (Jeremiah 29:11-12; Matthew 28:20), promising to never leave us or forsake us (Hebrews 13:5). The Christian clinician who believes and lives out these truths on a consistent basis, will bring

comfort to the client by modeling a peaceful spirit and assuring the client that God can use all things to work for His good as well as the clients (Romans 8:28). Further, the clinician who has prayed prior to the session, and in between sessions, has the sense of the Holy Spirit's presence to reveal truth to the mind of the troubled client (Philippians 4:6-7). In secular studies, MM has been integrated into clinical interventions as a plausible pathway to reduce psychological stress more productively as well as to regulate emotions corresponding to a wide range of clinical conditions. How powerful might clinical interventions be when the client understands and accepts this truth for themself? “My flesh and my heart may fail, but God is the strength of my heart and my portion forever” (Psalms 73:23-26). The journey from victimization to survivorship to thriving is often a journey of recovery in which someone, with the assistance of a therapist, becomes “strong at the broken places. It is the journey of the spirit and deep nourishment of the soul” (Morgan, 2009, p. 6).

Therapeutic Relationship as a Bi-personal Field

The therapeutic alliance as a bi-personal field has been developed by numerous researchers and offers an explanation of the complexities within individual and group settings (Baranger & Baranger, 2011; Bromberg, 2001; Eiguer, 2008; Ferro, 2006; Ogden, 1997). Baranger and Baranger (2011) assert the therapeutic alliance is a dynamic and reciprocal field co-created by the client and clinician. Mutual opportunities for growth are formed because of the dynamics that occur within the bi-personal field and these become the focus of the therapeutic alliance. To explain this more clearly, several terms need to be understood. First, according to psychodynamic theory, transference is a universal tendency for people to project issues from their past onto their current relationships. In essence, people expect others (in the present) to behave or respond in the same manner as people did in their childhood and respond accordingly.

Countertransference, the same dynamic, occurs when a therapist projects their personal issues onto their clients. Projective identification is a primitive defense in which someone induces in another person the feelings that are problematic. In a sense, they communicate their feelings nonverbally and evacuate them by provoking the same feelings in someone else. The result is that one person may not feel those feelings anymore, but the other person does. Countertransference and projective identification meet when clients are able to induce feelings in clinicians that trigger them, but the feelings are actually not a projection from the helper's past. Instead, it is a form of communication where the client's sentiments are placed into the therapist. The only way to know the difference is through self-reflective soul-searching relative to feelings with or because of clients, asking "Is this my issue or theirs?" Supervision is imperative because, by definition, a therapist may not be aware of this mechanism when it occurs.

Baranger and Baranger (2011) indicated that the bi-personal field is decided by the space and time of the setting and the unconscious vision that appears within the therapeutic relationship. The unconscious fantasy relies on imagery, emotion, and intuition without any logical constraints. They referred to the bi-personal field as the formation of a structure that is the outcome of the therapist and the client in the relational and dynamic space created by the unconscious thoughts or beliefs of both. In other words, there are dynamics that occur in the client's transference and the therapist's countertransference that creates its own life form or energy. This bi-personal relational encounter engages the experience of nonconscious communication. In order to utilize the relationship, the therapist first must recognize their own subjective experience and form words around their own experience and story. Kaufman (1995) described the same as a complex system moving in sync with the environment: Each step transforms the landscape. Like a circus acrobat whose balance remains in a state of flux, the

clinician changes with every unanticipated step taken by the client, due to the clinician creating new meaning for themself as well as in the relationship with the client. With the goal of facilitating smooth and balanced communication, the clinician may modify their intrapersonal and interpersonal process, becoming mindful of the co-creation process within the bi-personal field between them and the client. Next, the clinician may witness the proceeding and determine how to intervene, with the aim of restructuring and "dreaming" the change together, as Ogden (1977) and Bromberg (2006) asserted.

Intersubjectivity

Fornaro (2016) purported that intersubjectivity is a given state of existentially "being" and that there is a process of mutuality between therapist and client, even if the shared parts are not equal. Further, there is a meeting and melding of the minds in a shared state, sometimes known as "the third," a holistic perspective encompassing each individual's reality, creating an impact on various parts of the domains of self—for both participants. The concept of intersubjectivity is that both people contribute, neither one alone determining its directions, rather than being engaged solely in reactivity (Benjamin, 2018). In the therapeutic encounter, intersubjectivity allows for an authentic, spontaneous, and equal way the therapist and client to co-construct new meanings of themselves within different roles (Fowlie & Sills, 2011).

Intersubjectivity, within the helper relationship, has been perceived as a therapeutic tool and a field for interaction for both the client and the clinician (Cornell & Hargaden, 2005; Fornaro, 2016; Hargaden & Sills, 2002; Tudor & Summers, 2014). Intersubjectivity is a complex process that is ever-present as a mutual exchange between clinician and client who influence each other on emotional and psychological levels (Cornell & Hargaden, 2005). Within this context, there exists a dialectical interchange between conscious and unconscious types of

relatedness—involving the exchange of contact, connection, and ruptures. Finally, the process of intersubjectivity occurs outside of conscious awareness while both individuals are constantly affecting the other physiologically. An example of this is when a therapist sits with a client and notices their own breathing pattern in relation to the client's and how they may both make subtle changes as they sit together. This may be referred to by individuals as "holding space with another."

Anecdotally, a trafficking survivor had just learned that her whereabouts may have been discovered by her perpetrator. Utilizing prayer, and asking the Holy Spirit to intervene and enter the therapeutic space because of the need for wisdom and comfort, the therapist gently created a sacred space where the client felt safe. The client reported she believed her next few thoughts were deposited into her mind by God; that is, her safety plan was Him—not found in places where she lived, hid, or avoided. The truth God imparted to her sank deep into her core and knowing that an omnipotent, all-powerful God who loves her would not allow anything to happen to her that was not first sifted through His loving fingers, gave her great peace. Watching her body, facial expressions, and countenance change as she received this promise into her spirit allowed the therapist to witness the Divine interfacing with humanity, the therapist included. Both individuals experienced the Holy Spirit in a unique and personal manner. The therapist was affected as an active conduit, inviting God through the Holy Spirit, into that encounter. The Holy Spirit affected both and they affected each other.

The discussion above illustrates the mutual influence and reciprocal regulation, which is the foundation of the very notion of intersubjectivity (Cornell & Hargaden, 2005). However, this process may be ruptured in a variety of ways. An example of a rupture in this process may be when there is a disruption in identity when a therapist becomes numb when hearing a client's

accounts (Jirek, 2015). The unconscious process within the therapist may activate the avoidance response due to unresolved past trauma, and avoidance helps to maintain PTSD (van der Kolk, 2015). For the therapist, anxiety of the PTSD triggers avoidance, which then triggers the subjective removal of one's self from the therapeutic alliance. That process disrupts psychotherapy as the clinician is now so involved in the process of internal self-care that they are no longer involved actively in the bi-personal field and intersubjectivity is interrupted. This occurs intra-subjectively, defined as the ability to perceive one's own beliefs, desires, plans, and goals, constituting a "self-mentalization" (Lamagna, 2011). This dynamic takes place privately, within the therapist. Comparatively, intersubjectivity occurs between the clinician and the client, either via conscious effort or unconscious effort. VT creates the rupture within the therapeutic session when a therapist becomes engaged in their own self-care because of a loss of a sense of personal safety. This intra-subjectivity dynamic shift occurs within the therapist rather than in the reciprocal relationship between the therapist and the client and represents a disengagement that includes cognitive, emotional, and behavioral elements to seek safety, all of which occur with the rupture. Examples of rupture include the therapist making a joke, taking a sip of coffee, looking out the window, or shifting in one's seat. These are active but unconscious safety moves because the therapist has fractured the process of the therapeutic bi-personal field and is no longer connected to the client. The therapist disconnected from the client and is now engaging in self-care, causing disruption of the therapy session. At this point, the clinician may move from the process of VH to managing their own VT to maintain personal safety without even knowing it. The therapist's movement away, due to the trigger of their own trauma in the session, ruptures the intersubjectivity of the bi-personal field. At this juncture a Christian therapist, turning toward God and asking the Holy Spirit for guidance, moves back into a posture of VH, benefitting both

the therapist and the client. According to Baranger and Baranger (2011), it is evident that the propensity to perceive pathology alone within the client lessens the potential effects of trauma to merely negative, which is a clinically unproductive and injurious concept. Rather, the philosophy of intersubjectivity highlights the emotional milieu—the intersubjective conditions—and requires clinicians to evaluate how and why the dynamic is created and sustained within the client, within the therapist, as well as between the client and therapist.

Vicarious Resilience

Currently, the concept of VR is used to explain positive change after VT. VR is defined as "the positive impact on and personal growth of therapists resulting from exposure to clients' resilience" (Hernandez et al. 2007, p. 237). Multiple qualitative researchers have noted the presence of VR among clinicians working with trauma survivors with severe histories (Edelkott et al., 2016; Engstrom et al., 2008; Hernandez et al., 2007; Hernandez-Wolfe et al., 2014; Silveira & Boyer, 2015). VR offers a counter-intuition to the focal point in research regarding VT, burnout, and compassion fatigue when contemplating the mental health and physical well-being of clinicians employed in the field of trauma treatment and recovery. Researchers have indicated that specific trauma training for clinicians substantially enhanced compassion satisfaction and reduced compassion fatigue and burnout (Sprang et al., 2007). Linley and Joseph (2007) found that practitioners who were engaging in their own personal psychotherapy and professional supervision simultaneously with their therapeutic work reported more positive psychological findings. Other research broadens the breadth of the investigation by including compassion satisfaction as an issue of interest, a result that has been omitted in multiple studies of secondary stress and trauma work (Adams et al., 2008; Boscarino et al., 2004; Sabin-Ferrell & Turpin, 2003).

Other research highlights the negative and positive impacts of working with trauma (Stamm, 2002, 2003; Stamm & Figley, 2009). Research in the 1990s regarding compassion fatigue (CF) and compassion satisfaction (CS) led to a deeper dive and more recent work on the topics. The authors recognized that neither VT nor CF is synonymous with PTSD or STS (Figley & Roop, 2006; Pearlman & Carnigi, 2009; Stamm, 2006; Stamm, 2010). Individuals may endure negative secondary exposure effects and never develop a psychological disorder such as PTSD. Further, the authors noted that CF is not a diagnosis, but rather an identifying term and that a person suffering from CF may also possess a psychological disorder (Stamm, 2010). For example, individuals who experience burnout may also experience a level of diagnosable depression. Likewise, individuals may have a certifiable level of PTSD or some other physical, mental, or emotional disorder that is presumably attributable to their encounter with CF. Escalating priority in research has been placed on resiliency and conversion of unfavorable to favorable aspects (Pearlman & Carinigi, 2009; Stamm & Figley, 2009; Stamm, 2010).

In contrast, compassion satisfaction describes the gratification a clinician can experience from assisting others and feeling they are influencing others in a powerful and positive manner (Wagaman et al., 2015). Compassion satisfaction evaluates positive effects related to how successful one's perception as a supporter, within professional relationships with colleagues, and enduring perceptions about one's self and career choices (Rossi et al., 2012). In contrast, vicarious resilience evaluates the increase of clinicians' own resilience and growth based on the client's recovery experience. As a result of the client exhibiting an increase in resilience, the clinician will experience changes in life goals and perceptions, hope inspired by clients, heightened self-awareness and self-care practices, strengthened capacity for resourcefulness,

broadened recognition of clients' spirituality as a therapeutic resource and advanced ability to remain present while holding space with clients' trauma narratives (Hansen et al., 2018).

Resilience to trauma or loss is relative to the capacity of individuals in otherwise typical circumstances who experience a solitary and likely disruptive event to maintain relative stability, including healthy levels of physical and psychological functioning (Bonanno, 2004). Earvolino-Ramirez (2007) described resilience as the ability to preserve or recover mental health despite suffering adversity. Luthar and Cicchetti (2000) cautioned regarding the dangers of applying resilience to merely define personality attributes because such a perception may solicit blame on the client. The researchers recommended that clinicians avoid using "resilient" as a description, such as "this person is resilient," or "resiliency" to represent individuals. The term "resilience" should be correlated instead to indicate trajectories of transformation that are yielded as a result of life circumstances (Luthar & Cicchetti, 2000).

Researchers have also examined the presence of resilience development while recovering from trauma and did not want to suggest that individuals who displayed resilience during recovery were unaffected by their traumatic histories (Floyd, 1996; Phasha, 2010, Rutter, 2006). Instead, they purported that resilience was an affirmative result of trauma for people with exposure to highly adverse contexts (Rutter, 2006). Researchers have also examined the mutualities between the constructs of resilience and VT. Hernández et al. (2007) suggested that both VT and resilience are responses that are motivated by exposure to stress. They determined that while the psychotherapeutic process could create the conditions for VT, that process could also stimulate growth and VR.

The positive effects of spirituality were examined as it relates to resilience (Peres et al., 2007). Alawiyah et al. (2011) consulted survivors following Hurricane Katrina and discovered

that they also credited their resilience to spirituality. Aukstinaityte and Zajanckauskaite-Staskeviciene (2010) recognized the moderating component of compassion-satisfaction as an association with the participants who considered themselves to be Christians. Other studies (Galek et al., 2011; Harr, 2013; Van Hook, 2009) have shown a Christian belief system and spiritual focus can increase levels of compassion satisfaction due to an overall positive outlook on life. Thus, if spirituality affects the level of resilience, then the therapist has the potential to assist the client exponentially in resilience levels. However, the spiritual impact of VH has not been explored in the literature. This additional research potentially holds great benefit for the mental health field as clinicians expand the concepts of psychological resilience, emotional regulation, and behavioral growth to a deeper level—one that engages the Divine to interface with the therapist's core, the *Imago Dei*. God, who never changes and is always the same (Hebrews 13:8; James 1:17), purposefully engages with human beings who are in a constant state of change from conception until death.

The literature includes growth and movement in clients and therapists. All people grow and change in one direction or another, either for good or for evil (Willard, 1998). If the Holy Spirit is absent in one's life, evil predominates. Thus, a therapist may become more resilient but never become whole due to the lack of capacity to do so (Willard, 1998). The only way to become whole is through the process of sanctification in one's life (1 Thessalonians 5:23). The construct of vicarious healing is to bring therapists to wholeness in the center of their being, not merely change their behaviors, thoughts, or feelings. When a therapist is healed in the deepest and most personal place, that person is healthier and more equipped to assist the traumatized person.

Posttraumatic Growth

Multiple researchers (Arnold et al., 2005; Bowley et al., 2010; Engstrom et al., 2008; Hernández et al., 2007) have purported that working with traumatized clients may offer positive outcomes, including vicarious posttraumatic growth (VPG). According to these researchers, clinicians who are cognizant of the metamorphic possibility of hearing and engaging in clients' stories of growth can reframe their own emotional reactions to trauma. As therapists achieve a greater awareness of appreciation for their clients' attitudes of growth potential, hope, and strength, they are more apt to perceive their own strengths as individuals, including the ability to be a conduit of healing (Silveira & Boyer, 2015). Therefore, the beneficial effects of the therapeutic process include a bidirectional possibility; that is, counselors who are engaged in the therapeutic process hold the potential as recipients of positive effects, not merely generators of the same for their clients.

Tedeschi and Calhoun (1996, 2004) proposed the term posttraumatic growth (PTG) to describe the positive psychological change that may develop as a result of adversity. These researchers believe that PTG differs from the concept of resilience. Others considered resilience a positive adaptation trajectory despite difficult circumstances (Luthar & Cicchetti, 2000). In contrast, Tedeschi and Calhoun (1996, 2004) asserted that PTG exhibited levels of transformation that exceeds the ability to recover without impairment due to trauma. These authors stated that the difficulties associated with the effects of the trauma are necessary for PTG.

Tedeschi and Calhoun (1996, 2004) developed the Posttraumatic Growth Inventory (PTGI). The elements that define PTG are a greater appreciation of life, a changed sense of priorities, spiritual development, a greater sense of personal strength, closer intimate relationships with others, and the realization of new possibilities for one's life. The authors

conducted research to measure these five realms and found that survivors who suffered severe trauma disclosed greater positive outcomes and achieved higher scores in the majority of the PTG factors than those who did not experience trauma (Tedeschi & Calhoun, 1996). In addition, they reported that victims of trauma may experience a sense of fulfillment when they overcome the psychological symptoms caused by trauma. It seems reasonable, then, that the clinician and the client may feel fulfillment from these successes.

Intersection of Vicarious Resilience, Posttraumatic Growth, and Change Theory

As previously stated, clinicians can experience resilience or growth following their vicarious traumatization (Earvolino-Ramirez, 2007; Edelkott et al., 2016; Engstrom et al., 2008). The current iteration of change theory posits that while change is not linear, the action stage is where change and growth actually occur (Kritsonis, 2005). Prochaska and DiClemente's (1992) theory of change can be used to explain both vicarious resilience and posttraumatic growth. Research supports, through posttraumatic growth literature, that individuals can grow ("I am changed") or, through the vicarious resilience literature, rebound successfully ("I can survive and thrive after this"). In the past, change theory has characteristically been utilized for organizational or systems change, but there are benefits of using change theory in a new manner—to understand posttraumatic growth and vicarious resilience. Change theorists assert that change is not linear, but rather, it includes setbacks and relapse. The later stages of change are associated with changed behavior and growth. This suggests that to grow or rebound from experiencing trauma, a therapist may need to be in the action stage of change, defined as increased coping skills with behavior changes while the individual begins to employ some of the change processes (Prochaska & DiClemente, 1998). Thus, to experience VR or PTG, an

exploration of the intersection between change theory, VR, and PTG is needed to explore how to foster VR and PTG for secular therapists.

Change Theory's Intersection with Vicarious Resilience and Post-Traumatic Growth

The movement from precontemplation (seeing no need for change) to contemplation (acknowledging the problem but not ready to move on it yet) to preparation (focusing on the most suitable type of action to solve the problem) includes an individual's consciousness-raising, in essence asking, "Why did I do that?" or "Why might I have reacted that way?" as a result of certain situations. In consciousness-raising, increasing information about oneself and the problem becomes the focus and may be identified through observations of others, confrontations, or discussion of interpretations between individuals. As the clinician sits with and bears witness to the client becoming more resilient, they may note the growing resilience within themself, based on self-reflection. Consciousness-raising leads to progression throughout stages of change, which then leads to greater opportunities for building resilience. Resilience is a dynamic notion associated with emotional regulation through multiple psychological systems such as changes in thoughts and attitudes, self-awareness, and changes in self-efficacy. These adjustments lead to a heightened ability to endure and modify reactions to stressful situations (Nuttman-Shwartz, 2014). Thus, VR is directly linked to change within the therapist, from vulnerability in one area to strength in the same. That is, witnessing a client's resilience through self-reflection and active change toward growth can build resilience within the therapist as well.

VR identifies in a substantial manner how clients who are changing impact clinicians in manners that promote growth. This focuses on how a mutual exchange takes place in the therapeutic alliance and invites the opportunity to appreciate, attend to, and make sense of the process whereby clinicians themselves learn from and change with their clients. Clients and their

clinicians have a connection in which they mutually influence and assist in changing each other in the therapeutic alliance (Anderson, 2007).

As individuals move from contemplation to preparation in the early stages of change, a process of social liberation occurs, which clearly marks the need for change in patterns of behavior (Miller, 1995). The goal in this stage of change is to increase and adopt socially acceptable alternatives to problematic behaviors. What was once a helpful survival technique like dissociation, given by God to be momentarily healthy, has become maladaptive and requires change. Emotional arousal and processing, along with self-re-evaluation, take place when someone moves from contemplation to preparation to action (Miller, 1995). Being willing to deal with and navigate the flood of emotions and memories that surface when actively associating requires constant evaluation of the cost and consequence of staying present. It is vital for an individual to assess and reassess feelings and thoughts relative to their problem, as well as the rate of success with which they are adapting to new socially acceptable skills. Helping relationships helps expand the narrow vortex or filter of the world held by the traumatized client and expands it to become broader through emotional arousal and the self-reevaluation process. At this stage in the theory of change, the person is in the active process of making a change and maintaining that change over time (Miller, 1995). The final stage of change is maintenance, which serves as a review of what the person has learned (Miller, 1995). In change theory, the person maintains by utilizing countering and environmental control. The goal of countering is to substitute alternatives for problematic behaviors. Examples include relaxation, desensitization, assertion, and positive self-statements to bring correction to faulty or maladaptive behaviors and attitudes (Miller, 1995).

In reference to VH, the holistic process of change includes the deepest part of a person—the soul and spirit, not merely behaviors or thoughts—that integrates the power of the Holy Spirit with the core of that individual's being, which is then transformed. The process for Christian therapists at this point should be distinctly different from that for secular therapists, based on 2 Thessalonians 2:16-17: "Now may our Lord Jesus Christ himself, and God our Father, who loved us and gave us eternal comfort and good hope through grace, comfort your hearts and establish them in every good word and work." The reality for Christians is that the triune God is one's model for counseling. He has offered reconciliation ("eternal comfort and good hope"), which can be modeled to clients, but there also is the recognition that there is a second aspect to His work, which is transformation ("establish them in every good word and work"). God's comfort to His children is not an assurance that every hope and dream, or total health is realized, but rather, His comfort is more redemptive and foundational than that. God's comfort, in part through Christian therapists, is that despite sin, individuals have been invited into an eternal relationship with God because Jesus met all the requirements that fulfill God's wrath. The Holy Spirit gives power and guidance in daily life. God never throws sin back in the faces of His children, turns His back, or insists on living in guilt and shame. He will never withdraw His presence and promises, no matter how distorted one's cognitions, how skewed one's beliefs, or sinful one's behavior. The second part of His work is the transformation process when hearts are changed so that in the work done and words spoken individuals can progressively live as He chooses for people to live—for their best and for His glory. Whether there is a conscious awareness or not, people seek hope, grace, redemption, and transformation as the foundational reasons to seek therapy. These reap eternal rewards and should be the most meaningful aspects of the work of a Christian therapist.

Summary

There are many excellent therapists who affect positive change in their clientele, while themselves experiencing post-traumatic growth and vicarious resilience. Theory of change (Prochaska & DiClemente, 1998) may explain these processes of VR and PTG. However, the paramount element of spirituality, as it relates to the Holy Spirit, is absent from this theory. Therefore, the author is exploring a new construct to understand the additional element of spirituality that can elicit VH for trauma therapists, who aspire to the Christian faith. In the context of VH, this type of growth includes consistently opening oneself up to the power and daily guidance of the Holy Spirit, allowing God to assist in meaning-making, corrections of perceptions, or assumptions and finding full identity in Christ. The Holy Spirit is a crucial requisite when Christian therapists engage in their work. The Holy Spirit is referred to as the Counselor, Comforter, Helper, or Advocate (John 14:16–17). The scope of VH reaches beyond therapeutic behaviors or the appropriate type of self-care for the therapist. The current literature acknowledges the need for holistically addressing each client. However, it does not address the vicarious nature of that healing, spirituality based on the Holy Spirit, or the eventual positive effect that trauma may have on both the client and the therapist in a shared experience. Stages of change have been used as a counseling modality for understanding a patient's willingness to change their behavior (Asay & Lambert, 1999). However, to the author's knowledge, this modality has not been utilized to assess the therapist's willingness to grow with their client. Additionally, there is an opportunity to better understand this growth for Christian therapists, thus creating the need to address spirituality and add this component to allow for an exploration into how the Holy Spirit can heal therapists during their sessions with traumatized clients.

In a recorded interview with Dr. Siang-Yang Tan (Strawn, n.d.), he discussed the work of the Holy Spirit in five areas relative to clinical practice. First, the Spirit can empower the Christian clinician to detect the root of the client's issue through wisdom and the spiritual gift of knowledge, based on 1 Corinthians 12:8. Second, the Holy Spirit can impart spiritual direction by praying with the client or engaging in the reading of Scripture. Next, the Holy Spirit can touch a client and provide powerful experiences of grace and healing throughout the course of the therapy session, which may be gradual or happen through "quantum change" when epiphanies cause immediate transformation. This may occur when the clinician utilizes inner healing prayer with clients when appropriate and there is informed consent. Fourth, the Holy Spirit can help the Christian therapist to discern demonic presence through discerning the spirits (1 Corinthians 12:10), delineating diagnoses between mental illness and demonic oppression/possession. Once decided, the clinician can determine whether to refer to a ministry or prayer team for deliverance prayer. Finally, the Holy Spirit can author deep spiritual transformation of both people present in the therapeutic alliance, desiring a greater Christlikeness as they partake in spiritual disciplines with God's guidance and empowerment, which leads to growth and healing for both participants.

CHAPTER THREE: METHODS

Overview

The present study was conducted to address the gap in the literature regarding growth for counselors during their sessions with clients as well as explore the additional spiritual component that may serve as a reversal of traumatization for Christian counselors during sessions with their clients. This grounded theory study was conducted using an in-depth analysis of 12–15 interviews with counselors of various faith backgrounds. Qualitative data analysis software was used to aid in establishing emerging themes to form a broader theory that explained the qualitatively different experiences of Christian counselors from their secular counterparts.

Design

The present study utilized grounded theory (Charmaz, 1996; Heath & Cowley, 2004). This methodology was selected because it permits an exploration of the spiritual experience of vicarious healing, which has not been addressed in the literature. The inability of change theory to address spirituality is a major limitation in understanding the experiences of Christian counselors, and a new theory is needed to explain how their relationship with Christ shapes their experiences as counselors who experience vicarious trauma. Grounded theory allows for the formation of this theory through the words of the participants, ensuring that this inductive process ends in a theory stemming from their experiences, rather than the "expertise" of the researcher. A constructivist design posits that the truth is co-created with participants, and that truth is their lived experiences reflected through their words. The purpose of the study was to understand the unique experience of Christian counselors who experience vicarious trauma and explore how their experiences may be qualitatively different from secular counselors.

Research Questions

RQ1: How do the therapeutic experiences of Christian trauma-based counselors differ from secular trauma-based counselors?

RQ2: How does spirituality impact how trauma-based counselors cope with vicarious trauma?

RQ3: How can Christian trauma-based counselors use their connection to Christ to prevent the onset of VT?

Hypotheses

The alternate hypotheses for this study are:

Ha1: Christian trauma-based counselors will have qualitatively different therapeutic experiences than secular trauma-based counselors.

Ha2: Christian trauma-based counselors will be spiritually transformed during the therapeutic process through engagement with the Holy Spirit, while secular trauma-based counselors will experience either burnout or growth from the experience.

Ha3: If Christian therapists are open and willing to allow the Holy Spirit to work through them while they are in a bi-personal field with their trauma survivor clients then they can not only prevent the onset of VT but also receive healing along with their client due to intersubjectivity.

Participants and Setting

Participants were (a) licensed mental health professionals who were (b) over the age of 18, (c) provided care for trauma survivors, and (d) served the adult population.

Instrumentation

The author has created a semi-structured interview protocol with six main questions that allow for prompts and participant-led discussion [see Appendix A].

Procedures

The author drafted an IRB protocol and gained approval from Liberty's Institutional Review Board to proceed with the current study. Once approval was gained, the author communicated with her network of colleagues to gain participants. Informed consent was obtained and then interviews were scheduled and conducted. The author attempted to use snowball sampling by asking each participant to recruit 3 of their own colleagues until a minimum of 30 audio recorded interviews were completed and saturation had been reached. However, most of the individuals who were interviewed did not provide potential participants' contact information, or once contacted, the potential interviewees were not willing to participate due to scheduling issues. Participants were recruited through other means including posting the recruitment flier on the American Association of Christian Counselors website and a counseling website group in Georgia. The participants were interviewed using Zoom video conference software.

Participants digitally completed the informed consent and the consent forms were saved in a separate file on the external hard drive. Each participant was assigned a pseudonym and I ensured that no real names were used during the interview. Zoom interviews were audio recorded on an external audio recorder, and directly after the interview, I transferred the audio recording from the recorder onto a locked encrypted external hard drive and deleted the interview from the audio recorder. The next step was to upload the anonymous audio file to a transcription service to be transcribed. When the transcriptions were received, I saved them separately (in a different folder) then the audio recordings. I then saved the informed consent forms separately (in a different folder) from both the audio and transcribed interviews. The information connecting pseudonyms to participants was saved in a separate file as well. After transcripts have been cleaned and checked for accuracy, audio recordings were destroyed. The next step was uploading

transcripts into data analysis software, to code for themes. Only I have access to the connected data. My Board Chair, Dr. Kelley Orr, has access to the anonymous transcripts and audio. De-identified data (or clean data) will be reported on in the dissertation report and future publications.

Data were coded using Atlas.ti qualitative data analysis software concurrently with data collection. The author immersed herself in the data through reading and re-reading transcribed interviews and initially coded for data associated with spirituality, vicarious trauma, healing, growth, and burnout. Data that emerged as meaningful to the author was coded as well to build themes from the collected data. Results from this data analysis will be written and presented to the dissertation chair and committee. Data will be stored on an encrypted drive for 3 years. No physical copies of data were created; all digital information was stored via an encrypted drive. After 3 years, I will destroy the data by clearing the encrypted hard drive.

Researcher's Role

As a human instrument, I recognized my bias as a Christian. I utilized neutral questions to combat that bias, excluding leading questions, emotions, or judgment. While there was an assumption on my part that God, Jesus, and the Holy Spirit are real, I did not sway the participants as they answered, but maintained the integrity of their responses so the data collected came directly from them without impact from my influence. I held the assumption that Christians can be healed in a way that secular individuals cannot. Further, knowing my participants had an influence on the interviews. For example, it may have increased the depth of knowledge gained or determined how comfortable the individual was with speaking to me. Participants who were aware of my faith may have felt a level of expectation to answer questions influenced by that perspective.

I am the founder and Executive Director of an anti-trafficking non-profit organization and am a respected member of the community. I chose the people in my current network because I respect the work that they do. I am a part of this community even though I am not a clinical therapist. I have both insider and outsider positionality. Because I am a Christian, I believe that spirituality and vicarious healing are inherent to understanding the experience of vicarious trauma.

Data Collection

Data collection consisted of semi-structured interviews with 26 mental health professionals. University institutional review board approval was obtained to protect the rights of participants. Participants began with 3 of the author's colleagues and then snowball sampling was attempted to gain more participants from their professional circles but was unsuccessful. Participants were recruited by posting the recruitment flier on the American Association of Christian Counselors website and a counseling website group in Georgia. The author obtained written informed consent from all participants prior to conducting interviews. During interviews, the participants answered demographic information along with the questions listed in Appendix A with room to discuss other relevant information as it unfolds. The interview protocol was drafted based on a review of the literature and professional experiences of the author. Interviews were conducted online via zoom with the participant. Participants received gift cards worth $50. Interviews were audio recorded and transcribed verbatim using pseudonyms to protect the identities of the participants. The transcripts were thoroughly read and analyzed to form inductive codes which were then combined into larger themes to ultimately form a new theoretical framework for understanding the experiences of coping strategies that Christian therapists use to combat vicarious trauma.

Data Analysis

Data were transcribed verbatim. Transcripts were read numerous times to become immersed in the data. After re-reading the transcripts, the author began to code. Data were coded inductively using qualitative analysis software, Atlas.ti. Although the author was using an inductive coding framework, the first interview was assessed for codes related to vicarious trauma, coping, and spirituality. After that, interviews were coded for themes that emerged for the author. After all interviews were coded, the author returned to the data to ensure that no codes were missed. After a second re-code, the author began to group the codes into emerging themes. Once all themes were grouped, the author then assessed what needed to be re-coded or discarded. Themes were then grouped together into broader themes to ultimately form a larger theory.

Trustworthiness

Credibility

Credibility is confidence in the "truth" of the results (Amankwaa, 2016) and is dependent on the richness of the data and analysis and can be strengthened by triangulation (Patton, 2002), instead of depending on sample size alone, seeking to represent a particular population (Stumpfegger, 2017). Denzin (1970) introduced four types of triangulation, which may be used in conjunction with each other. The first is data triangulation**,** which includes utilizing multiple sources of data (including from existing research). Qualitative researchers often utilize this method to assure that a report is comprehensive, robust, and fully developed (Lincoln & Guba, 1985). The second type is methodological triangulation, or using a mixed methods approach (with a focus on qualitative methods). The third type of triangulation is investor triangulation, including multiple researchers, which increases the credibility of the research in order to reduce the researcher's influence. Engaging multiple analysts to review findings or observe the process,

will provide a check on selective perception and explicate blind spots in interpretation and analysis. The objective is to interpret the data in multiple ways. This research project utilized investor triangulation due to the addition of an assistant who helped analyze the data and evaluate codes and themes, as well as a clinical psychologist serving as Dissertation Chair. Lastly, theoretical triangulation involves using more than one theory as a conceptual framework for the study. The credibility of this research project was increased using theoretical triangulation, utilizing the theories of bi-personal field, intersubjectivity, and sacred space to form the conceptual framework for vicarious healing.

Dependability

Dependability occurs when findings are shown to be consistent and can be repeated (Amankwaa, 2016). Criteria consist of overall understandability, argument flow, and logic. Both the product and the process of the research must be consistent (Lincoln & Guba, 1985). Dependability occurs when the same results can be achieved in future studies (Amankwaa, 2016). The concept of VH should yield similar results in the future in the same manner that VT, STS, and CF have produced similar results over the past several years of research. The flow of the argument for VH, based on the theoretical framework discussed previously, gives way to general understandability and logic when one considers that VT, as the priming factor of VH, can lead to healing Christian therapists who are therapeutically aligned with their clients, utilizing the power of the Holy Spirit in therapy sessions. The basis of dependability in results can, in part, be attributed to the assumption that the Holy Spirit is dependable every time He is invited to participate in sessions, even if the dynamics are individualized to the pair in the therapeutic alliance.

Confirmability

Confirmability is the extent of neutrality or the degree to which the results of the research are influenced by the participants and not the researcher's motivation, interest, or bias (Amankwaa, 2016). The interpretations of a study conducted by a quantitative researcher require neutrality, which can be accomplished through a confirmability audit which consists of an audit trail (Lincoln & Guba, 1985). An audit trail is a candid description by the researcher to describe steps taken from the onset of the research process to the development of results and reporting of findings (Lincoln & Guba, 1985).

> These are records that include the following categories for reporting information: 1) Raw data - including all raw data, written field notes, measures or documents; 2) data reduction and analysis products - including summaries with qualitative summaries and theoretical notes; 3) data reconstruction and synthesis products - including structure of categories (themes, definitions, and relationships), findings, conclusions and a final report including connections to existing research and an integration of concepts, relationships, and interpretations; 4) process notes - including methodological notes (procedures, designs, strategies, rationales), trustworthiness notes (relating to credibility, dependability and confirmability) and audit trail notes, 5) materials relating to intentions and dispositions - including inquiry proposal, personal notes (reflexive notes and motivations) and expectations (predictions and intentions); 6) instrument development information - including pilot forms and preliminary schedules (Amankwaa, 2016, p. 11).

Additionally, memoing, and tabling will be utilized to record the logic processes that occurred during the collection and analysis of data.

Transferability

Transferability indicates that the findings have applicability in other contexts (Amankwaa, 2016). For this study, the other contexts may include first responders such as law enforcement, medical personnel, and child welfare workers, who have experienced VT. One approach that can be utilized to encourage transferability is thick description (Lincoln & Guba, 1985). Thick description is a method by which to obtain a type of external validity. By describing an experience with a satisfactory description, one can initiate evaluation regarding the degree to which the results are transferable to other situations, times, settings, and people (Amankwaa, 2016). The researcher should include specifics, such as the atmosphere, climate, location setting, participants present, attitudes of the participants involved, bonds established between participants, reactions observed that may not be captured on audio recording, and feelings of the researcher. One-word descriptions are not sufficient in thick description development. The researcher, essentially, is expressing a narrative with sufficient detail that the reader attains a meaningful description of the research events. This can be cultivated through maintaining records and journaling, whether handwritten or electronic for review by the reader (Amankwaa, 2016). In other words, thick description explores the greater meaning behind the participants' words, noting body language, voice inflections, and emotional responses to determine the deeper message being conveyed.

Ethical Considerations

In alignment with the American Counseling Association (ACA; 2014), this research project will enrich the existing profession's knowledge base and endorse a broader understanding of the elements that contribute to a healthier community. The author strived to minimize bias through reflexivity and respect diversity through designing the study and implementing the research protocols (ACA, 2014; American Association of Christian Counselors [AACC], 2014).

The author was compliant with state, federal, and institutional regulations relative to confidentiality and took all necessary steps to respect the participant's privacy (ACA, 2014; AACC, 2014). The author was aware of the responsibility in managing participants' bio-psycho-social-spiritual well-being throughout the research process and implemented prudent precautions to mitigate physical, emotional, or social harm through working with clinicians rather than survivors to minimize secondary trauma, and provided resources following the interview (ACA, 2014; AACC, 2014). Additionally, individuals had the right to decline requests to participate in research or stop the interview at any point in time without being penalized. Individuals received explanations of each portion of the form in clear language through the informed consent procedure that encouraged necessary dialogue between the researcher and potential participants (ACA, 2014; AACC, 2014; American Psychological Association, 2017). Information obtained during the course of research is confidential and procedures were implemented to ensure confidentiality (ACA, 2014; AACC, 2014). The author did plan, conduct, and report research accurately for both a published dissertation and future journal articles or presentations. The author did not engage in misleading research, fraud, distortion, or misrepresentation of data, or deliberately deliver biased results (ACA, 2014; AACC, 2014; American Psychological Association, 2017). During this project, the author took care to disguise the identity of participants and ensure that their identities are protected. Additionally, the author ensured that the discussion of results did not have identifiable information and will cause no harm to participants (ACA, 2014; AACC, 2014).

Summary

Vicarious trauma can impact any therapist. The current literature allows for a thorough comprehension of the positive change that can occur for secular therapists following vicarious trauma including vicarious resilience and post-traumatic growth. However, Christian therapists

may have qualitatively different experiences, which current theory cannot fully address. This present study utilized a grounded theory to obtain a greater comprehension of this phenomenon that can aid Christian therapists in battling vicarious trauma. Using the theoretical frameworks of intersubjectivity, bi-personal field, and sacred space, a new construct has been introduced, known as vicarious healing. Because VT affects the very essence of a therapist's being, including the soul and spirit of the individual, it is vital to extend self-care beyond the physical capacity to manage the stress and C-PTSD symptoms that result from VT. Clinicians are often instructed and trained to engage in self-care activities that occur outside of the professional therapeutic setting to manage the VT symptoms incurred by engagement with their helping profession. VH occurs within the therapeutic setting, regardless of the client's or therapist's traumatic history, the educational and clinical background of the therapist, or the clinician's level of expertise or experience. As long as the therapist is a Christian who believes that the Holy Spirit will accept the invitation to enter the sacred space and impart wisdom, discernment, and healing to the client through the therapist as a conduit of His power, vicarious healing is imminent. In the Bible, Isaiah prophesied that Jesus would come to "proclaim freedom for the captives and release the prisoners from darkness" (Isaiah 61:1b). Christian therapists can serve as the divinely led and inspired channels through which the healing power flows in a manner that secular therapists cannot. The awareness of the Imago Dei within a Holy Spirit-led Christian is the foundational connection between the Divinity and the humanity of the therapist, which places the therapist on equal footing with a client who is also recognized as an image bearer of God.

CHAPTER FOUR: FINDINGS

Overview

The purpose of this research was to describe mental health clinicians' experience with vicarious trauma in the United States. This study aimed to further develop the conceptualization of vicarious healing in trauma-based, licensed, mental health clinicians to understand if and how they experience vicarious healing in their practice. The objective was to understand the theory more holistically so that trauma-based therapists can utilize this construct to protect them from VT. The author researched vicarious healing as a spiritual construct generally defined as an understanding of how a person's spirituality (sense of God and its relation to the clinician and the world) shapes their experiences as trauma-informed service providers, mitigates the deleterious effects of trauma work, and provides an avenue for them to grow in said spirituality. While there are existing constructs of vicarious resilience and posttraumatic growth, the present study inductively built a new theoretical understanding of vicarious healing.

The contents and organization of this chapter include the data collected according to the following themes: becoming a conduit of healing in a sacred space, Christian and secular therapists, and healing. The next section of this chapter includes a presentation of the participants' answers to the interview questions in the order that they were asked in the interview, followed by a summary of the answers to those research questions.

This sample ($N = 26$) was comprised entirely of Christian clinicians. The demographic information for this sample is as follows: The majority of this sample was female ($n = 21$). Most participants were in their 40s ($M = 46$), ($R = 26–73$). Participants lived in Delaware ($n = 11$), Maryland ($n = 3$), Georgia ($n = 2$), Pennsylvania ($n = 2$), Florida ($n = 1$), Michigan ($n = 1$),

California (*n* = 1), Virginia (*n* = 1), Massachusetts (*n* = 1), Alabama (*n* = 1), and two participants worked in states other than where they worked in along the mid-Atlantic. This sample was primarily Caucasian (*n* = 17), followed by African American (*n* = 8) and Hispanic (*n* = 1). Participants were in clinical practice for an average of 17.5 years. Participants worked in the following types of practice: Community Outpatient (*n* = 1); Nonprofit (*n* = 2); Outpatient private (*n* = 2); Pastoral and clinical combo (*n* = 2); Prison system (*n* = 3); Private practice (*n* = 9); Public mental health (*n* = 3); School & Private (*n* = 3); Victim Advocacy Center (*n* = 1).

Data analysis resulted in 203 codes that were then collapsed into 7 larger codes. These seven codes were: (a) Becoming a Conduit of Healing in a Sacred Space, (b) Christian vs. Secular, (c) Client: Trauma, (d), Clinician: Background, (e) Clinician: Healing, (f) Clinician: Pitfalls of Trauma Work, and (g) Clinician: Preventing Trauma. A thorough exploration of these seven codes led to the development of three larger themes including becoming a conduit of healing in a sacred space, Christian and secular therapists, and healing.

Participants

The requirements for participating in this study included living in the United States, working with adult clients who have experienced trauma, claiming Christianity as a lifestyle, and working as a licensed mental health clinician. There were 26 participants in this research.

Tamara

In her early 50s, Tamara has worked with human trafficking survivors for the last 7 years and in a school setting as a counselor prior to becoming licensed. She is Caucasian and has lived in the mid-Atlantic region as well as the South during that time. Without prompting, Tamara quickly introduced the Holy Spirit into the discussion and the theme of spirituality was woven throughout, with some tears shed as she described the “covering” that God has placed over her in

this work. Prayer, worship, her love for God, and an overall sense of her spirituality were evident throughout the interview.

Marissa

Marissa is a 53-year-old Caucasian and an outpatient mental health clinician, describing her income range as upper-middle class. She has worked in various settings including a pregnancy care center and private practice, at which she is now supervising other clinicians as well as taking on a full-time caseload. She graduated over 24 years ago with her graduate degree and was immediately licensed in the northeast. She currently resides in the mid-Atlantic. She describes the degree of trauma experienced by her clients in a "4-tier" fashion. Most of her clients in the last several years have been at the highest (4th) tier. Her years of experience and self-awareness brought rich material to this study as she shared experiences that gave credibility to the theory of vicarious healing.

Abby

Abby is a 58-year-old Caucasian female living in the mid-Atlantic. Abby continues to see clients via Telehealth due to original Covid precautions. She has been working as a mental health clinician in private practice since 2003. She estimated that about 80% of her clients have a traumatic history. She was able to articulate examples of her personal growth and professional development relative to God and her spirituality, which added another level of depth. Her vulnerability and humility were noted within minutes of starting the interview, as well as her personal interest in the topics discussed and excitement to read the results of this study.

LouAnne

LouAnne is a 62-year-old Caucasian, currently residing in Florida. She holds a specialized licensed counseling degree for trauma victims and survivors of human sex trafficking, having worked with this population for the last 5 years. Additional experience includes working with leaders worldwide who have experienced burnout and vicarious trauma. She has 35 years of experience in the mental health field. Her answers were insightful and thoughtful, seemingly fueled by regular introspection and placing herself before God to seek understanding on multiple issues.

Amanda

Amanda is a 28-year-old Caucasian female residing in the mid-Atlantic. She has been licensed as a mental health professional for the past 7 years. She works with incarcerated adult males in a prison, within the Health Department, located in the mid-Atlantic. She was one of the first participants that reported no experience with vicarious trauma or vicarious healing, generating the question of whether someone must experience vicarious trauma to experience vicarious healing. That theme is one that was explored in the remainder of the interviews. She was unable to give specific examples to most questions asking for such, but instead gave general, more broad answers.

Mahlon

This participant is a 64-year-old Caucasian male, living in Michigan. He sees clients in person as well as via Zoom and has been in practice as a licensed clinician for the past 15 years. In prior years, Mahlon worked as a pastoral counselor for over two decades as an ordained minister. He is bi-vocational. In his clinical practice, the majority of Mahlon's clients are pastors, clergy, and missionaries, many of whom he describes as "quite traumatized." His references to

the works of Charles Figley, Charles Spurgeon, Jim Wilder, John Frame, and Bessel van der Kolk made for a richly personal, professional, and theological discussion.

Nikki

Nikki is a 31-year-old African American female, residing in Maryland. She is employed by an organization that serves homeless adults with addiction. Her work prior involved serving veterans and their families in a mental health setting and, prior to that, she was working in a prison with 60–70 inmates with co-occurring disorders. Although she worked under a supervisor for several years, she has only been licensed for the last 3 years. Her interview was succinct, one of the shortest, and the easiest to code.

Dawn

Dawn is a 28-year-old Caucasian female who currently resides in California. She is a health psychologist at a medical center and had been working with clients with a history of sexual assault, immigration to the U.S., and parental conflict from childhood sexual abuse. Prior to her current work, she worked at a rape crisis center. She articulated the overlap of vicarious trauma, burnout, and compassion fatigue, having experienced each of them at various levels. She spent some time discussing Hope Theory, her dissertation topic, with a focus on goal orientation and self-agency as it relates to vicarious trauma and healing. This is the only participant that reported no personal growth or resilience as a result of working with trauma survivors. She did, however, experience vicarious trauma and vicarious healing.

Maureen

This participant is a 44-year-old Caucasian female living in Maryland. Her private practice allows her to see patients in her home state and via Zoom in Delaware. She has been a licensed clinician for the past 24 years and has been in private practice since 2000.

Approximately 80% of her clients had a traumatic history in the past 12 years. She has served as a clinical director at an agency that received training from Bessel van Der Kolk. The majority of her answers contained the movement of God in her clinical work with examples that confirmed her responses.

Margaret

Margaret is a 55-year-old Caucasian female who lives and works in Virginia. She works with a wide range of clientele, including youth, adults with little or no income, and highly educated adults in the middle-class range. She has been in private practice since 2007 and has also worked under contract with several agencies. One of the most fascinating dynamics she brought up was that much of her vicarious trauma has not come from working one-on-one with clients because she engages with the whole person (moments of laughter in the midst of pain or joy in the struggle) and not just the trauma. The violent or traumatic images on the screen (i.e., television or news) are traumatizing to her due to the one-dimensional nature and lack of personal connection to know that person's resiliency or support system. Her role as a pastor's wife for a season of time and her background as a pastor's child lent to a discussion surrounding expectations that may lead to various pitfalls of trauma work.

Monique

Monique is a 55-year-old African American female who resides and works in Delaware. She has two private practice offices but is currently still seeing clients via Telehealth. The population she serves is adults of various races and ethnicities. Approximately 95% of her clients have a history of trauma. She has worked as a licensed clinician for the past 20 years. She was one of four participants who reported no experience of burnout or personal resilience as a result of the work with trauma survivors.

Becky

Becky is a 28-year-old Caucasian female currently residing in Massachusetts. She is employed at a prison to conduct support check-ins on a regular basis and crisis assessment evaluations for inmates. Becky also sees clients for childhood/attachment issues, marriage, and family and is a certified EMDR practitioner in private practice. She became a licensed clinician and has been working with trauma clients for 6 years, since 2016. Her earliest employment included working at a Department of Children and Families funded residential facility for boys ages eight to 20 with behavioral disorders and a history of sexual offenses. She stepped away from that job due to burnout and a lack of supervisor support. Most noteworthy about this interview is the discussion of the client's spirit as it relates to their own belief, rather than only ascribing to the Triune God of the Protestant/Evangelical faith as a healing agent.

Bradley

Bradley is a 52-year-old Caucasian male that works and resides in Delaware. The population he serves includes clergy and the general community, with most of his clients (99%) classified as adults. He has been working as a licensed clinician for the past 25 years. Only about 20% of his clients have reported histories of trauma in two and a half decades. He preferred nondisclosure related to his annual income. He was one of the few participants that displayed emotion in the form of tears when telling of an account that caused him vicarious trauma and was comfortable with candor and vulnerability.

Dennis

This participant is a 56-year-old African American male that resides in Maryland. He considers his socioeconomic status to be upper-middle class. His private practice is in Maryland, but he also has clients in Virginia, engaging through virtual platforms. He described his

breakdown of clientele as exclusively adult (60% couples, 30% individuals, and 10% families). Of the individuals, approximately 70% are female. During his clinical practice over the last 18 years, he estimated that at least 90% of his clients had a trauma history. Dennis not only answered the questions throughout the interview, but he also expressed a depth of understanding of the concepts and framework around this study, adding a level of excitement for the researcher. His answers provided rich and thought-provoking data, adding new elements that had not yet been described up to that point.

Pip

This participant is a 58-year-old African American female living and working in Delaware. She is in private practice and works as a behavioral health consultant in a school setting. She has been a licensed clinician working with trauma survivors since 2013 (about 9 years) and reports that at least half of her clients present with trauma histories. Many of Pip's answers held deeply personal meaning due to her lived experience with some trauma in her childhood and her faith in God was evident in every answer she provided.

Susan

Susan is a biracial (Caucasian and Hispanic) 30-year-old female. She resides and works in Pennsylvania at a nonprofit private practice. Her clients range from children through age 65. She preferred not to share her annual income range or socioeconomic status. She reported that 99% of her clients have had some sort of trauma in their history. She is 30 years old and has been in practice since 2017 (about 5 years). She is currently enrolled in a clinical psychology program in Pennsylvania with hopes to specialize in neuropsychology. Pip was one of the few that did not experience burnout and reported only one short-lived instance of vicarious trauma.

Roger

Roger is a 68-year-old Caucasian male who lives and works in the mid-Atlantic. He serves families and individuals ages 12 and older. About 90% of his clients are adults and about 40% report traumatic histories. He has been a mental health clinician for 9 years. Before becoming licensed, he was a pastoral counselor and a certified rehabilitation counselor. He had a private practice in individual counseling for about 32 years. He was the only participant that reported no vicarious trauma, burnout, or personal resilience as a result of his work with trauma survivors.

Rhonda

Rhonda is a 59-year-old African American female who resides and works in Delaware. She serves a "very vulnerable population with various mental health diagnoses" and sees adolescents as well as adults. She has been a licensed clinician for the past 35 years and reports that at least 75% of her clients present with a history of trauma. An interesting portion of the discussion was that any burnout she experienced was not a direct result of working with traumatized clients, but rather the systems at large that were not trauma-informed that created frustration.

Tracy

Tracy is a 55-year-old Caucasian female living in Delaware and practicing in Maryland. Tracy spent many years as a school bus driver prior to her work in mental health. She has been a licensed clinician for the past 4 years and reports that about 40% of her clients have suffered trauma. This was a short (45 minutes) interview with succinct answers and she led the discussion to the educational system (specifically graduate school) leaving students ill-equipped and without knowledge of vicarious trauma and burnout.

Emmie

This participant is a 29-year-old Caucasian female residing in Alabama. The demographic population she serves includes children, families, couples, and individuals. Approximately half of her clients have experienced trauma. She reported that it is her difficult experience and work with clients that taught her skills to eventually avoid burnout rather than her graduate education, which she felt left her unprepared. She also discussed cultural Christianity as a lifestyle in the South that brings ease to the discussion of God within sessions and outside the therapeutic milieu.

Lucille

This participant is a 53-year-old Caucasian female who resides and works in Delaware. Her clients are youth and adults. She has been in practice as a licensed clinician for the past 30 years. She expressed a different angle when discussing what she has learned from her clients. Rather than healing only from past trauma because of the work, she shared about current and future decisions being impacted by clients' histories. She has made personal decisions that likely would have been different if it was not for hearing the impact made in the clients' lives.

Kathy

Kathy is a 47-year-old African American female living in the mid-Atlantic. She works in a private practice in the evenings and as a school counselor during the day. The majority of her clients in private practice are adults up to age 55 and about 75% of her clients have suffered trauma. Kathy has been working in this field as a licensed clinician for the past 13 years. She is upper-middle class. She is the only participant that reported no vicarious trauma, personal growth, or personal resilience as a result of working with her clients. Part of her reasoning is that

for the past few years, due to Covid, she did not meet in person and has continued virtual sessions, so the dynamic of transference is different.

Viola

This participant is a 40-year-old Caucasian female who lives in New York and sees clients in Pennsylvania. Currently, she serves adults only, most of whom are women. About 80% report traumatic histories in her current practice over the last 8 years. Four years prior, she worked at a victim advocacy agency, working with youth and adults. At that time, 100% of her clients had traumatic histories. She resigned from that job due to experiencing vicarious trauma and a lack of supportive supervision. She reported that she had experienced childhood trauma, but would not have recognized it as such if it were not for helping her clients see their same experience as traumatic.

Tina

Tina is a 46-year-old African American female living and working in Georgia. She works mostly with adults, although she has served adolescents. She has worked as a mental health clinician for the past 20 years. She reported almost changing careers on two separate occasions as a result of burnout and vicarious trauma. She shared a detailed and vivid description of an instance in her work with a client where she experienced a remarkable vicarious healing event.

Sheila

Sheila is a 62-year-old Caucasian female that lives and works in Maryland. She is currently employed via contract work as a mental health clinician. Previously, she was a coach and co-owned a private practice with another clinician in Pennsylvania. Early in her career, she worked at the County Health Department. She has been working as a clinician for the past 35 years. She estimates that about 85% of her clients have traumatic histories. She likened vicarious

trauma to vicarious learning, stating that “you learn by just being with people and being near them in their vicinity” and referenced countertransference multiple times. She had changed jobs about every 5 years, in part, to avoid burnout and vicarious trauma.

Frank

Frank is a Caucasian male in his early 60s, currently living in New York, after having lived and worked in Delaware and the eastern shore of Maryland for over 25 years. He was not comfortable sharing his annual income. Prior to the 26 years of clinical practice, he was a pastor, offering pastoral counseling for couples and individuals. His specialty was crisis marriage therapy and has counseled several thousand people over the course of his two careers. He experienced multiple accounts of vicarious trauma early on in his practice but noted that each time it happened, the effects and length of time it took to recover lessened.

Results

Theme Development

The researcher had an assistant during this project’s analysis. The interviews were coded individually by the researcher and the assistant resulting in 203 codes that were discussed at length for intercoder reliability. During this coding examination, there was extensive conversation regarding the process to combine or collapse similar codes. This intense conversation resulted in the decision about which codes represented agreed upon analyses. This led to a total of 7 codes: (a) Becoming a conduit of healing in a sacred space, (b) Christian vs. secular, (c) Client: Trauma, (d) Clinician background, (e) Clinician: Healing, (f) Clinician: Pitfalls of trauma work, and (g) Clinician: Preventing trauma.

Once the codes were agreed upon the researcher and assistant then began to group codes into larger themes that described a group of codes. An example of this was combining

"Clinician: Conduit of Healing," "Clinician: Inviting the Holy Ghost," and "Sacred Space" into a larger code of "Becoming a Conduit of Healing in a Sacred Space" Participant 4 shared:

> Lord, you got to give her a picture—because even though you may know God's using me, and I know He gives you those word pictures and you say it, and some people just resonate with them and they click. But others, only God can show them. I pray, "Lord, just show them—give them an image." Then it resonates with the client and now we got a ballgame here and we can work together. The Lord is so good that way. He really is. He wants our healing. He wants us to be made whole in him.

This quote was coded as Clinician: Conduit of Healing. Participant 6 stated, "I think that if we can invite the Holy Spirit in a very practical way…the more we can invite him in, I think the better. So, what we expect him to do when he gets there, is reveal," which was coded under Clinician: Inviting the Holy Spirit. Participant 26 stated:

> What a privilege it is to watch the Holy Spirit move. That's when I realized that is the most powerful source for me. Because if I don't have the Holy Spirit walking into session, if I don't pray before we start a session, if I don't pray when we end the session, I find that I'm more and more unknowingly relying on me, and I am the biggest deficit they would have without Christ.

This quote was coded as Sacred Space. These statements were centered on inviting the Holy Spirit into each session so that Christ could work through the clinician to help heal the client. Thus, these three (and additional) codes were collapsed into a larger code of "Becoming a Conduit of Healing in a Sacred Space."

The second larger code was Christian vs. Secular. Participant 10 commented:

> I know that for trauma survivors, any space that instills their value and their worth, any space that speaks peace, any space that brings light to the darkness, is a sacred space. Even if they are Buddhist or whatever. There's darkness in the world and anything that's bringing light into darkness is a sacred light. For me, the teachings of Christ are beautiful teachings and those are my guiding principles for my life, but nor would I minimize how my colleagues who maybe don't view that in that way. I don't minimize the way that they bring light into their clients into their spaces.

That quote was coded as Religion vs. Spirituality. Another smaller code that was merged into the same larger code was Secular Therapist and Vicarious Healing. Participant 13 stated:

> I think there are many talented clinicians out there who are not of the faith realm, who have incredible skills that are part of being a good therapist. I think they can actually be quite a good conduit for the Spirit to work. The only absence there is giving the glory to the Lord. I think that's what is missing in that situation.

Another example of a smaller code merged into the same larger code is entitled Shared Values of Christianity and Counseling. Participant 5 stated that the tenets of Christianity are actually congruent with therapeutic tenets. She stated, “Specifically, cognitive behavioral therapy is like that Bible verse that says all things that are good and pure, think on these things. That is a tenet of cognitive behavioral therapy.” She stated that the more she learned about therapy, the more she recognized similarities with Christianity. Since CBT is evidence-based, secular therapists often utilize this in sessions to bring truth and healing.

The third major code is Client: Trauma. The first smaller code to be merged into the larger code was Trauma Type. Participant 7 discussed that dynamic within the session relative to vicarious trauma for the therapist:

> If you are someone that has experienced a lot of trauma as a child, I think that would increase or probably make you feel those symptoms a little bit more heavily, because you've already had it. Let's say, you've been assaulted, when you were five and you have a client that has the same thing. I think we would feel those symptoms a little bit more heavily. It'll probably bring some flashbacks, maybe take you back to that time when you were younger, compared to someone that doesn't necessarily have those experiences in their childhood.

The second smaller code to merge into the larger code is Abuse: Human capacity. Participant 7 recalled:

> I suffered childhood sexual abuse. I remember a time I had a client who shared about her being chained up in a basement for hours as a little girl and her dad would come downstairs and rape her repeatedly and leave her there and never feed her. And I think things like that can trigger—for me it was more triggering, real-life experiences for me--the fear and neglect, the hypervigilance of waiting for that to happen again, when they're going to come back, that kind of thing. So, for me, those are very real things to have.

The third smaller code to merge into the larger code is Client: Childhood. Participant 3 stated:

> Childhood has a huge impact on who they are and how they are as an adult. And understanding some of that, I'd like to connect dots, right? I don't find fault or blame, but I do like to say, okay, so this is what happened when you were 8–look at the same thing, that same kind of behavior. Who taught you that way? Let's learn, let's re-parent the inner child. And to know that is such a valuable part of the process also was healing for me, because I have to do that for myself, too. I can't ask a client to do something I wouldn't do for myself.

The fourth major code is Clinician background. An example of a smaller code that merged into this larger code is Clinician: Shared experience with client. Participant 1 commented, “It’s still a relationship, where it's a shared experience of some really hard stuff. And resiliency—is really one of the best resilient factors—is to not be in it alone. So, the client shares that experience with the counselor.” Another smaller code that merged into the larger code is Clinician: Childhood experiences. Participant 8 commented:

> I think of those things that I experienced as a child that are still impacting me today. I don't want those to continue impacting me. Or being able to also look back and recognize what are the things I'm thankful for and being able to hold both the things that were difficult and the things that were good.

The last example of a smaller code to merge into this larger code is Clinician: Connection to childhood. Participant 15 stated that she was raised in a Christian family. “All my brothers and sisters are Christian, my husband has been a pastor for 35 years. Just having a strong Christian foundation has really helped to shape and mold me and the way I think.” The fifth major code is Clinician: Healing. The first smaller code that was merged in is Clinician: Understanding of resilience. Participant 16 shared:

> Many of them feel that there's no meaning to their life and there's no purpose. And so being able to find their faith or any spirituality, builds resilience. It makes them feel like I have a purpose, I have a sense in life, and I have something that I need to follow. And I think just having that sense of your self worth, through spirituality, faith, religion, helps build resilience because they're not lost in the world. The second smaller code that was merged into the larger code is Clinician: Benefits of the work.

Participant 19 discussed a difficult time in her life stating, “Working with clients dealing with grief because of my own personal experience with bereavement, has helped. I was able to take that experience into the therapy relationship and help people kind of get through that.” A third smaller code that was merged into the larger code was Clinician: Peace. Participant 25 shared, “I think the missing ingredient that secular therapists can't fully experience is peace. Things get better, but they don't have that full healing where they can actually give out to help others to the same degree and be totally free because I think that only comes through the Holy Spirit.”

The sixth major code is Clinician: Pitfalls of trauma work. An example of a smaller code merged into this larger code is Clinician: Spiritual downfall. Participant 2 commented:

> I think that what is very difficult for Christian clinicians, is that when you walk with the traumatized and you hear stories, it challenges your view of God, your theology, and the spiritual fallout that can happen to a clinician for walking with traumatized clients. It is part of a Christian therapist’s vicarious traumatic experience. It challenges the way, up until that point, they view God and what He will and will not allow in their life.

Another example of a smaller code merged into the larger code is Clinician: Experiences of VT. Participant 8 noted:

> I remember one time I was having a nightmare. As far as how I experienced the vicarious trauma, I was noticing parallels–what I was talking about with my clients, and then when I was experiencing that in my own life, even though I hadn't necessarily experienced that specific trauma. Also other symptoms, whether they included changes in mood and fatigue, which you can see in the context of trauma, but then it can also overlap with burnout and compassion fatigue.

The final code that was merged into this larger code is Clinician: Emotional demands. Participant 10 shared her thoughts on maintaining emotional health under the weight of the heaviness of clients' traumatic material:

> And I've just learned what only experience in therapy teaches you. And that's just, I don't have to do anything. And sometimes there's absolutely nothing to do and that feels so uncomfortable. But the power of the session is just in the presence of bearing witness to somebody else's suffering. Right? Like, there is no doing. It's just how am I bearing witness today?

The seventh and final major code is Clinician: Preventing trauma. The first smaller code to merge into this major code was Clinician: Combatting VT and burnout. Participant 10 agreed with Participant 5 who stated, "I would absolutely say that younger clinicians need really good supervision for a solid five years. I'm a firm believer that everybody doing this work should have a therapist, maybe not that they go regularly, but that they could go when they need to." Another example of a smaller code that merged into the larger code was Religion: Worship, in which Participant 1 shared:

> Church is where I find the powerful response. That's where I find the strength. That's where I find God leading and taking it for me—the hope of the healing for the client, big time—and my prayer is every morning at home, but also when I'm in corporate worship. That's a very powerful time where the Lord and I come together in a really raw, emotional way. And I lay all that at Him at his feet, and He does amazing things.

The last smaller code to be merged into the larger code was Clinician: Tending to family. Participant 20 commented, "Learning how to take care of myself better so I can take care of

others. With my own family growing, I have to be more intentional with allotting my own personal resources to manage everybody who needs me."

Building codes into larger themes helped to progress analysis from individual thoughts to overarching themes that were presented in the data. Once the combining of themes was complete, the process was discussed at length, interviews were re-read, demographic analytics were re-considered, and the meanings of the themes were re-considered as a whole. Themes were then collapsed into larger groupings that represented the data in total. This grouping led to three major themes. These themes were Becoming a Conduit of Healing in a Sacred Space, Christian and Secular Therapists, and Healing. These final themes were then examined and discussed at length which led to the emerging theory of Vicarious Healing.

The data was transcribed verbatim. Transcripts were read numerous times and the researcher listened to the interviews at least twice to become immersed in the data. After this process, the researcher began to code. Data were coded inductively using qualitative analysis software, Atlas.ti. Although the researcher was utilizing an inductive coding framework, the first interview was assessed for codes related to vicarious trauma, coping, and spirituality. Beyond the first interview, the following interviews were coded for themes that emerged for the researcher. By the end of the last interview (#26), there were a total of 203 codes, including specific ideas or concepts that were discussed in the interviews originating from the participant. After all interviews were coded, the researcher returned to the data to ensure that no codes were missed. The third interview added multiple codes and the remainder of the interviews each added at least a few more. After a second re-code, the researcher grouped the codes into 7 emerging themes. The themes included: (a) Becoming a conduit of healing in a sacred space, (b) Christian vs. secular therapists, (c) Client trauma, (d) Clinician background, (e) Clinician healing, (f) Pitfalls

of trauma work, and (g) Clinician-preventing trauma. The 203 codes were very specific to particular aspects of trauma, vicarious trauma, the life and background of the clinician, spirituality of all kinds, the difference between secular and Christian therapists, various aspects of a Christian life (i.e., prayer, hope, faith, forgiveness, love), healing, burnout, compassion fatigue, posttraumatic growth, therapeutic tools (EMDR, CBT, mindfulness, guided imagery, deep breathing, grounding techniques), clinician training (or lack thereof), therapeutic interventions, fear, mind-body-spirit connections, evil, trust/mistrust, workplace dynamics, worldview, coping strategies (vacations, time off, reading, hobbies, changing jobs), supervision, resilience (for client and clinician), PTSD, complex trauma, levels of difficulty regarding clients and demographic questions. Once all themes were grouped, the researcher assessed what needed to be re-coded or discarded. Themes were then grouped together into 3 broader themes, organized by what could be folded into larger themes, to ultimately form a larger theory. These are discussed in the next sections. The codes that did not fold into or fit into the broader themes included solitude, equine therapy, fear, helplessness, judgment of others, intimacy, anguish, anger, reading for self-care, power differential, and spiritual downfall.

Theme 1: Becoming a Conduit of Healing in a Sacred Space

Andrews (2001) examined what many mental health practitioners already know—the therapeutic alliance influences outcomes and has strong effects on clients. Participant 5 reported that, as Christians, therapists should be in the work to minister to people through the power of the Holy Spirit. “I think that's really kind of the reason for me why I do my job. I don't really do it as well as I probably should. But that is kind of why I am even in this field.” The therapeutic alliance has been researched for decades in multiple studies finding that the quality of a client’s perception stands out as the most important determinant factor of outcome (Martin et al., 2000;

Orlinsky et al., 1994; Roth & Fonagy, 1996). This study researched a dynamic that has not been studied relative to the therapeutic alliance: The power of God Himself, through the Holy Spirit, to create sacred space in the therapeutic milieu. This researcher examined how a Christian therapist might create the safest, most healing therapeutic space. Participant 8 reported a shift in her thinking from "I want to be able to help people" to recognizing that she needs to be open to being impacted in the process, "and God is the one that's going to be doing that because it's not just me helping someone in need. I'm growing alongside someone. And that's such a different shift in how to think about what happens in the therapeutic space." Participant 15 conveyed "that counseling space becomes sacred. And relying on Jesus—you know that you have some power, there's power that's higher than you that can help you." Christians who truly rely on the teachings of the Bible hold a deep-rooted belief that everything contained within that historical document is real and true. Christian therapists can bring that truth into the clinical mental health setting by ascribing to the scripture found in John 17:17-26 (ESV):

> Sanctify them in the truth; your word is truth. As you sent me into the world, so I have sent them into the world. And for their sake I consecrate myself, that they also may be sanctified in truth. I do not ask for these only, but also for those who will believe in me through their word, that they may all be one, just as you, Father, are in me, and I in you, that they also may be in us, so that the world may believe that you have sent me. The glory that you have given me I have given to them, that they may be one even as we are one. I in them and you in me, that they may become perfectly one, so that the world may know that you sent me and loved them even as you loved me. Father, I desire that they also, whom you have given me, may be with me where I am, to see my glory that you have given me because you loved me before the foundation of the world. O righteous

> Father, even though the world does not know you, I know you, and these know that you have sent me. I made known to them your name, and I will continue to make it known, that the love with which you have loved me may be in them, and I in them.

In essence, this scripture declares the possibility of bringing the presence of a loving God into sessions. Participant 14 commented, "I believe that the Holy Spirit who desires good, loves the client, and wants good things in the client's life can work in spite of me. I believe that the Holy Spirit is present in all sessions." Participant 3 shared what 100% of the participants expressed, that prayer is included in the session only when the client has asked or has communicated acceptance of such in the session. Further, she stated:

> I don't work in an environment where that would be permitted to act overtly and invite the Holy Spirit out loud into sessions. As Christians, though, I think we should invite the Holy Spirit with us into every interaction, even if the other person doesn't know He's there. We can know He is there. I pray during this session, to myself—to the spirit. I'll do that because not everyone wants prayer in the session. So, I'm constantly praying, but I really try to empty myself…there's no judgment, there's none of that. I'm just trying to take in and let what comes out be what the Lord will want for them.

Participant 24 shared that she provides a disclaimer to her clients that there will never be any two sessions that may be alike. God knows what each person needs (Luke 12:24). She stated that each session will be according to the leading of the Holy Spirit:

> I may not necessarily always say to the client according to where they are spiritually, but I'm still allowing the Holy Spirit to guide the situation. You have to allow the Holy Spirit to help you and teach you and guide you in how to deal with that person because you can do more harm than good, thinking that you're going to work with two different people

> with the same situation. You may hurt one...help one, but hurt the other, trying to use the same therapeutic concepts at that time.

Participant 20 made a statement that serves as the overarching theme of all participants in this study: “When I'm invited to do so by my client, I love to bring the Holy Spirit in, in a visible way, to vocalize, to talk about it, to process it to help my client, using that as much as they allow me to do.” There are times when a client does not share the Christian faith or is uncomfortable with prayer or discussion of God, as highlighted by Participant 25:

> You know, it's just sometimes I've found with trauma, that they're coming in a place where, you know, ‘God isn't answering my prayers. I can't pray. I'm just mad’ and they just can’t—and you need to meet them where they are and be Jesus to them.

Part of becoming a conduit of healing in a sacred space is being respectful of the client’s comfort level, spirituality (especially when it differs from the clinician’s), and emotional state during a session. Creating sacred space in therapy does not require open prayer, proselyting, or discussion of God, but rather a prepared clinician who has placed themself before God in order to bear the fruits of God’s Spirit to the client. The fruit of the Spirit “is love, joy, peace, kindness, goodness, faithfulness, gentleness, self-control” (Gal. 5:22-23, NIV). The therapeutic relationship, when filled with those characteristics from the therapist, will be one of sacred space, regardless of the client’s state of mind or personal spiritual beliefs.

Clinician as a Divine Vessel

God, as a Triune being, is three distinct persons sharing one essence: Father, Son (Jesus), and the Holy Spirit (1 John 1:3; Matthew 16:16; John 14:26). The results of this study indicated that every one of the 26 participants invited God, Jesus, or the Holy Spirit into therapeutic sessions on a regular basis. Participant 1 utilized guided imagery in the session and stated:

> I help them go to their safe place and their safe place includes Jesus. And they do have encounters in which Jesus specifically speaks to them. And they keep a running list of the things that He has said to them. So once that's even established, that's a powerful tool. So, we go back to the power of Jesus Himself telling you, "I see you and you're going to be okay." That is powerful, immensely powerful. We can do a guided imagery and her body completely calms down. I say "Let's pull out that sheet and let's revisit everything Jesus has told you." When you go into your safe place within, it is powerful. It's transcending the pain. It sets the emotions in a different place.

Participant 6 expressed his thoughts on that type of imagery:

> The whole idea of taking Jesus back with you into your past–I really am drawn to that—captivated by that…I sure like the idea of taking Jesus back into the past and in finding comfort and finding healing and restoration in those very specific traumas from the past. I think that's really a work that has to be done somehow. I think where I'm reluctant, as I've seen it misused to become in the inception kind of thing that scares me to death when a clinician has that kind of access into somebody's deepest, darkest soul. Especially if they've got their own unresolved stuff.

Most of the participants agreed that humility and self-assessment are required in order to allow the Holy Spirit to work through them as a conduit, ridding themselves of "their own unresolved stuff" (Participant 6). If clinicians view themselves as divine vessels that God can utilize, the first step is to prepare ahead of time. Participant 10 stated:

> I don't know if it's such an invitation on the spot in session, or if it's me inviting the Holy Spirit into me before I start my day. That's assuming the Holy Spirit is a third entity in a room. And I know the energy from which I operate, and I know that the hope that I hold,

> and I know that in my depths, it's the Spirit. My clients are going to feel the power and the peace and the love of the Holy Spirit through my presence. So, if I'm all dysregulated, and I haven't slept, and I haven't been taking care of myself, and I'm not doing my own work, and then I haphazardly go into my office and say, "Holy Spirit, calm." Well, that's irresponsible.

The researcher agreed that the onus is on clinicians to be responsible for seeking their own healing and mental well-being before addressing clients. If a clinician fails to do so, then the conduit through which God can work is hindered, as stated by Participant 13:

> My whole belief system, at least in terms of my work, is I'm just an instrument. It's the Holy Spirit that really resonates and gets the job done, so to speak, and my job is to be available. My job is to make sure that I'm healthy, that I'm present and that's my responsibility, and how God uses that in the session is up to God. So, I'm prepared, I'm educated, and I'll do my part to be ready for that client.

Participant 4 addressed that specifically:

> For me as a Christian therapist, it starts in the preparation of the meeting before I meet with somebody. It's my prayer time, my work with the Lord before I start. Thinking personally about what I need to bring before God to lay before him.

One of the ways that Christian clinicians can prepare themselves is to live by the standards of conduct and principles in the Bible. When clinicians are not obedient, they can hinder the work of the Holy Spirit in their lives, which may bleed over into their professional lives. Participant 1 gave an example of such:

> I believe we can resist, as Christians who are conduits of the Holy Spirit, just like we can have pastors who are preaching and conduits of the Holy Spirit, who are resisting things

> that are happening that God wants to do in their mind. And they struggle. I've counseled pastors and they can struggle with that. I don't think that's any different than a therapist in the same situation. I guess there are specific things like unforgiveness, bitterness, resentment, resistance, you know, because you feel that, if you've experienced trauma and you're angry, oftentimes you can feel that is justified. Even if God says, "Forgive," you feel it's justified to be angry. The Holy Spirit might be ministering to you to forgive, forgive, you need to forgive, and you're saying to other people, "You need to forgive.... the pathway to healing is forgiveness. You need to forgive, let's pray and forgive." You as a therapist need to forgive, but you're not forgiving. That's going to be a problem.

Participant 25 shared her thought process regarding ownership of her spiritual condition,

> My conduit has to be clean and unobstructed and that brings me to confession. I needed to come before God and just say, you know, I confess, I'm so sorry. It's not about me, it's about you. And I need to get recalibrated. And the Holy Spirit recalibrates me.

Participant 11 recalled a specific account when she had to remember that God is the one doing the work, not her. She admitted there were times "when I get ahead of myself on that, and as I've worked in this field long enough to know, I've been a Christian long enough to know, that God will humble me if I don't pay attention to that." Once a clinician has gone before the Lord, confesses, and turns back to God in humility, the Spirit is free to flow in and through them "according to His own mercy, by the washing of regeneration and renewal of the Holy Spirit" (Titus 3:5, ESV). At this point, the clinician is positioned as a conduit for the Holy Spirit to work and bring wisdom and truth. Participant 11 reported that she starts her day off with prayer to "just let Him use me as a tool and serve the purpose to give God glory. And I try to bring that into my sessions, as well."

Another consideration for a Christian clinician is understanding the mind-body-soul connection of trauma work. Brady et al. (1999) highlighted that working with trauma survivors influences the clinician most deeply in the spiritual realm and that perhaps more than any other domain, it is one's spirituality that is deeply affected by engaging in trauma work. The spiritual faith of clinicians is often contested when faced with their clients' traumatic histories and human cruelty. Holding therapeutic space with trauma survivors forces professionals to question their own sense of meaning and hope. Pearlman and Saakvitne (1995b) asserted,

> We have come to believe over time that the most malignant aspect of vicarious traumatization is the loss of a sense of meaning for one's life, a loss of hope and idealism, a loss of connection with others, and a devaluing of awareness of one's experience. . . best described as spirituality. (p. 160)

Hence, spirituality and VT are directly associated. Injury to a clinician's spiritual life is a probable outcome of VT and is reasoned by many to be the most alarming threat to trauma therapists' well-being. Participant 18 recognized the spiritual component of illness and her responsibility for her own soul-care:

> Whether it be physical illness or mental illness, there is a certain spiritual component to illness. I need to protect myself from being under any attack from the enemy. So it doesn't matter what illness I work with, whether it be physical, mental, emotional, that's what I do.

Divine Impartation of Wisdom to Clinician as a Conduit

Each of the 26 participants viewed themselves as conduits for the work and move of the Holy Spirit, invited through prayer into the therapeutic environment. Participant 13 stated:

> I want this to be the Lord's area, not mine. Who am I? I am just the tool. I tell them counseling is not magic. It's just when a trained professional and someone in need come together to see what the Lord does. That's really the kind of formula it is.

As Christians, there is an inherent belief that partnership with God and human beings brings about His kingdom on earth, including healing and wholeness for those who are suffering and wounded according to 2 Corinthians 1:3—"Praise be to the Father of compassion and the God of all comfort, who comforts us in all our troubles, so that we can comfort those in any trouble with the comfort we ourselves receive from God." Participant 2 shared her thought process that God has the answers. She invited the Holy Spirit into the therapeutic process every session. By doing so, she acknowledged:

> That He is the answer. And that I can relax and trust the Holy Spirit to work through me and not lean into my own human resources. It's an acknowledgement for me as the clinician, that He's the one that's doing this work. I'm just part of the process--a very small part of the process.

Participant 17 echoed that sentiment, stating that she sees herself as "an instrument that God uses to help people. My gift is in healing, teaching, and serving, and so I'm his instrument to use however He sees fit." Participant 23 simply stated, "I'm just a tool. I'm not the repairman." Participant 21 prayed on a regular basis to invite the presence of God into her clinical work. She recognized that God "could just come in and heal the whole situation" without her "doing anything, but a lot of times, it's a process." Here is her prayer: "I'm your vessel to use. Use me the way you want to use me in this situation. I'm the conduit for you. I'm just the therapist trying to work with this person. How can you guide me to be able to do that?" In another example, Participant 23 shared a typical prayer:

> Lord, you have placed me with this client for this time. I pray that you use me in whatever growth you want to happen in this client, knowing that it is not my responsibility. This is a blessing for me to be a part of the work that you're doing in their lives. I pray that you help me guide them towards healing, towards hope, towards peace.

Holy Spirit as a Therapeutic Tool

In the life of a Christian, the Holy Spirit has an important role, one that can assist therapists to gain greater insight and discernment to help their clients, that is to bestow onto believers wisdom by which one can understand God, life, and oneself. “The Spirit searches everything, even the depths of God. For who knows a person’s thoughts except the spirit of that person, which is in him? So also no one comprehends the thoughts of God except the Spirit of God” (1 Cor. 2:10- 11). Because humanity has been given the incredible gift of the Holy Spirit, “We hold the ability to comprehend the thoughts of God, as revealed in the Scripture, with the help of the Holy Spirit. This wisdom is from God, rather than wisdom from man, and as such is perfect” (1 Cor. 2:12-13, NIV). No amount of human knowledge, clinical training, or years of experience can ever replace the Holy Spirit’s all-knowing wisdom. Every participant that gave the Holy Spirit an invitation into that space, reported His work and movement in therapy sessions. Participant 22 shared her experience:

> I can say that there's a shift in the room. I can definitely say there's a shift in the room. I can tell that. It just happens. I'm not saying I get any warm tingles or anything. But I can tell when it comes out. It feels different. I can't tell you what the feeling is. But you can tell in the atmosphere. There is a crazy shift in the room and there is immediate, like understanding...that you don’t have to say anything else…so it's like a peace.

Proverbs 2:6 states, “For the Lord gives wisdom; From His mouth come knowledge and understanding.” Ephesians 1:17 confirms that “the God of our Lord Jesus Christ, the Father of glory, may give to you a spirit of wisdom and of revelation in the knowledge of Him.” Participant 20 explained, “There have been plenty of times where I've been very much like ‘Jesus take the wheel’ in sessions when it comes to many things, but especially trauma. And, and as a believer, I believe that God has answered me in those moments.” Participant 19 shared, “Sometimes while my client is talking or really struggling, I am quietly praying for healing for them and guidance for me. But certainly before each session, even if it's a quick "help me." Participant 4 gave a detailed description:

> I believe that when you as a therapist bring the Holy Spirit into your sessions, He's there with you, right? He's there with you. The spirit will bring to your memory those things that you know about Him, and He'll give you supernatural power and words of wisdom and understanding about a person that they've never even said about themselves. He gives you the supernatural way to love them. It's incredible.

While God’s presence is powerful and capable of instant healing (Ex. 15:26; Matt. 8:7; Jer. 17:14), most participants agreed that the therapeutic healing process is one that takes time, patience, and often painful navigation to achieve. God can use His children (Christian therapists) to bring wholeness and restoration to those who have suffered brokenness and trauma (John 14:12-14). Participant 12 described this process:

> I think God can give people courage. I definitely don't think that prayer alone and leaning into spirituality alone will just heal trauma on its own. In the same way that I think if someone you know is really sick and needs medication, you’ll pray for healing, but if that's the only thing you did, that’s irresponsible. Are there cases of miracles happening?

> Sure. But generally, that alone isn't going to do it. And I'm a big believer that God gave us brains and the ability to be able to come up with these strategies to help heal the trauma and to create the medicine that helps heal."

Another benefit of utilizing the power of the Holy Spirit in sessions is that God can impart words of knowledge and comfort that will speak meaningfully to the client that had been previously unknown to the clinician. Participant 9 shared:

> So my invitation to the Holy Spirit is my constant walking with Christ who is within me so when people are in front of me I just start praying "Not my will, but yours," and "What do you want me to say to them, Lord?", and "Help me help them," or whatever it might be. I don't talk about it until the opportunity comes for us to start speaking about Jesus. I'm literally saying, "Holy Spirit, I'm depending on you" and that's how it's working. It's not on my strength.

Participant 12 described her prayers as a result of a loss for words at times in session:

> Countless times, I'm asking God to bring the right words and just use my mouth because, you know, a lot of these kinds of trauma-based issues…like who are we to have the words, you know? The right words to say to a particular client that I can have really difficult sessions with and then I find myself at a loss for words. And that's when I really try to lean into Him.

James 1:5 states, "If any of you lacks wisdom, you should ask God, who gives generously to all without finding fault, and it will be given to you." Participant 6 confirmed, "That's when God really gets involved and can do great mighty things, when we're at the end of our own resources." Participant 15 confirmed the power of the Holy Spirit to give her insight:

> But when God is in it, and He tells you what to do, you know, it's always going to be the right thing. It is always going to be the right thing. The client is always going to be benefitted as well as myself. And I've seen this happen in sessions. And thank you God, because I would have not thought to ask that question…so yes, I've invited it. And I've seen it.

Along the same vein, Participant 16 discussed the importance of utilizing the Holy Spirit to create sacred space:

> I think that sometimes we think that we're all using these toolboxes that we're taught in school for therapeutic purposes. But I also think that being able to invite, you know, the Holy Spirit to help us as well, to guide us, when we feel like we're at loss, is good. We have all these toolboxes. But this client, right now, does not need this therapeutic thing that we just check off on the list. And so then those are those moments where it's just giving it to the Holy Spirit to help guide you. So I think it's important, as a Christian counselor, being able to invite that in with you to your clients in your sessions because sometimes you just kind of need that guidance.

All participants agreed that therapists must gain the education, tools, techniques, and attend trainings regularly to gain expertise in the mental health field and to not do so would be irresponsible. Clinicians have many therapeutic techniques that are effective and helpful in the healing process. They should regularly engage in what has been empirically tested and proven to decrease anxiety, depression, and PTSD symptoms as well as increase hope, coping skills, and overall mental well-being. There are times, though, that therapists have utilized every bit of training and technique they know and still feel at a loss. Rather than being a last resort, an

invitation to the Holy Spirit to invade therapeutic space and create sacred space can bless the clinician as well as the client. Participant 7 described such a blessing:

> That's when God really gets involved and can do great and mighty things, when we're at the end of our own resources. I was doing all these interventions, nothing was working. I started praying for the client, and wow, these things were changing! There's a lot of meds and therapy, etc. But for me, I feel like you can't do anything without God. So yes, I'm a therapist, but I'm also a Christian. I believe therapy works. But I feel like there are certain battles that you can't do without God, like, how can you do it? It's not possible.

Participant 8 provided the summary for this section of the chapter:

> I have definitely utilized prayer for my clients. And if things that they're struggling with seem to be at the limit of what I'm able to help them with, it's being able to put that essentially in God's hands. I say, "God, you know, better than I, where they're at, so help me to facilitate what they need." And how I think about my clinical work in the context of my theological beliefs, has also been very impactful."

God as Sovereign

Christians assert there is nothing that happens in the world that is outside the influence and authority of God Himself. As sovereign creator, God has no limitations. Consider just a few of the claims the Bible makes about God: (a) "God is above all things and before all things. He is the alpha and the omega, the beginning and the end. He is immortal, and He is present everywhere so that everyone can know Him" (Rev. 21:6); (b) God created all things and holds all things together, both in heaven and on earth, both visible and invisible (Col. 1:6); (c) God knows all things past, present, and future. There is no limit to His knowledge, for God knows everything completely before it even happens (Rom. 11:33); (d) God can do all things and accomplish all

things. Nothing is too difficult for Him. He orchestrates and determines everything that is going to happen in the life of every person, in America, and throughout the world. Nothing is impossible with Him (Jer. 32:17); (e) God is in charge of all things and rules over all things. He has power and authority over nature, earthly kings, history, angels, and demons. Even Satan himself must ask God's permission before he can act (Ps. 103:19). God is sovereign and holds the ultimate source of all power, authority, and everything that exists. Only God can make those claims; therefore, it is God's sovereignty that makes Him superior to all other gods. Participant 14 shared that biblical worldview:

> My general strategy for life is that God is in control. And I include in that both good things and bad things. The same God that resurrected Jesus also had him on the cross. It was his will, according to what Jesus prayed in the garden of Gethsemane, that Jesus be on the cross. And so there's that same God, who is still good, and still in control. And so that perspective is a life perspective for me, and then therefore, you know, that comes into how I respond to the things that clients share. So the way I deal with them is to reflect on that and stay grounded in that truth that God is in control. And then to make it more specific, and more tangible, at least for me, is the recognition that whatever a client is saying to me, God already knew about it. And He has peace, joy, love, and He has care. And I'm just finding out about it at that time. But He already knew about it and He's already dealing with it. And as long as I stay in touch with that, that presence in mind, as the Bible says, I'll be in a good place.

Traumatic experiences can, and often do, change individuals' worldviews relative to perceptions about God, themselves, and the world. The thought of a traumatized client may be, "If God is sovereign and loving, how did He allow such evil to happen to me?" This sentiment

may translate into either God being loving but not sovereign, or not sovereign but not loving—an understandable conclusion that is often confused by the current condition of the world and events in personal lives that are painful, horrible, and unexplainable. The Christian clinician, seeking guidance from the Holy Spirit, can help navigate a client to a "peace that passes understanding" (Phil. 4:6). The clinician needs to model this peace, creating a sense of safety. Participant 2 echoed this concept:

> Anyone that's gone through trauma has thoughts and feelings about God that are most likely distorted. So they bring that distortion into that therapy relationship, but you're the flesh and blood in front of them. So you represent that-- that relationship is critical. And it's, you want to be well trained, you want to, you know, be educated and, you know, practice within your, you know, within your sphere. However, I think the relationship that you build with his clients is just as important because that --their ability to trust you enables them to trust Him.

Participant 17 addressed the inherent tension that occurs with suffering through the lens of a biblical worldview and the role of the Holy Spirit within tension and suffering:

> The Holy Spirit has some responsibilities and some duties that Jesus outlines pretty well in the book of John. He is a counselor. He provides comfort. Second Corinthians 1, where He's the father of and a provider of comfort, and he uses the Holy Spirit to provide that in situ with folks. And through adversity, His desire is to establish a closer connection. So tension, which is through various ways, our culture, and in families, I guess universally, is viewed as a danger for most folks. Whereas what God views tension as is an opportunity to connect, attach, and receive. And the Holy Spirit provides all that opportunity by inviting people in, giving them comfort, and then providing them with

> information about what's right, and what's wrong, and who God is. And then He is, of course, the instrument of healing for that individual.

In order for the clinician to experience God's comfort to model to the client, the therapist must first come to an understanding and acceptance of God's sovereignty. There is no way to explain the horror of this world and the intentional, excruciating pain that human beings can inflict on others unless it is viewed through the lens of human free will, scripture, and God's sovereignty. Romans 8:28 promises that "in all things God works for the good of those who love Him, who have been called according to His purpose." Consider, as a Christian clinician, the implications of that promise. God is sovereign and He loves every person, and nothing will ever come into someone's life that He does not either decree or allow. Accepting this tenet as a clinician creates a safe and sacred space for the client.

Participant 20 shared her thought process when she explained her past work with a client that experienced horrific interpersonal trauma:

> So, for me, it's necessary, especially when you hit this moment, as a clinician when you think, "I have no idea what to do. Now, I am stuck, or I was just confronted by this hurt, and I have nowhere to put it. It doesn't make any sense. There's no logical way to explain this to anyone. No one should have to experience this." So what other way is there to process this than supernaturally?

God may allow suffering into the lives of his children for a higher purpose (Is. 55:8-9). Often, God may heal to bring glory to Himself or encourage others to put their faith and hope in Jesus Christ. This was the case in the death of Lazarus when Jesus raised him back to life (John 11:1-45). Other times, healing does not manifest. Even in the case of impending death, there can be deference to the greater good. A believer who is dying can influence the living toward God

And His message of peace, love, and hope in Christ. The One who sent Jesus for humanity will graciously give individuals "all things" they need to do His will or honor Him (Rom. 8:32). As a loving Father, He may deny healing and instead utilize infirmities directly to consecrate His children or show His provision through the suffering (2 Cor. 12:9). Even in the answer "no," Ps. 34:18 states, "The Lord is close to the brokenhearted and saves those who are crushed in spirit." It is wise to differentiate between spiritual and physical healing. For example, Is. 53:5 (quoted in I Peter 2:24) is often misapplied. The framework of this scripture is spiritual rather than physical healing.

Clinicians often enter the work of mental health because they have a desire to help others who are suffering but then find themselves unable to explain events in the lives of their clients, which may result in feelings of inadequacy or helplessness. At this point, the resources of the clinician have ended and the caring, personal love of God through the power of the Holy Spirit may be utilized as a resource in the sacred space of therapy. Participant 2 shared her thoughts about this dynamic in the therapy setting:

> We must remember that we are not Him. Our job is to connect them with their true Healer…their true Jehovah Raffa, who is their healer. That is our job. This challenges the false narrative that Christian therapists may carry that we are responsible for the healing of other people. The outcome includes an absence of hyper-responsibility for clients. The fruit would be the fruit of the Holy Spirit…you're not anxious…you're not carrying burdens that aren't yours and you're able to love better when you're not feeling a sense of responsibility that is not yours."

Recognizing the healing and peace-giving hand of God when He is invited into that space requires that individuals acknowledge Him and His work. God assures believers that there will

be sufferings and pain in this life, but that they will produce endurance, character, and hope, when committed unto Him (Rom. 5:3-4). Psalm 6:2 records a plea from a suffering soul, "Have mercy on me, Lord, for I am faint; heal me, Lord, for my bones are in agony." Knowing God sees, hears, and is omni-present while walking with a client on a healing journey can bring restoration and clarity to a confused worldview. Participant 16 commented, "I do find that the ones that heal faster, are the ones who are inviting that into the sessions." Participant 13 shared her role in sessions relative to God's sovereignty:

> I want to truly have the experience of the Lord in my work, and I have to be in balance. That means I know where to end. I know where my role is and I know what it isn't. And I want to stay in my role. Because what happens on this side is God's domain, so I go to that point and that's it…that's enough, that's sufficient. I'm enough there. The rest of that is God's domain with the client, not me. And so it would have to be that me as a vessel simply is a channel for the spirit to work, using whatever I bring to the table. So long as God gets the glory and man does not, it's a good thing. It's the other way around that's going to be a problem."

Clinicians on a personal level have the freedom to choose whether to access the power of the Holy Spirit in their own lives and then whether to access that in the therapy session, as stated by Participant 14:

> The Lord can't work for me, effectively, unless I have balance and must have balance in life, and where I'm coming from. And God is not going to force us to live a life of balance. If we want to go and be a lone ranger or be some kind of hero, you know, God's gonna say "Go for it, but you're on your own," you know. And there's going to be human thought. We have to choose to get in line.

This choice of "getting in line" is the main difference between Christian and secular therapists.

Theme 2: Christian and Secular Therapists

Similarities in Christian and Secular Therapists

Posttraumatic Growth

This study examined posttraumatic growth (PTG) in therapists working with trauma clients. There were overwhelming similarities in responses (24 of 26) that secular and Christian therapists both experience PTG, which seems to be inherent in trauma work. All 24 participants that answered gave personal examples of their own PTG. Participant 5 stated:

> I think growth can occur through working with individuals who have experienced trauma and it helps us understand the macro level of why trauma occurs, like where it comes from, a lot of times. Like that saying, "Hurt people hurt people", it allows us the opportunity to be more empathetic even to people who might cause trauma and helps us understand complex trauma in a larger context.

Participant 8 shared her experience with PTG:

> At least in my experience, part of my own growth has been due to that. So I went into this field because I felt called into this field and I wanted to make a difference. And throughout my training, I actually came to realize that like, oh, there's a lot in my own life that needs healing that I need to work through. And I think there is so much emphasis and pressure on me being the one to help others that I kind of forgot about my healing process in this. And so, there's been this like, shift in thinking of how I want to be able to help people. But in order to do that, I have to really be open to me being impacted through this process. And that God is the one that's going to be doing that because it's not

> just me helping someone in need. It's me growing alongside someone. And that's such a different shift in how to think about what happens in therapeutic space.

Participant 9 shared:

> For me, it's been faith and seeing God show up in the middle of darkness, watching their faith and hope grow. The transformation in them has brought me to a deeper level with Jesus. That's my growth. Do I believe that secular therapists that are not Christians could still experience post-traumatic growth? Oh, absolutely.

Participant 2 stated:

> I believe that they can attend to their mind and body in similar ways. So, where a secular clinician is different from myself, is the way in which we attend to our spirit, mind, and body. I believe that—yes, a secular therapist can experience post-traumatic growth. It just may look different."

Participant 23 comments:

> I think there can be some growth from the level of discomfort from the pain that is felt around trauma in a secular therapist, as they worked with a client who was processing through something that can still promote a sense of peace or betterment in the therapist.

Participant 14 explained:

> I would say it is expected. It's incumbent in the process-- personal growth, yes. You cannot stretch yourself around these big, heavy things that these clients bring you, and not grow. So, you have to grow, secular or Christian. You're challenged in what you think is good and right. I have clients who are still in traumatic situations. I have a client who's still doing things that aren't good or healthy. It stretches me because I wouldn't be doing these things. Just to simplify this, if I have a client that smokes weed or shoots up heroin,

> and they're doing it because that's where they are and that's what they're experiencing, it stretches me because I'm not an advocate of shooting heroin. But the client's coming to me for engagement, so I have to be able to handle that in order to be engaged. So we can take that example and apply it to clients who are engaged in trauma, specifically sex trafficking, and I need to be engaged with them. And so it stretches me for sure. With what I think is healthy conduct, healthy choices. I don't see how you could not be stretched by working with clients who've experienced trauma.

Vicarious Resilience

Of the 26 participants, 18 reported they have personally experienced vicarious resilience (VR) as a result of working with trauma survivors. A few commented that their resilience came from another source, as stated by Participant 17:

> I'm not aware of that. My primary resilience is in Christ. I haven't really thought too much about resilience—what we call perseverance in the spiritual realm. I'm sure that I've been buffeted by going through adversity with people, I'm just not aware of an awareness level of increase in resilience, that word itself.

The majority of participants (more than half) agreed that secular therapists may experience VR as often as Christian therapists. Participant 4 commented, "I do think you can grow in your resilience, so long as you're not carrying all that weight of their trauma and feeling like you're the only one that can fix them, whether you're Christian or not." Participant 23 commented:

> I do think that working with patients or clients that have trauma has created a sense of strength in me that I feel like I can really sit with people in their pain and not being uncomfortable by it. That's a resilience skill that I have been taught by working with

> clients from trauma that I definitely use in my regular life in relationships with people who are hurting, even if I'm not counseling them. So that can probably happen for secular therapists, too.

Participant 3 discussed a particular client that had a situation that would have created great pain and suffering in her own life if it would ever happen to her (the loss of her husband):

> I think of how I might take that on, but to be able to walk with her through that and see her resiliency and her going through the grief process, and that is encouraging to me. It helps build my strength in case of that event, or even a smaller one. Just be reminded that life is hard and it gets harder as we go forward. But it doesn't mean that it's not something that we can't enjoy at the same time.

Overall, the participants discussed the possibility that VR can and does occur with secular and Christian therapists alike.

Burnout

Extensive research has indicated that all mental health therapists are at high risk of burnout (Aukstinaityte & Zajanckauskaite-Staskeviciene, 2010; Barnett et al., 2007; Coaston, 2017). All participants agreed that both secular therapists and Christian therapists are at risk for burnout in this profession. Out of 26 participants, 12 reported no experiences with burnout. The notable difference between those that experienced burnout versus those that did not in this study was utilizing self-care and prayer as buffers. Participant 14 offered a unique explanation regarding his lack of burnout, as well as citing his wife's support and time away from work:

> I just have great admiration and appreciation for people and their stories. These truly are treasures to me. Really just kind of appreciating what people survive and how they survive in their own mind and how do they manage their responses and reactions to the

things that they go through? I'm a bit of a narrative therapist, not formally, but certainly, it's kind of the way I think. And I like narratives, beginnings, middles, and ends. That just kind of keeps me engaged. It keeps me interested. When a client starts telling a story, I'm with them. They have my attention. I would say that's the major reason that I haven't really dealt with burnout. Another reason is staying grounded. It's really God's domain. I just really feel sincerely that God is handling all of this. Participant 4 discusses another unique point, combining topics of this study: "It comes back to being humble. If you think you're the savior of everyone, you can build resilience, but it's not going to be motivated. It's not gonna be the right motivation and you'll burn out.

Vicarious Trauma

Vicarious Trauma (VT) is considered an expected deleterious result of working closely with trauma survivors (Brady et al., 1999, Chouliara et al., 2009; Harrison & Westwood, 2009), which would include both secular and Christian therapists. Of the 26 participants in this study, 23 reported experiencing VT in their careers as mental health professionals. Participant 2 has experienced only a few short seasons of VT spanning than 10 years in the work and has discovered what helps her to mitigate its effects, stating, "If you attend to yourself, your own spirit, your own walk with the Lord, your rhythms that refresh and renew you, then those things insulate you from the vicarious trauma." This is not a practice that secular therapists would employ related to the Holy Spirit, but they could attend to their own spirituality for refreshment. While VT is a consideration for all clinicians, one of the few participants (number 17) that reported no experience with VT commented, "One of my gifts is that I'm able to keep boundaries while maintaining empathy." This would be possible for secular therapists as well. Participant 22 attributes her lack of VT to scheduling difficult patients early in the day when she is more

refreshed, setting boundaries in her personal and professional lives, and self-reflection. Secular clinicians can utilize those same buffers to ward off VT. Engaging in regular supervision and scheduled time and space to react to the trauma histories of their clients may mitigate the effects of VT (Richardson, 1999). Secular and Christian therapists share equal opportunities to do so.

Instrument of Healing

Nearly half of all participants (12 of 26) agreed that God can use secular therapists as conduits of healing regardless of their spiritual status, including Participants 1, 2, 3, 12, 13, 14, 15, 18, 21, 24, and 25. They reported that God can use anyone as His vessel because He desires to bring healing to the client, even if the therapist is unaware of the Holy Spirit working. God has no limitations and can use whatever means necessary to bring restoration to those He loves (Job 42:2; Mark 10:27). Even if God does choose to heal through a secular therapist, though, there is a missing element that is not experienced by that clinician, described by Participant 25:

> I think secular therapists can get close to it. But I think the missing ingredient that they can't fully experience is peace. So, things get better, but they don't have that full concept of healing where they can help others to the same degree. I think that only comes through the Holy Spirit. Participant 14 discusses a unique perspective that therapists (Christians and secular included) may have differing views on what it means to be a conduit of healing due to the various interpretations and definitions of the term, “healing”: I think the determinant is going to be the extent of this healing. Is it merely acceptance of prior trauma? You know, what is healing? Is it some dynamic of the Holy Spirit that only Christians receive? Because only Christians receive salvation. Only Christians receive regeneration. Only Christians receive sanctification. So that's a Christian-exclusive thing. Is healing part of that? Should it be? Or is it a desired part of that? If it is, then they

would receive that. And many therapists who may be atheists do have an appreciation for them seeing themselves as being in the work of a higher power? The issue isn't whether or not they've received that concept that a higher power is using them for good in someone else's life. Most of the times that I've talked to therapists about this, the struggle is the identity of that higher power. Is it in the name of Jesus? Or is it some other name? Or is it you know, non-personal, those kinds of things? But in the course of events, where they're a conduit for this higher power, do they, or can they receive healing? So again, we're struggling to define healing here. But can they receive some inner benefit? Yes, I would say so. It's just determined to the extent that we define healing. Yes, but I'd say so. Yes. And ultimately, my hope is that whatever they receive would result in salvation. That would be my hope, might be God's hope as well. But it might not be their hope, it might not be their desire, right? It may be different.

Differences in Christian and Secular Therapists

Resources in the Therapeutic Environment

There are several differences between secular and Christian therapists relative to lifestyle and therapeutic space. Secular therapists do not pray to the Triune God or ascribe to the presence and power of the Holy Spirit. They also would not be sensitive to the subtleties of how God is working within the therapeutic space, which also leads to the lack of divine resources that can be utilized as described by Participant 26:

> When we realize we are led by the Spirit, we have access to the most powerful source in all of the universe: God Almighty, the person of Jesus, and the power of the Holy Spirit. And if I'm not going to tap into that, then I've already started out at a deficit.

Without access to these divine resources, the secular therapist is left to rely on human resources. While they are often beneficial in many situations and result in positive outcomes, human resources still lack the depth of individualized assistance for each client. Only God knows the intricacies of His creation and the inner workings of the heart and mind of every client (Ps. 139). Participant 24 shared her thoughts on why operating from a secular standpoint is not her choice:

> I don't care for working in a secular setting because you really can't mention God like you'd want to unless, you know, of course the client brings it up first. But you're kind of limited. For me personally, I do it privately whether I'm in secular or private settings. It doesn't matter. Because to be honest, I can't do anything aside from the Holy Spirit. That's just being honest.

Love for Others

All 26 participants in this study referred to the principle of God's love and care for others, especially those who are suffering. They viewed themselves as broken vessels, but also as human beings that represent Christ's love in the therapeutic space. The scripture that frames that worldview is found in Ps. 34:18, "The Lord is close to the brokenhearted and saves those who are crushed in spirit." Participant 8 discussed love in this context:

> I think the kind of the next thing that comes out of this is the building up of the client and holding a better view of themselves. I think it comes with the element of love, of being able to show them what it means to be loved and to give themselves permission to love themselves. And that comes out of my understanding that God loves all of us, and that we all deserve that love.

Worldview: Eternity

In order to bring God's love into the therapeutic alliance, a therapist must be open to God using him or her in a manner to which secular therapists would not be agreeable. Further, this includes a specific purpose to which secular therapists would not ascribe—loving as a catalyst for people to accept Christ and for the assurance that souls will spend eternity in Heaven. Participant 9 explained, "I feel like I've always loved on people. But now I love on them with a different goal in mind. It's not just for their healing here. It's eternity in mind, consistently—and so that's been the difference." Without the knowledge and relationship with Jesus Christ, a secular therapist is unable to love clients in the same way Christians are equipped and commanded to love each other. John 13:34-35 (ESV) states, "A new commandment I give to you, that you love one another: just as I have loved you, you also are to love one another. By this all people will know that you are my disciples, if you have love one for another." This is a deep, unconditional love that connects with the Imago Dei inside another human being, rather than a positive mutual regard offered by a secular clinician.

Humility

There is a level of humility inherent in Christianity that should be displayed by the faith-based clinician that a secular therapist does not share. Understanding the helping role in the context of being Jesus' hands and feet is a concept that secular therapists do not find amenable. Participant 26 described this dynamic:

> I realized there are some good therapists, some fair therapists, and there are some very, very good therapists. And I find on the Christian level, the very, very good therapists are those that realize that "He must increase, and I must decrease," because He that comes from above is above all. God has given us some talents and giftings, of which we need to

> understand that, when we close our eyes in death, He will give to someone else. We are blessed to be able to know and be humbled that God is using us in the time that we live. It's those very, very good therapists are the ones that utilize the power of the Holy Spirit, realizing that at the end of the day, we have nothing to say unless we tap into Him.

Humility as a clinician also includes acknowledging that there are so many unknowns that are impossible for a human being to discern or uncover in order to bring restoration or healing to a client, as expressed by Participant 25:

> I think praying for insight into a situation is how we are able to instill hope. I mean, Jesus is the hope. He is the reason for the hope and to provide answers to hopeless situations. And, you know, guidance for healing. And being able to have discernment and knowledge about a person that you wouldn't otherwise know. To work in this field, and to do that without the Holy Spirit's direction...well, you can be really, really wrong.

Self-Care vs. Soul-Care

Research indicated that therapists working with trauma survivors should engage in self-care to avoid burnout and VT (Coaston, 2017; Figley, 2002; Harrison & Westwood, 2009; Owens-King, 2019). This holds true for both secular and Christian clinicians. Self-care activities that participants shared in this study included reading, vacations, massage, hobbies, time with family and friends, reading the Bible, dancing, singing, taking a run/hike/walk, time with a pet, travel, spending time alone, puzzles, talking to a supervisor, and maintaining a lighter work schedule when needed. The difference between secular and Christian views is noted by Participant 2 in this study. She asserted, “So much in the Christian therapist’s life is done in the spirit and it challenges those deep ways of thinking. How we’ve carried our beliefs are triggered in the therapeutic process.” When asked to share her self-care regimen, Participant 9 stated:

> That always seemed to be an interview question in our field. So it's always been there and I think back to the answers I'd give and it would be stuff like, "Oh, I like to, you know, exercise and dance and all of that." But now I've gotten older and my relationship with Christ has grown. My idea of how I carry the burden of others has definitely changed. So it isn't really exercise or anything like that. I don't know that that ever really helped—I mean it helps some. I'm not saying I don't do those things, but when it comes to bearing the burden of others, Jesus has what is going to do it. I got nothing else.

Participant 6 spoke of soul-care in the context of building capacity for his ability to care for others, rather than self-care that addresses emotional and physical needs only: I've tried to be really intentional in terms of a spiritual margin of error and it's my intimacy with God, my own relationship to God. Again, not just jumping through hoops of like, yeah, I read my Bible every day. I'm very, very strict keeping that time—not for legalistic reasons—but because it's my survival. It's my umbilical cord to God. That's a very sacrosanct part of my capacity building spiritually. Every morning—and I've been pretty good at this for a long time—is a protected time of devotions with God and private worship, where I read the Bible. I do have a pretty extensive reading schedule.

Self-care is known to decrease symptoms of burnout. Vicarious trauma, however, affects the very core and soul of a person, affecting beliefs about themselves, others, and the world, requiring soul-care. Participant 2 discussed the neurobiology of trauma and how it relates to a shift in worldview:

> If our amygdala overtakes us, you know, that fight or flight or freeze, it kind of shuts us down, shuts down our thinking. It shuts down our ability to integrate what we know and the truth that we know and the experience that we're having. And so it disconnects the

> experience from the truth, which is where people get stuck. It's not as much what we go through, as it is how we process and what we believe about what we go through that feeds post-traumatic stress symptoms. VT can also create a sense of hopelessness in clinicians.

Participant 8 discussed how her worldview addresses this type of despair:

> There is the traumatic acknowledgement that we're in a broken world, which is a byproduct of the events from the garden. But then Jesus came into the world to give us a new hope for the future, and how there's a promised hope for a new earth and a new heaven. And so being able to hold all of that in the context of someone going through something very difficult helps when it doesn't seem like there's any answer or solution.

Self-care does not address vicarious trauma. Even though it was not an official research question, the topic arose in discussion with most (15 of 26) participants. They agreed with that statement, sharing personal examples. Participant 9 shares how her ability to mitigate VT changed from her experiences as a young clinician as she became a more seasoned therapist: So in the beginning, I feel like I've done the trauma treatment protocols over time. And maybe that's where the vicarious trauma actually comes from…because we're doing it the self-care way, instead of this way, which is with Jesus. It's not that it's not difficult, but now I'm doing it from a place of knowing that Jesus is going to work this out for them. If it helps me continue to do the work that I'm doing, then that would be my resiliency. And that's how it changed over time. Because I used to do it without Him. Now, I don't ever want to do it without Him.

Participant 1 shared how her time with God mends her soul, protecting her from carrying the burden of vicarious trauma:

> That’s where I find the powerful response. That's where I find the strength. That's where I find Him leading it and taking it for me, the hope of the healing for the client, big time. My prayer is every morning at home, but also when I'm in corporate worship. That's a very powerful time where the Lord and I come together in a really raw, emotional way. And I lay all that at Him—at His feet, and He does amazing things.

Theme 3: Healing

The definition of healing has not been clearly demarcated and there are inconsistencies among mental health providers as to how to describe the term. For some participants, PTSD symptoms related to VT (“This pain keeps re-opening the old scar”) are manageable, to others it could represent physical, emotional, or spiritual strain or discomfort (i.e., “I can live with his scar and it does not hurt anymore”). For others, healing brings a measure of fullness or restoration (“I don’t even have the scar anymore”). Thus, the newly coined phrase, “vicarious healing” has clinicians offering various nuances of the novel concept. When asked what she thought VH might mean, Participant 2 reported:

> In recent years, vicarious healing has come in the form of understanding the need to attend to my own soul and to tend to my own mind, body, and spirit in order to be able to be fully present for those who God calls me to serve. And the fruit for me is the absence of fear, and the absence of hyper responsibility. That’s fruit for me, that I have healed from what I've experienced and from the vicarious trauma. My symptoms with vicarious trauma have been more flashbacks and the heightened sense of responsibility creates hyperarousal.

In discussing the spiritual aspect of trauma with the same participant, she noted that interpersonal and complex trauma affect the soul of an individual; Therefore, the healing must

take place in the same part of the person. No human being has access to that depth within another human being. She offered, “It really is only the Lord that can take us to that healed place at the foundation of who we are. And that looks different for each one of us.” The suggestion here is that in order for vicarious healing to occur, it requires a touch from God.

Instances of Vicarious Healing

Participant 24 shared a specific incident that she described as vicarious healing in a session:

> I can remember a time specifically where I had a session and someone came in, and he is a mighty man of God, but he was in a really bad place. And the Lord wanted him to realize that He had not changed his mind about him. And so, this one particular time, I said, “Okay, we're going to close out, but I invite you to pray”. And I just felt led to do that. And it was like, as he began to open his mouth, you could literally see his countenance change. And you could hear the power and the strength. And by the time it was all said, he cried, but by the time he was finished, that weight that was on him had lifted.”

She described the feeling she experienced as she considered herself a conduit of healing in that situation as “hopeful” and “encouraging.”

Participant 5 recalled times when she viewed herself as a vessel through which the Holy Spirit flowed:

> I do know that there have been times where I've been placed where I was to minister to a person or even just said something that I didn't think was significant, but they found so significant because I'd asked God to speak through me. And I knew that God had used me in that moment. As far as vicarious healing, I do think that I have had experience with

> that. It made me feel closer to God, which is kind of—in a large sense—is what healing is—us being made new through Jesus Christ. That is the healing process. So, yeah. It made me feel closer to God and empowered to do God's work.

Participant 8 reported her recognition that she needed healing in her own life, once she became a therapist:

> I think there is so much emphasis and pressure on me being the one to help others that I kind of forgot about my healing process in this. I want to be able to help people. But in order to do that, I have to really be open to me being impacted through this process. And God is the one that's going to be doing that because it's not just me helping someone in need and growing alongside someone. And that's such a different shift in how to think about what happens in therapeutic space.

Participant 9 stated:

> Healing for me comes from watching my clients heal and from sitting at the feet of Jesus. I've had the honor and the privilege to walk through some of the darkest journeys with people. And that is a blessing for them, but it's healing for me. Because I get to see what God can do in other people's lives. That's the blessing that we get by just sitting with them. And the vicarious healing that I receive would be from sitting with Jesus and experiencing His grace, and what it means to really be walking with him.

Participant 16 processed the potential for VH during the interview by asking questions and discussing her experience with the researcher:

> I was just thinking, when we're open to receiving the Holy Spirit and then just kind of allowing the Holy Spirit to do you know its thing and heal this child…I never really thought about vicarious healing in that way. And maybe a lot of clinicians without

> knowing it, actually do that. Even me as a faith-based counselor, I never really thought about how many of the sessions that I've done have been successful because of me. Or has it been the Holy Spirit, you know, guiding me and the clients as we've both been open? You know, I mentioned the clients who do accept the faith based and how I mentioned that they do heal much faster. So then I was just thinking, is it really me and my work as a clinician, or was it the Holy Spirit this whole time? You know, I never really, you know, thought about that. We need to be humble. We're just tools, and the Holy Spirit is just trying to do its work in the world.

Aspects of Vicarious Healing

The researcher considers the difference between vicarious healing, vicarious resilience, and post-traumatic growth: Vicarious resilience is derived from watching another person live through and overcome hardship and suffering. In other words, one person draws from the grit of another. Post-traumatic growth occurs as one lives through experiences and learns life lessons as a result of those experiences. In other words, one person draws from their own lived experience to come to another conclusion. Vicarious healing is the healing that occurs within the therapist as a direct result of the work of the Holy Spirit and does not require drawing from an external source (person or situation). For this to occur in sessions within the therapist, the clinician must be used as a tool for healing. One of the examinations of this study is to discuss whether the clinician must be aware of the dynamic for vicarious healing to occur, or if God will move on behalf of a client even if the therapist is not actively inviting or engaging with the Holy Spirit. As a conduit of healing, Participant 1 discussed her partnership with God as a trained professional:

> I lead my client and do deep breathing, you know, therapeutic tools like that. I can do these things and see improvement. But when the Holy Spirit comes in, that's a whole new level. The prayer...it's the partnership with the Lord, with Him in charge. And He is the master healer. I pray for him to use my mouth and be in my thoughts, my thoughts to be His thoughts. And it's Him. It's Him. He gives me what I need.

As a clinician, she was actively inviting and engaged with the work of the Holy Spirit and describes her experience as healing for herself as she delivers a divine message to clients. “It’s as if He is healing me in the process, because wherever He is, there is healing.” The researcher considers the possibility that as healing flows through the therapist into the therapeutic space to help the client, the clinician is also healed as a by-product of the divine message from the One who is called “Wonderful Counselor, Almighty God, Eternal Father, and Prince of Peace” (Is. 9:6).

Barriers to Vicarious Healing

Participants discussed various barriers to vicarious healing that include the therapist’s traumatic childhood, an unhealthy dynamic within the therapeutic environment, and the clinician’s unaddressed emotional, spiritual, or psychological issues that could lead to a lack of readiness of the therapist to become a conduit. Participant 2 discusses a traumatic childhood and the effect that may have on the therapeutic alliance:

> If a clinician has a childhood that was based in solid attachments, and of course, had godly adult figures that were trustworthy and that clinician was able to have healthy attachments as a child, then their ability to embrace the healing, the vicarious healing process is going to be easier because of the trust factor. Those trust factors are built in those childhood years. It will impact an adult's ability to grab a hold of the power source

> and trust in God's healing process in their lives and allow Him to do that. That is where your beliefs about God are often birthed—from your childhood. There are adult figures that represent Christ in that session. As clinicians hopefully we are modeling that for clients, so that they can learn healthy attachment, in order for them to be able to attach in a healthy way to the Lord. And so that healing process requires healthy attachment.

Participant 23 shared a similar perspective:

> So the trauma that my clients are discussing that hits closer to home because of trauma that I've experienced creates a different reaction in me that may need more healing—they may be more sensitive to vicarious healing or may make it harder for me to feel vicarious healing because I may still have wounds there.

Participant 14 shared:

> Even though a person can be a therapist and a Christian, that doesn't mean that they are healthy or healed. It doesn't mean that they don't have unforgiveness, or bitterness or resentment, or depression. It just doesn't mean those things and I would say that those things can hinder the healing that we're talking about. If someone has not done their work, or early chapters in their story, it usually leads to over functioning in their helping role. That limits the amount that the Spirit can work and vicarious healing is that much more hindered."

Participant 16 shared that "an individual's willingness to partake in that healing could deter it. How open they are to that and are they ready for that?" Participant 20 commented, "I think that as clinicians, we need to be very aware of what our own baggage is and our own rules. Because otherwise, we can sink too deep into the vicarious trauma and be so deep that the vicarious healing is too hard." Participant 23 stated that she "would experience less vicarious

healing if I cared less about my clients." Participant 5 offered another hindrance to VH stating: As Christians, we're supposed to be on the lookout for the way that God is moving and the Holy Spirit is working in a person. And so not being perceptive to the impact that the Holy Spirit's work has on a person would shape somebody's experience with vicarious healing.

Participant 16 shared that perhaps VH cannot take place if the client is not open to the power and working of the Holy Spirit. Participant 4 discussed the hindrance that may occur based on the therapist's self-proclaimed role:

> There was a time early in my therapy that I would feel I was their Savior. That I was the only one that they could connect with and a lot of times that's what they'd say a lot. You know, I don't want to or I can't go. I can't talk to anyone else. I can only talk to you. So that's where that temptation comes in --it's only me that can help you. And that is something you have to fight off. I have fought against the reality of recognizing I need some space away from you. You know, I need to take a step away here.

Participant 25 offered a perspective that may be less obvious than previous responses:

> I think what obstructs it is that people benefit from being traumatized. They have a lifestyle and they've gotten used to that. That's the only way they get their sympathy, affection, or love, is by being sick as opposed to being well, and they use that to gain love, affection, or whatever. That's one thing. Of course, sin obstructs that and so does fear of success. People talk about fear of failure, but I think with traumatized people, sometimes the fear of being successful is very traumatic, and that's comfortable. That's, you know, even as crazy as it is, being successful is new territory.

Secular Therapists and Vicarious Healing

Participant 1 stated that healing can happen for secular clinicians, but "it's not going to go to the depth that I think a Christian can. It's just going to be a lighter dose of healing, more so than if it's faith-based." One of her therapeutic offerings is equine-assisted psychotherapy. As she recalled an experience she had during a session, she related VH to secular therapists, "I totally believe that even if it wasn't my faith involved, watching that one client with the horse—and that had nothing to do with me being a Christian--and I felt a sense of calm and healing." The question that begs an answer is: Is it truly VH or is it posttraumatic growth or vicarious resilience?

Participant 2 shared a similar thought process:

> The majority of work done in the vicarious healing process in the Christian clinician is often done in the spirit. That impacts mind and body, but it's at a much deeper level--it's what we believe. It's what we believe about ourselves, what we believe about the world. And that healing goes to the very core of who we are. I believe that so much in the Christian therapist's life is done in the spirit, and challenging those deep beliefs that are triggered in the therapeutic process.

Participant 5 reported a different view stating, "I think that secular therapists are capable. I think anybody is capable of experiencing healing through the observation of others being healed," but qualified that statement by commenting that they can achieve "the knowledge that healing is a possibility, which, in my mind, is the first step of healing." Participant 13 shared yet another different viewpoint:

> Anyone can be an instrument of the Lord. God can work through all things and all people. So I think that can happen. The only missing element there is giving the Lord

> praise at the end and recognizing the Lord's hand in a given situation, in a certain moment. I think there are many talented clinicians out there who are not of the faith realm, who have incredible skills that are part of being a good therapist or a social worker. I think they can actually be quite a good conduit for the spirit to work. The only absence there is giving the glory to the Lord. I think that's where that is missing in that situation.

The question posed is: Does God use anyone, even if they do not invite Him into the therapeutic space, because He can use whatever He deems necessary to bring healing to someone, even if He is not acknowledged in the process?

When asked if secular therapists can experience VH or only PTG and VR, Participant 14 shared his thoughts:

> I think the determinant is going to be the extent of this healing. Is it merely acceptance of prior trauma? What is healing? Or is it some dynamic of the Holy Spirit that only Christians receive? Because only Christians receive salvation. Only Christians receive regeneration. Only Christians receive sanctification. So that's it, that's a Christian exclusive thing. Is healing part of that? Should it be? Or is it a desired part of that? If it is, then they would receive that. And as we do know that many therapists who maybe are atheists do have an appreciation for them seeing themselves as being in the work of a higher power? The issue isn't whether or not they've received that concept that a higher power is using them for good in someone else's life. Most of the times that I've talked to therapists about this, the struggle is the identity of that higher power. Like, is it in the name of Jesus? Or is it some other name? Or is it, you know, non-personal, those kinds of things? But in the course of events, where they are a conduit for this higher power, can

> they receive healing? Or, you know, we're struggling to define healing here. But can they receive some inner benefit? Yes, I would say so. It's just determined on the extent that we define healing. Yes, but I'd say so. And ultimately, my hope is that whatever they receive would result in salvation. That would be my hope.

The common thread in discussion among participants revolved around the definition of healing and the various aspects that must be present to be qualified as such. The elements of intersubjectivity, the bi-personal field, and sacred space are necessary elements for VH to materialize. Vicarious healing in psychotherapy takes place when the therapist (a) is transformed through the Holy Spirit, (b) experiences insight and the sharing of sacred space (c) experiences the integration of growth through mind, body, and spirit engagement, (d) encounters permanent change and (e) views self as an agent of healing for the client.

Participant 15 shared a perspective that assumes the same healing for both the secular and Christian therapist based on the heart and character of God rather than the belief system of the therapist:

> I believe it would be the same healing. They may not have the understanding, as we as Christians have of what happened. But I think that the healing would be the same because it's the same God. I mean, He rains on the just as well as the unjust. And so when God heals, He heals. You may not understand how, why, what, but you still receive the benefit.

Participant 18 shared that viewpoint, quoting the same scripture verse about God making the sun rise on the evil and on the good, raining on the just and the unjust (Matt. 5:45), adding "So, yeah, it's possible because we can guide, but He chooses and He heals the unsaved, just as well as the saved. So, yeah, it is very possible." Participant 21 shared the same belief, commenting, "If there's an openness and understanding of it…I think it's possible for a secular

therapist to feel, to experience vicarious healing. I think it's the openness and the awareness and understanding."

From another viewpoint, Participant 22 believed it is "almost impossible" for a secular clinician to experience VH because there would be no invitation for the Holy Spirit to move in that setting. Participant 24 agreed and noted the difference, commenting that "the ultimate healing is going to take place when the Holy Spirit touches them. Until then there's only coping mechanisms taking place." Participant 25 added another dimension: Secular therapists, they get close to it. But I think the missing ingredient that they can't fully experience is peace. So things get better, but they don't have that full healing where they can actually give out then to fully help others to the same degree and be totally free because I think that only comes through the Holy Spirit. Hence, answers from several of the participants reveal that VH would not be available to secular therapists as defined by the conceptual definition.

Summary: Research Question Responses

RQ1: How does vicarious healing occur for trauma-based mental health professionals?

While Vicarious Healing as a theory is new in concept, there were multiple participants who expressed the existence of its presence but labeled it as "wholeness" (Participant 8), "healing as a whole person" (Participant 5), or "honest in the presence of God's spirit" (Participant 13). There is a real-life account given by Participant 1 when she shared her experience with the youth who was mute and then finally spoke after the clinician opened herself up to the move and work of the Holy Spirit in the session. That experience is how the concept of Vicarious Healing may occur for mental health therapists. The Christian therapist asks the Holy Spirit to be present and active in the session, which may take on various forms. For example, when creating a "safe place" in EMDR or otherwise, the therapist could suggest that the client

invite God into that safe space to hear from Him directly or just to be in His presence. As the client may or may not share the details of their private safe place, the therapist may still observe a calming effect, words of wisdom, or some sort of healing during that time. The therapist may acknowledge that they ushered in that presence of the Holy Spirit and served as a conduit of healing for another person, which is fertile ground for VH. Participant 1 recalled a specific time with a client:

> We definitely talked about the power of the Holy Spirit, the leadership of the Holy Spirit, the healing power, the guidance, all of these things that are powerful. And we have discussions about it regularly, actually. A client, if they're really upset, I'll lead them to and through a guided imagery. And they always create it. That's like one of the things we do early on in counseling, like, Where are you? Who's there? Look around and what does it look like?" Like they create their own safe place, then I use that later and bring them back there when needed. And for a couple of them, their safe place includes Jesus. And they do have Jesus encounters in which Jesus specifically speaks to them. And they keep a running list of the things that He has said to them. So once that's then established, that's a powerful tool. So we go back to the power of Jesus Himself telling you, "I see you and you're going to be okay." That's powerful, immensely powerful. Another means of VH occurs when the clinician prays before the session and asks the Holy Spirit to guide the conversation, giving the therapists meaningful words and clarity for the client—perhaps a powerful "aha!" moment.

Participant 5 shared such an experience:

> There was just this one particular time where I asked the Lord just speak through me as I was going to meet with the client. I used the word "blessing" instead of "lucky" or

> something that's not a huge deal. But, the woman that I was working with, she looked right at me, and she said, "I really think God just worked through you to say that!" She said exactly what I had prayed for that day. And even though to me, it didn't seem like a big deal, I did get the sense that I was told to say "blessing" instead of "lucky." In that moment, I was like, "Oh my gosh, that was God."

Other times, the Holy Spirit may be invited into the session by the therapist and while sitting in the therapeutic space the client has their own thoughts, without the assistance of the therapist. When Participant 21 was asked about whether she experienced VH, she discussed the passive role she played in the therapeutic space, while experiencing inner healing simply by holding space with clients. She stated, "I think for sure, a lot of times clients stories, and just the progress that they make certainly touches me as I witness it–and has a profound impact on me. It makes me think twice about issues in my own life or how to even deal with them or how to heal them."

Vicarious Healing can be viewed as another "tool in the toolbox" for clinicians that was not introduced as part of the higher education curriculum received by Master's level therapists. Participant 16 shared:

> I think that sometimes where I work in the faith base, we all think that we're all using these toolboxes that we're taught in school for therapeutic purposes. But I also think that with the faith-based counseling that I do, being able to invite the Holy Spirit to help us as well—guide us, when we feel like we're at loss. We might have all these toolboxes. But this client right now does not need this therapeutic thing that, you know, you just check off the list. And so, then those are those moments where it's just kind of giving it to the Holy Spirit to just help guide you, and just see what comes out…the outcome of this. So,

> I think it's important, as being a Christian counselor, to be able to invite that in with you, with your clients in your sessions, because sometimes you just kind of need that guidance, instead of just going through a therapeutic workbook.

No matter the way it occurs, as the conduit of divine intervention, the therapist recognizes how the Holy Spirit intercedes in a supernatural way, creating a unique and personalized healing path for each client that would have been impossible without the Holy Spirit revealing miraculously. Vicarious Healing in psychotherapy takes place when the therapist (a) is transformed through the Holy Spirit; (b) experiences insight and the sharing of sacred space; (c) experiences the integration of growth through mind, body, and spirit engagement; (d) encounters permanent change; and (e) views self as an agent of healing for the client.

RQ2: How does spirituality impact how trauma-based mental health professionals experience vicarious healing?

Every participant agreed that spirituality has a heavy impact on how mental health professionals experience VH. Participant 9 discussed her connection with Jesus relative to VH. She stated, “Sometimes it feels like burdens, right? When you see people hurting and in the conversations that you have with them, sometimes it feels heavy. And the vicarious healing that I receive would be from sitting with Jesus and experiencing His grace, and what it means to really be walking with him.

Participant 13 added:

> The clinician hopefully continues to heal from their own wounds because they're doing their own work, and then working with the clients continues them in a state of healing. So old wounds should continue to be healed because I'm in the presence of healing and I'm surrounded by a healing kind of capacity.

Participant 15 stated:

> I know that God can do all things. He's just waiting for that invitation to do His work. And so, if a client is willing to go there, it's a wonderful thing to see how God can work in life. So, I take the lead of the client, but I've seen God work so many miracles just in one session.

Participant 4 shared:

> Sometimes it does take additional work, intense work in order to allow God to come in all those areas of your life that you set up behind a protective wall-- to break down those walls and find healing. He's already healed it. Sometimes we just have to walk through it. And I don't necessarily think you have to go in and dissect everything. No, you just have to open the door and let God go in there. He cleans it all out. So I do think when God reveals it in His timing, you have to let Him in there. He cleans it out.

Participant 7 discussed the intersection between therapy and spirituality:

> There's a lot of meds and therapy and all this stuff. But for me, I feel like you can't do anything without God. So yes, I'm a therapist, but I'm also a Christian. So, I believe therapy works. But I feel like there are certain battles that you can't do without God, like healing. How can you do it? It's not possible.

Participant 9 discussed two different ways someone can heal, "Healing for me could come from watching my clients heal, or healing could come from sitting at the feet of Jesus. Both, actually." Participant 10 shared that she did not feel as though prayer to invite the Holy Spirit into a therapeutic space for Him to work supernaturally is necessary. She stated that "inviting the Spirit into a session is not nearly as important as the Holy Spirit being in me. And this is because Jesus said the kingdom of God is within. It's within." She also added:

> There are days that I am aligned with what I know is the Spirit of Christ. That's when the therapist, I show up, and no matter what the circumstances my clients are facing, there is this energy of hope. And this energy of healing. That's not contingent on any circumstances changing.

Participant 16 stated:

> I think that the client should continue to seek that (healing) and not just think, "Okay, well, we did a faith based session, and now I'm healed," and then that's it. It's not just, "I'm healed, thank you for these sessions," and then just go on. You have to continue the work, you have to continue finding the Holy Spirit. You need to continue your walk with your spirituality, your faith, but you can't just stop after the session, because healing never stops.

Participant 2 shared the same viewpoint, in that the job of the clinician "is to connect the client with the source of their healing," so they can access God outside of the session, rather than seeking healing from the therapist. Participant 6 discussed the danger of therapists believing in their own power to heal, apart from God. He stated:

> When I viewed myself as somehow the fixer, the magician, the Messiah, especially years ago, those kinds of issues really, really troubled me because I started blaming myself and figured that I somehow didn't see what I was supposed to see. That I wasn't good enough. And again, I don't want to at all go too far the other way and become proud and think that I'm all fine the way I am. But I've come to realize that timing and God are a huge part of this and the level of their own brokenness.

Participant 20 wondered about the definition of healing. She asserted, "I don't know that I've ever seen anyone walk out of my sessions without a scar. The wound might be healed, but

the scar remains, the memory remains, and the impacts are still there." She discussed the benefit of that reality and that it may keep the individual from repeating the same mistakes. She further stated, "I would say that the Holy Spirit uses trauma, as horrific as it is. I've seen so many people who've experienced trauma and gone on to help others and God made it a beautiful thing in their life." She commented that the trauma is not erased or forgotten. She believes that healing occurs in a manner that morphs from a wound to becoming something that beautifully changes people, "Even if it's not the way I would have chosen to be shaped."

RQ3: How can vicarious healing be harnessed so that it can be shared with all trauma-based mental health professionals?

Participant 1 believed that secular therapists can experience "a lighter dose of healing, more so than if it's faith based." She equated this with anxiety or depression scores improving while symptoms still remain. Participant 9 agreed:

> I don't think they're gonna experience the fullness. I think that's the word, the fullness of Christ. However, there are a lot of secular therapists that are believers, they just don't realize that God is using them in that way too. Just because they're a secular therapist doesn't mean that they're not a believer, I was a believer, but I was not using the power of the Holy Spirit to do the work that God has purposed me for. So God could possibly use that as a way to really draw their relationship to him, which by default, is healing.

Participant 1 continued to discuss secular and Christian therapists that can both experience a level of healing. She commented that "even if it wasn't my faith involved, watching that one client with the horse…I felt a sense of calm and healing." Participant 8 commented:

> Essentially, the question is, do you need to know the Holy Spirit is present for Him to be doing something? And my answer to that would be no. Even for secular therapists. When

> the Holy Spirit is present, if there's an openness and willingness, even if the person doesn't even know necessarily what they're open to, God can work when not acknowledged. I can provide kind of an example, I suppose. So when we talk about love, the Christian belief is that love cannot be present without God. So the implication is that if you're not a Christian, you're incapable of experiencing love. And I believe that as long as you're open to love, then God is present. Even if you're not aware of that connection.

Participant 6 has another viewpoint, discussing healing in either a full and life-changing alteration or a limited sense of recovery from specific types of trauma. “I think there could be a measure of that in a secular clinician. Especially if we define the recovery, just again, in a limited way, of certain cognitive, affective and behavioral kinds of changes that can occur.” He believed it “would be limited.” His therapeutic approach with secular clients is a short and brief behavioral therapy approach. He finds it dissatisfying, but views it as his only viable therapeutic option. He stated, “So we'll focus on specific behaviors, self-talk, or something that needs to change. I'm not secular. I see the eternal picture. So, I don't know how a secular therapist would Benefit.” Participant 7 agreed, stating “They don't believe in the Holy Spirit and God, and so it would be absent because that's not their go-to. They don't pray or think to pray so I don't think that would be the result for them.”

Participant 8 shared her thoughts:

> It might be more limited in some ways. But I also don't think it's outside the realm of possibility because secular therapists are still making a positive impact on people without there being a faith element. So, I want to believe that it can be the same case with vicarious healing.

Participant 11 believed that VH is possible for secular therapists based on the principle of mindfulness. She stated:

> If they're able to teach them self-skills or they're able to teach themselves how to check in and how to take care of their body, their responses, and self-care, and their clients start to do those things and notice a difference then, yes. I think it's very possible for them to be able to experience that vicarious healing because they see they are making a difference in their lives.

Every participant believed that there is a degree of healing that can occur in the therapist as a result of holding space with trauma clients, regardless of their faith. Participant 16 believed that VH is dependent on the clinician and "their willingness to open their minds and just at least be able to open to that experience. They don't have to be 100%, but being able to experience that so they can do that with their clients, as well." Participant 2 believed that secular therapists would experience a form of VH, but that attended to their spirit in a different way. She compares the potential secular experience to that of the Christian, and states, "Then, as believers we recognize is not true, authentic Christianity, but they attend to their spirit in a different way. But I believe that they can attend to their mind and body in similar ways." Participant 15 held yet another viewpoint:

> I believe it would be the same healing. They may not have the understanding, as we Christians have regarding what happened. But I think that the healing would be the same because it's the same God. I mean, He rains on the just as well as the unjust. And so when God heals, He heals. You may not understand how, why, what, but you still receive the benefit. We would have that understanding, and maybe they don't, but God could be using us as Christians to help... to help them to understand what happened.

These themes were then combined into the theory that emerged from the data titled Vicarious Healing. Vicarious healing is conceptualized by the author as an understanding of how engagement with the Holy Spirit creates the sacred space for Christian therapists to experience healing and growth while navigating through trauma with their client, thus allowing the therapist to have a more profound understanding of and a deeper connection to the *imago Dei* to acquire a transcendence in the spiritual realm that brings personal safety and peace in the physical realm. Vicarious healing (VH) in psychotherapy takes place when the therapist (a) is transformed through the Holy Spirit, (b) experiences insight and the sharing of sacred space (c) experiences the integration of growth through mind, body, and spirit engagement, (d) encounters permanent change and (e) views self as an agent of healing for the client.

CHAPTER FIVE: CONCLUSION

Overview

The concept of vicarious healing is a new construct with this research study laying the foundation for the discovery of what is possible when the Holy Spirit is actively invited into a session through a Christian therapist. The researcher learned about a scenario with a colleague a few years ago and felt directed by God to create this new construct in the trauma therapy world. The following scenario changes names and protects the privacy of all participants. The following describes the catalyst that precipitated the development of vicarious healing through this dissertation.

Suzanne, a Christian and relatively seasoned mental health clinician, was engaged with a female youth in an equine clinical psychotherapy session. The young client, Becca, had been mute for a length of time due to her previous trauma. Suzanne was meeting with Becca once a week for several weeks and seemed to be making small strides with improvement as the weeks passed by. One particular session left Suzanne feeling a bit frustrated that the therapeutic tools she utilized were seemingly not effective with Becca. As a Christian, Suzanne regularly prayed for her clients during and in between sessions. She made a decision to step away from the area where Becca and the equine specialist stood, in order to pray. She invited the Holy Spirit to actively engage in the situation to help Becca and to give Suzanne guidance. There was no rush of wind, a bolt of lightning, or a voice from the heavens. There was nothing different in the physical realm other than a felt presence of the Divine. She notices that the short, hard brush strokes of the curry comb in Becca's hand melted into soft, long, massage-like strokes. The horse responded and relaxed, as did the three humans in that arena. Sensing as though they were on holy ground, Suzanne paused for a long while and held space with whatever was happening,

challenged to put words to the experience. After a few minutes, Becca turned around to face Suzanne. Becca began talking about cats, how much she liked them, and about the neighbor lady that had many cats and how cute they are. The lengthy monologue was met with deep emotion for Suzanne as the therapist prayed for a breakthrough. She made the comment that, as she observed Becca in the healing process, she knew that it was God who made the difference and she could take no credit for the healing. She commented that she felt differently after the experience and that a part of her felt as though she was healed, too. At that moment, the researcher felt a God-given direction to research that phenomenon as her dissertation topic and to name it, "Vicarious Healing."

Hypothesis

1. Christian trauma-based counselors will have qualitatively different therapeutic experiences than secular trauma-based counselors.

    a. While this project concluded with an interview sample comprised entirely of Christian clinicians, there were in-depth conversations regarding their relationship with Christ and how they used that relationship to guide their therapeutic practices with clients, and how they relied on Him for coping outside of their sessions.

Participant 8 shared:

> Specifically, with trauma, my theological beliefs have informed my clinical work in regards to understanding that we live in a broken world, and that the trauma that the clients are experiencing are a byproduct of that broken world, and trying to make sense of it in that being faced with that reality without giving up hope. And so, my faith is able to introduce that element of hope amidst that brokenness.

These statements indicate that Christianity shapes her entire experience as a trauma-based clinician. However, there are numerous aspects associated with trauma-based interventions. Participant 10 shared that, “Any space that instills clients’ value and worth, any space that speaks peace, any space that brings light to the darkness, is a sacred space.” Participant 1 reported that “Even if it wasn't my faith involved, watching that one client… had nothing to do with me being a believer or a Christian, and I felt a sense of calm and healing.” Participant 5 added, “I think that secular therapists are capable. I think anybody is capable of experiencing healing through the observation of others being healed.” These statements suggest that there are aspects of clinical work that could be shared with secular trauma-based counselors. While Christianity greatly impacts the experiences of Christian clinicians, the data suggests that there may be aspects of this work that are shared between secular and Christian clinicians.

2. Christian trauma-based counselors will be spiritually transformed during the therapeutic process through engagement with the Holy Spirit.

    a. Most participants shared that they believed they could be healed from their experiences of vicarious trauma stemming from sharing space with their clients while centered on Christ.

Participant 20 shared:

> I've experienced vicarious trauma walking through the darkness with them and then walking into the light with them. I have watched someone who's experiencing healing and then my wounds are aided in a way by this client, by their healing. So, experiencing healing with the client is always a beautiful thing for me, as one of my favorite parts of this job.

Participant 22 had similar beliefs as indicated by the following experience. She shared, "And it came out from the Lord to the client and God said that was for me. Like I knew it was for me. So, to me that, too, is a vicarious healing. It was for them, but it was for me."

However, this idea of healing from the Holy Spirit was not universal. Participant 5 shared that she had not experienced healing in her clinical work because there was no engagement with the Holy Spirit and her clients in session. She believed that the client must be aware of the presence and power of the Holy Spirit in order for VH to occur. "I think that there are therapeutic techniques that can promote healing. But when we're talking about through the Holy Spirit, I think that the client has an obligation to engage with the Holy Spirit on a personal level for healing to occur." Participant 12 reported that VH is possible without the power of the Holy Spirit:

> If they're open to it, if they believe people can actually heal, if they believe they are actually capable of helping people find healing, then yes. I think confidence in their own clinical abilities is important. I think that belief that it can actually happen is probably the biggest.

3. If Christian therapists are open and willing to allow the Holy Spirit to work through them while they are in a bi-personal field with their trauma survivor clients, then they can prevent the onset of VT due to intersubjectivity. Intersubjectivity is a complex process that is ever-present as a mutual exchange between clinician and client who influence each other on emotional and psychological levels. Within this context, there exists a dialectical interchange between conscious and unconscious types of relatedness—involving the exchange of contact, connection, and ruptures (Cornell & Hargaden, 2005).

a. The confines of this project did not allow for a complete exploration into the prevention of vicarious trauma.

Participant 9 relied on the Bible for VT prevention:

> I have the Scripture in Isaiah posted, right where I can see it about how God gives me His words of wisdom. So then I can comfort the weary, that is by His strength and not mine. So I definitely think that as long as I'm taking care of my soul, my relationship with Christ, then I know that I can sit wherever He wants me to with whomever He has in front of me. So it's definitely been the buffer against it.

Participant 13 shared, “I tell them, you know, coming to a counselor doesn't mean squat, big deal. It's when you bring with—who you are, that really makes the difference.” He discussed intersubjectivity without knowing the definition:

> They've taken the risk of being really transparent. You know, I lift that up. We're called to be Christ-like. And I think that honesty is going to really help our process. And that is, in a sense, creating a space, that the Spirit can do some things, and it's just --I'm not sure how to articulate it. But there's many a time when I finish a session I'm thinking, wow, I know what a privilege that was. I mean, just to be witness to that. And I didn't say a darn thing. It's just the idea of being here. . . . And if I'm feeling that the clients feeling that, it's just a wonderful, wonderful thing. And that to me is very real. So I couldn't tell you what was being stirred or, who knows, but something happened there. And that was really wonderful. And that's why I do what I do. That's why I love what I do.

Participant 1 shared that she learned coping skills to combat the onset of vicarious trauma after experiencing it within the context of intersubjectivity. She stated:

> I tell them, thank you for the privilege because I get a front-row seat into hearing and seeing what God is doing. And I can't even tell you how grateful I am to walk alongside you in this. And thank you for sharing, and letting me hold this space with you. And so, as iron sharpens iron when I watch and I see God bring restoration. That is crazy good.

Participant 21 discussed how intersubjectivity feels empowering to her in sessions, stating,

> I've talked with people about surviving and what that means. I was trying to instill a sense of empowerment and strength for them, but then, in turn, they give it back to you, like it's projective." However, Participant 17 did not agree that intersubjectivity could prevent the deep level of VT, but rather the skills of the therapist. He did not associate "between working with clients with trauma and personal gain other than the satisfaction that's yielded by being able to serve others." He considered prevention of VT in terms of "developing skills and being able to interact with trauma" that may be enhanced. He stated that the more experience he gets, the better he is at "navigating the trauma with other people---not as surprised, not as shocked. . . . able to maintain a level of objectivity without that shock valve that is so much a part of trauma and what damages people.

Summary of Findings

Experiences with VT

Trauma-based therapists described their experiences with secondary traumatic stress in various ways. A majority (23) of the 26 participants reported experience with VT. The range and severity of symptoms varied among them based on whether they had a meaningful connection to the client, the season of life they were in at the time of VT, their backgrounds and childhoods, whether or not they had personal experiences with trauma, and the culmination effect of years of hearing traumatic material. The 23 participants reported the following symptoms in their

experiences with VT: Disgust, fear, anger, anxiety, nightmares, intrusive thoughts, feeling panicked, loss of sense of safety, shame, relational issues in family relationships, lack of boundaries, and "working too hard for the client," emotional involvement with a client, powerlessness, the birth of an autoimmune disease, sleep disturbances, marital conflict, emotional frailty, fatigue, extreme changes in mood, paranoia, hopelessness, and a change toward a negative worldview. Of the 23 participants, 16 reported an overall sense of burnout that accompanied the VT and that the season lasted over a several-year time period. The remaining 7 reported instances with a particular client where the VT was acute in nature.

Participants 5, 17, and 22 reported no experience with VT. Participant 5 is a 28-year-old with 6 years of clinical experience. When asked why she believes she has not experienced VT, she reported "setting really firm boundaries between myself and my work" as well as a "worldview that consists of the fact that I'm not responsible for people's lifestyles or choices which might contribute to their circumstances." She continued that her goal is to "prevent or avoid trauma within my own self and household. So, it's more like a worldview than an actual like skill, I guess." Participant 22 is a 47-year-old and has been practicing as a clinician for the past 13 years. She reported no VT due to the ability to compartmentalize and the way she schedules clients so the "heavy ones are not scheduled at the end of the day." She admits to suffering from VT in her personal life, but not professionally with clients. Does spirituality impact how trauma-based counselors cope with vicarious trauma?

The majority of the participants do cope with VT by utilizing spirituality. Due to the requirements of this study, all participants were Christians. Separately, each one ascribed to the power and invitation of the Holy Spirit into their personal and professional lives. The overall

consensus was that God welcomes those who are exhausted and vulnerable to come to Him for refreshment and life-giving energy. Matthew 11:28 is such an invitation:

> Come unto Me, all you who are weary and burdened, and I will give you rest. Take my yoke upon you and learn from me, for I am gentle and humble in heart, and you will find rest for your souls; For my yoke is easy and my burden is light.

The practice of prayer, the indwelling of the Holy Spirit, attending worship services or church, and reading of Scripture were common practices of every participant in this study, whether they experienced VT. The 23 that did experience VT, engaged in those practices to mitigate the effects of or gain healing.

Participant 1 shared an example of how corporate worship at her church is an opportunity to bring her weary mind and soul to the Lord:

> That's a very powerful time where the Lord and I come together in a really raw, emotional way. And I lay all that on Him, at his feet, and He does amazing things. So during praise and worship, I close my eyes to the best of my ability and continue to sing along. And when I do that, I put each one of my clients who is really struggling before Him. It's like an image. He always gives me some sort of a picture, like whether chains fall off, like when the drum beats, “boom, boom, boom”, in the music, if it's a real heavy drum kind of song. Literally, the Lord shows me things coming off of them. It just brings me to tears. And I put each one of my clients before Him-- sometimes the image is that emoji where it's two hearts that are peeling around each other and they look like they're kind of swirling together. It’s like His presence or His love is just like a tornado of a swirl around them. Sometimes that's what it looks like. It just depends. Whatever He gives me, and I cover them in that time. And He just brings me to tears. And I know that He's in

> their story. I know he's doing it. He's working on them. I know He's showing me their freedoms are coming. And it is just the most beautiful, intimate moment that He allows me to have during that corporate worship.

Spirituality impacts a trauma-based therapist's experience with VT, as described by Participant 2 because "part of a Christian therapist's vicarious trauma journey often has a spiritual piece. It challenges the way, up until that point, they view God and what He will and will not allow in their life." If the Christian therapist ascribes to God's goodness (Ps. 31:19; Lamentations 3:25), love (I John 3:1; John 3:16), sovereignty (Eph. 1:11; Rom. 8:28), and provision (Phil. 4:19; Matt. 6:26), then that spiritual framework serves as the coping mechanism for VT.

Connection to Christ and Prevention of Vicarious Trauma

Many of the participants discussed their connection to Christ as a way to mitigate the effects of VT once they display symptoms, so it would make sense that the connection to Christ could just as well prevent its onset. Further, one participant discussed the filter through which Christian therapists could view trauma and the vicarious deleterious effects on the therapist. Participant 10 discussed the parallel of a clinician's ability to avoid VT with a biblical account:

> Jesus was saying that the kingdom of God is within. It's within. It's not like when the Jews thought the Messiah was going to come save them from Roman rule. They were oppressed, they were being traumatized. They were an oppressed people, and they believed that the Messiah was going to come in and save them from Roman rule, and bring them all power, peace, and prosperity. And he failed to do all those things pretty miserably. And I think about the parables over and over, and Jesus was saying, "This is what the kingdom of God is like, this is what the kingdom of God is like," they still didn't

> get it. And He kept telling them, "This is what the kingdom of God is like." Because He died, was murdered, unethically. And when they finally got it, maybe not until the Holy Spirit came, and said, that it doesn't matter who has the power. It doesn't matter what the circumstances say, it doesn't matter. Nobody can take what's inside of here, and so on. That's an interesting phrase, vicarious healing. I think that those days that I am aligned with what I know of the Spirit of Christ. When as the therapist, I show up and no matter what the circumstances my clients are facing, it's just this energy of hope. And this energy of

Participants 5, 17, and 22 had no experience with VT. Participant 17 reported that the avoidance was due to his "spiritual intimacy with God" and that he is "able to keep boundaries while maintaining empathy." He also shared the following:

> The primary connection that I maintain by His grace is with Him and Him alone. And then the rest proceeds after that. I'm primarily based in a Christ-centered life, which is a deep, intimate relationship with God. And that takes precedence just because He is primary and sovereign in my life. And that connection provides a buffer for engaging in an over-weakened state in other people's experiences.

Participants 5 and 22 did not state any spiritual reasons for the buffer against VT, as stated in their responses in the previous section.

Spirituality Impacts Coping With VT

The data suggested that the coping skills utilized by Christian trauma-based counselors may differ as far as giving their traumas and feelings to God. Participants 7, 17, and 26 reported similar coping mechanisms with Participant 17 stating, "There's connection there for therapists in the Holy Spirit, in Christ, in God, where the healing takes place in rest and comfort and truth."

Participant 7 built on this idea when he stated, “I go to church, I read my word. I pray, I center what I do around Christ then that changes my daily functioning.” Participant 26 seems to have had similar experiences when he reported that he keeps perspective in his own life when he acknowledged that he is “led by the Spirit and has access to the most powerful source in all of the universe–God Almighty, the person of Jesus and the power of the Holy Spirit.” While using their religion and relationship to Christ to cope with vicarious trauma was a common experience, it is unknown how this coping skill differs for members of other religious beliefs. Clinicians who ascribe to other spiritual beliefs may have a similar experience with turning to their higher being. Atheist clinicians who do not believe in any higher power would not have prayer or spiritual relationships to depend on, which may make other coping skills more salient.

Christian trauma-based counselors may be able to use their connection to Christ to prevent the onset of Vicarious Trauma. Participant 9 shared that she keeps a scripture from the Bible posted on her wall in plain view to remind her that she can comfort her clients through God’s strength and not her own. She asserted, “I definitely think that as long as I'm taking care of my soul through my relationship with Christ, then I know that I can sit wherever he wants me to with whomever he has in front of me. So it's definitely been the buffer.” This belief was shared by other participants, such as Participant 1, who stated, “I absolutely know that God keeps a certain level of covering over me. He protects me from the depths of the content of these people's stories. I absolutely believe He keeps a covering over that for me.” These perspectives suggest that clinicians who invite Christ into their therapeutic sessions and depend on Him to guide them are better able to cope with potential vicarious trauma due to their belief that God will provide what is needed. These clinicians who put their faith in God and give Him the power and credit for the healing of their clients are better able to navigate the potential impacts of vicarious

trauma. In allowing Christ to guide them, the data suggests that these clinicians are better able to adjust to their more intense sessions due to their understanding that Christ will provide what is needed.

Discussion

Can Secular Therapists Experience HV?

There are people in this world who are upstanding, ethically strong, moral, and kind but do not ascribe to Christianity. They want to see goodness prevail and participate in the process to be giving, positive and helpful in their corner of the world. For example, philanthropists hold an innate desire to help other people, but not in the name of Christ. God can and often does use those philanthropists for the greater good to bring about His divine purposes in the lives of others, even when those individuals are unaware they are vessels for His service. In the same way God can way philanthropists, so can therapists, whether or not they are believers. However, is the process that occurs within therapists themselves the same in believers and non-believers? Are secular therapists used as vessels in the same way as their Christian counterparts? The Lord can use secular therapists for healing their clients because God can use any tool He chooses. However, that cannot be defined as vicarious healing because these therapists have not been personally touched in their core and healed in their spirit. Instead, they have been used as a tool for the client to bear witness to their growth or resilience, characterized by PTG or VR. Viewed from this vantage point, secular therapists cannot experience VH, because they do not invite the Holy Spirit into their lives, thoughts, or sessions. In order for VH to occur, the therapist (a) is transformed through the Holy Spirit; (b) experiences insight and the sharing of sacred space; (c) experiences the integration of growth through mind, body, and spirit engagement; (d) encounters permanent change; and (5) views self as an agent of healing for the client.

There is another viewpoint held by a few participants in this study that believe that secular therapists can be used as a conduit of healing by God in spite of the therapist if God deems it necessary for the wellbeing of the client. Effective secular therapists have an empathic connection, which is a characteristic of God and an element of the *Imago Dei*, whether they acknowledge it or not. All human beings are created in God's image, so even secular counselors often display divine characteristics that reside in their souls. Every human being has an eternal soul whether or not they acknowledge that reality.

What Might Obstruct VH in a Christian Therapist?

A Christian therapist must be certain to not obstruct the move or work of the Holy Spirit because of actual sin or by omission. Intentional sin can block the move of the Holy Spirit due to a lack of confession and submission to God's will for Christians. Further, believers can ignore the Holy Spirit (Romans 1:18), resist the Holy Spirit (Acts 7:51), quench the Holy Spirit (1 Thess. 1:19), or grieve the Holy Spirit (Eph. 4:26-30). So, how do Christians know if they are hindering the work and power of the Holy Spirit? Part of the answer to that question lies within the spiritual disciplines. When a believer is trained in the consistent discipline of prayer, fasting, solitude, the study of God's word, service, worship, and confession, the Spirit of God employs this fertile ground to bring divine healing and impart wisdom to clients through the clinician as a conduit.

Another hindrance to the work of the Holy Spirit in the life of a Christian is a momentary lapse of walking in the fruits of the Spirit (i.e., peace, joy, patience, and self-control) as found in Gal. 5:22-23. For example, a pastor may be driving on his way to church one Sunday morning and encounter another driver who angers him. The emotions of road rage are overwhelming and

suddenly he is not in the spiritual state of mind to be Christ-like, even though he ascribes to Christianity.

Is VT a Prerequisite to Experiencing VH?

There were a few therapists in this study that did not experience VH nor had they suffered VT. There must be a consideration, then, that in order to experience healing in the soul, there must first be traumatization in the depth of the soul. Therapists may experience Compassion Fatigue or burnout, which can adequately be addressed with typical self-care measures. VT requires a level of healing that engages soul care for the clinician due to moral injury caused by holding space with traumatized clients. Soul injury is described as "a penetrating wound within our deepest self that pierces beyond the defenses of our ego" (opuspeace.org). Disturbance of an individual's fundamental identity weakens and lessens their sense of goodness/beauty and incites an ominous sense that they are defective/skewed. This dynamic is not addressed by taking a vacation, time off work, engaging in a hobby, or getting a massage. This deep traumatization is only wholly addressed by healing the soul, where the trauma occurred, by the power of God.

Implications

VT challenges the way clinicians perceive God and what He will and will not allow in their lives. In other words, a therapist may wonder, "If God allows a child to be brutally tortured and sex trafficked at a young age by a parent for many years, then what will God allow in *my* life?" The same God that raised His Son, Jesus, from the dead (Rom. 8:11-14) is the same God that allowed Him to be on the cross after a brutal crucifixion (Is. 53:5). This realization can cause trauma to the soul of a clinician and requires soul-care to heal it, not coping strategies for burnout or compassion fatigue.

This study focused on trauma therapists and their experiences with VT, burnout, and CF. Trauma therapists are warned about unaddressed trauma in their own lives and the subsequent potentially high occurrence rate of triggers within sessions due to holding space with clients' traumatic histories. Other therapists, however, such as family and marriage therapists, may not have the same awareness as trauma-based clinicians. Many therapists do not consider family/marriage therapy as trauma-based. Is this a potential trigger for what has been left unaddressed in their own histories? For example, a marriage therapist may counsel a couple in which the wife experienced trauma years prior that had never been addressed. During therapy, the wife discloses the traumatic event, causing the marriage therapist to be caught unaware of the trigger or VT. All clinicians should be aware that every therapeutic encounter, regardless of the therapy type or modality, could bring VT and the consequential need for VH. Although troubleshooting and crisis management may be effective tools relative to handling burnout and CF, ongoing stress management and capacity-building strategies keep clinicians from experiencing repetitious burnout. Vacations, time off work, hobbies, massage, or exercise do provide a reprieve from burnout or CF. The approach to healing VT comes in the form of VH which is a different approach than burnout prevention. Once the vacation ends, so does the reprieve from burnout. VH, on the other hand, is permanent.

Future therapists in graduate school often spend little time learning about VT and burnout due to a lack of information in the curriculum that addresses these issues. Academia would serve students well to include VT as part of an assigned portion of the curriculum (to include all types of therapy) and introduce the concept of VH for those who are open to the spiritual aspect of therapeutic sessions. There exists a heart-soul-mind interaction, even if the person is not aware or actively participating in the process, that is the framework for VH to occur. If therapists were

equipped as graduate students to combat VT with VH, the mental health and well-being of all therapists would improve and, as a result, would create a healthier milieu for those they serve.

Delimitations and Limitations

The researcher began to wonder how might therapeutic experiences of Christian trauma-based counselors differ from secular trauma-based counselors. Due to the confines of this project, this researcher's sample consisted entirely of Christian trauma-based counselors. Differences between Christian and secular counselors were discussed in several interviews, but further research is needed to explore the experiences of secular trauma-based counselors. Findings from interviews with Christian trauma-based clinicians were inconclusive. Clinicians such as Participant 2 shared that leaning on God improved her practice and allowed for true healing. Participant 16 believed that "The people that invite the Holy Spirit into their session heal faster." However, Participant 10 felt differently, reporting the following:

> My clients are going to feel the power and the peace and the love of the Holy Spirit through my presence. Not as though we're just sitting there, and I'm a clinician doing therapy, and we're gonna invite this outside source to come into the room, and then all of a sudden love and peace is going to be there. No, not like that.

This participant did report that she prays at the beginning of her day prior to going to work and asks God to be in her and work through her. She believes that He does even though she does not specifically invite the Holy Spirit into her therapy sessions. All clinicians did believe that their relationship with God greatly altered their general experiences as therapists.

Recommendations for Future Research

Christian clinicians used common coping skills such as support from family and friends, setting emotional boundaries, and supervision from more experienced clinicians. Literature

supports that these coping skills are highly effective and widely used. Therefore, while Christian counselors have specific coping skills that they use, further research is needed to better understand how their coping skills relate to their secular colleagues.

Additional research is needed to determine how a clinician regulates emotions and feelings in session with a client whose trauma conjures up VT. Another potential area of study includes exploring whether Change Theory, bipersonal field, and the therapeutic alliance could provide a framework for addressing in-session VT. In addition, it would be beneficial to identify if there is a difference in the effect and treatment of VT relative to gender.

Specifically, studying if VH is possible for secular trauma-based counselors as they are not aware or ascribed to the work of the Holy Spirit in their sessions as a mode of healing would be beneficial. Future research expanding on the idea of shared vicarious healing aspects of all therapists is needed to gain a more holistic understanding of the experience of secular clinicians to better assess potential differences in their clinical experiences. Would secular trauma-based counselors experience either burnout or compassion fatigue from the vicarious trauma experience rather than the vicarious healing that Christian therapists would experience? The effects of experience and age are variables lacking in research. Further study is needed to determine if young or inexperienced clinicians have a greater increase of VT and burnout and whether veteran clinicians have a greater increase of VT and burnout due to cumulative effect.

Summary

Currently, there exist several self-care strategies that mitigate the effects of VT. Self-care does not inherently offer healing; it only temporarily provides self-soothing. The activities used to combat burnout and CF are not effective in countering VT. This author explores the possibility of a real-time, in-session strategy found within a spiritual framework, inviting Christian

therapists to be open and willing to consider themselves a vessel of God's grace and unconditional love, creating a sacred space. This newly developing construct is known as "vicarious healing" (VH). The foundational premise of this new construct is this: If a therapist can be vicariously traumatized by holding space with and hearing accounts from a client, then the inverse may also be true. Holding space, specifically a sacred space, with a client that allows for their healing, can create healing vicariously within the clinician as well. Sacred space has been noted in the literature to be an element of the therapeutic alliance. Vicarious healing, however, reaches beyond the therapeutic alliance and creates change in both the client and the therapist, bringing emotional, psychological, and spiritual healing to the clinical therapist. Secular and Christian therapists alike may be able to experience VH, even if they are unaware of the presence of the Holy Spirit, or acknowledge that the healing of their traumatized souls was a direct result of God's work in their lives. VH may be the bread and butter for the preparation and mitigation of VT.

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APPENDIX A: INTERVIEW PROTOCOL

1 to 1.5 hour long semi-structured interviews with six main questions. Prompts and discussions will be led by the participants.

1) Can you tell me about vicarious trauma?
    a. Can you tell me about a personal experience with vicarious trauma?
    b. Can you tell me about how you overcame that experience?
2) Can you tell me about burnout?
    a. Can you tell me about a personal experience with burnout?
    b. Can you tell me about how you overcame that experience?
3) Can you tell your thoughts on experiencing personal growth stemming from your work with trauma survivors?
    a. (IF they believe in it) Can you tell me about a time when you did experience growth from working with a trauma survivor
    b. (IF they don't believe in it) Can you tell me more about your beliefs on personal growth as a trauma specialist?
4) Can you tell me your thoughts on experiencing personal resilience stemming from your work with trauma survivors?
    a. (IF they believe in it) Can you tell me about a time when you did experience resilience from working with a trauma survivor
    b. (IF they don't believe in it) Can you tell me more about your beliefs on personal resilience as a trauma specialist?
5) What are your thoughts on fighting vicarious trauma or burnout with personal growth or resilience stemming from working with trauma survivors?
    a. Can you tell me about a time when you used this growth or resilience in your own practice to overcome your own personal vicarious trauma or burnout?
    b. Can you talk more about your thoughts on fighting vicarious trauma and burnout?
        i. Can you share with me what may be helpful for combatting vicarious trauma and burnout?
6) Given everything we've discussed, can you tell me about what vicarious healing would mean to you?
    a. Can you tell me what vicarious healing would look like?
    b. Can you tell me a time when you have experienced vicarious healing?
    c. Can you share some other factors that may impact vicarious healing?
        i. Can you share how your religious beliefs may shape your experience with vicarious healing?
        ii. Could you share about how your childhood or background with trauma could impact your experience with vicarious healing?

Demographic Information: (age, race, gender, where they practice, where they live, SES [socio economic status, annual income ranges (under $25 a year, 25 – 35, etc.)], religion, population served, and how long they have been working with traumatized clients.

APPENDIX B: FIGURES

Figure 1

Demographics: Age & Gender

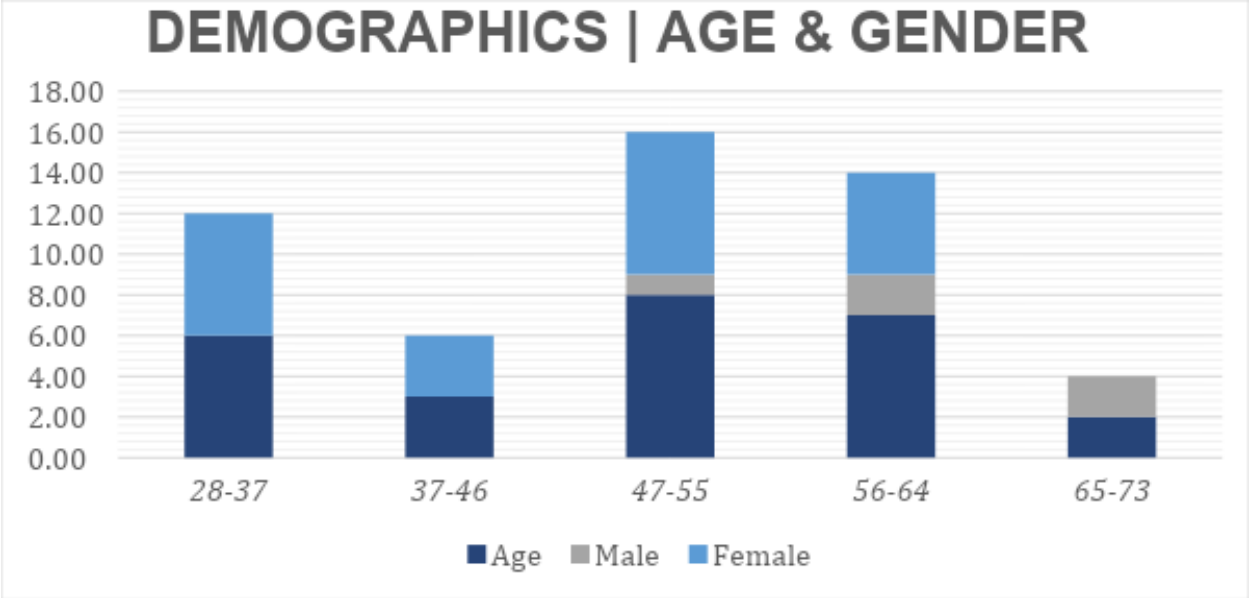

Figure 2

Demographics: Race & Religion

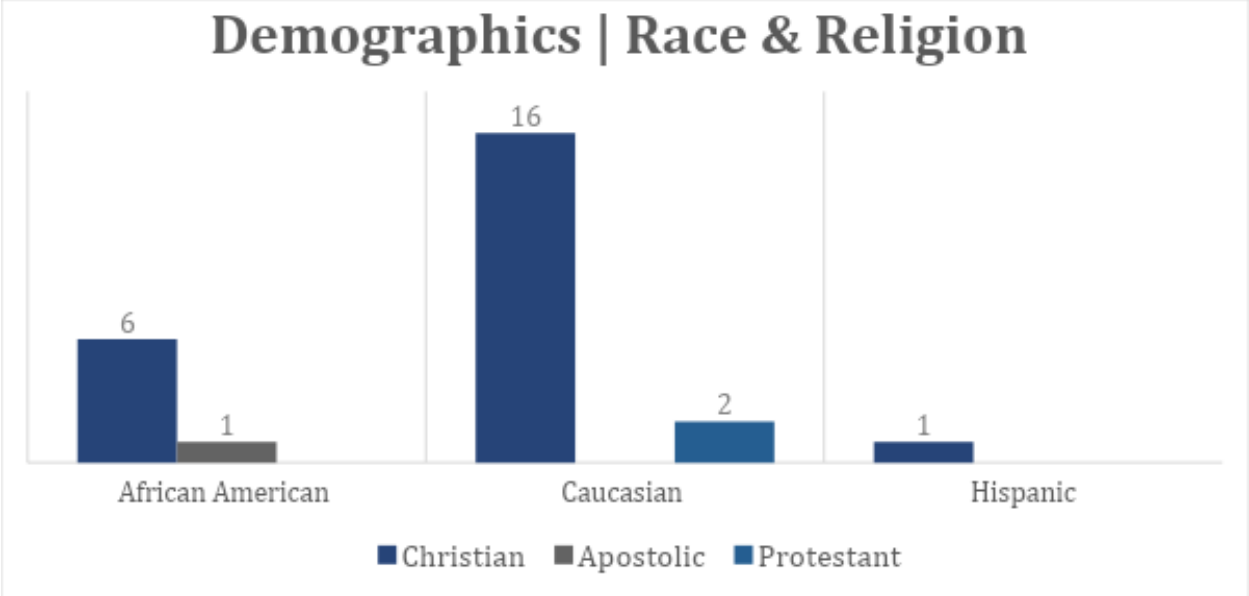

Figure 3

Demographics: Age, Gender, & Religion

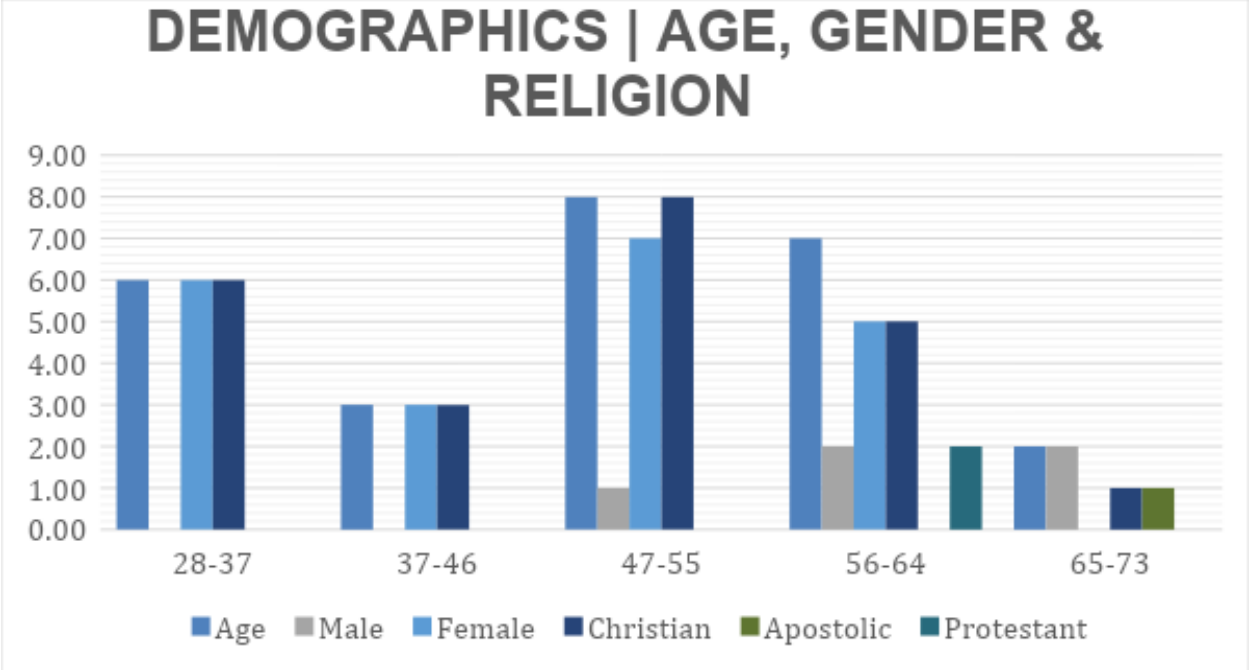

Figure 4

Demographics: Location

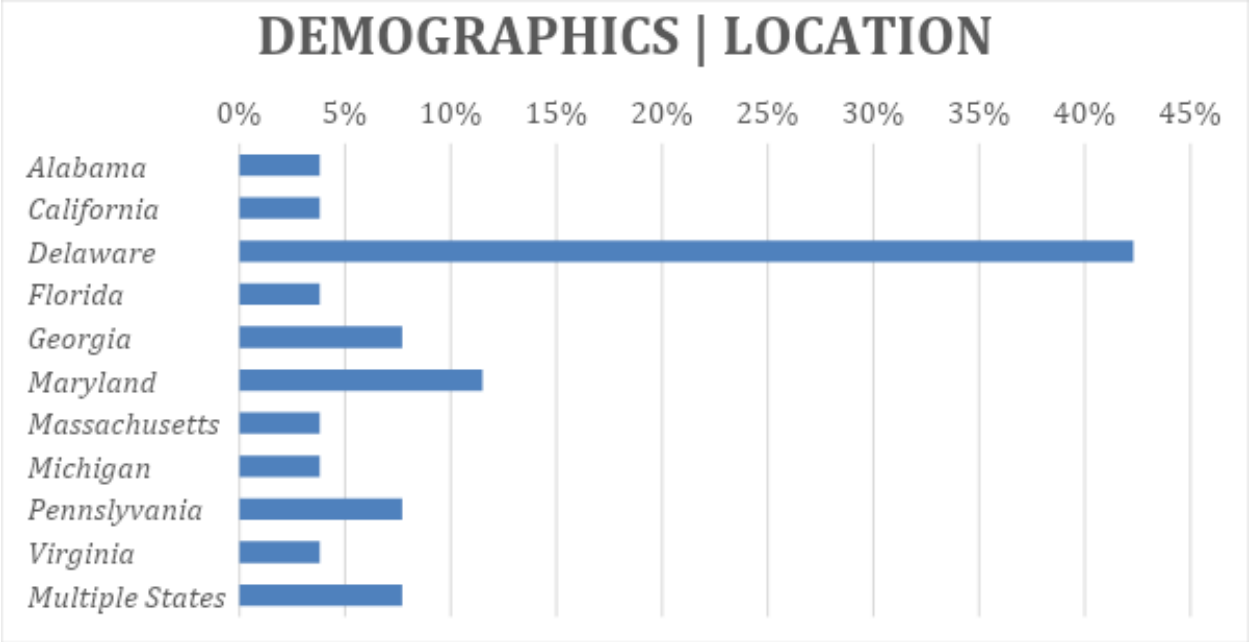

Figure 5

Years in Clinical Practice

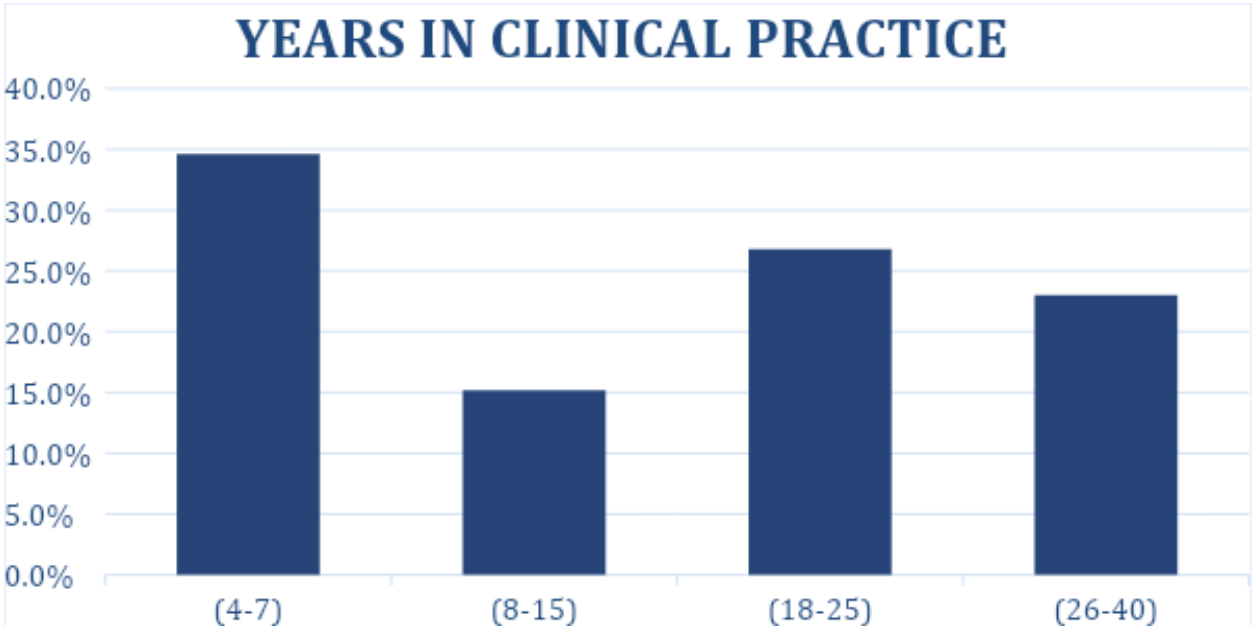

Figure 6

Practice Type of Participants

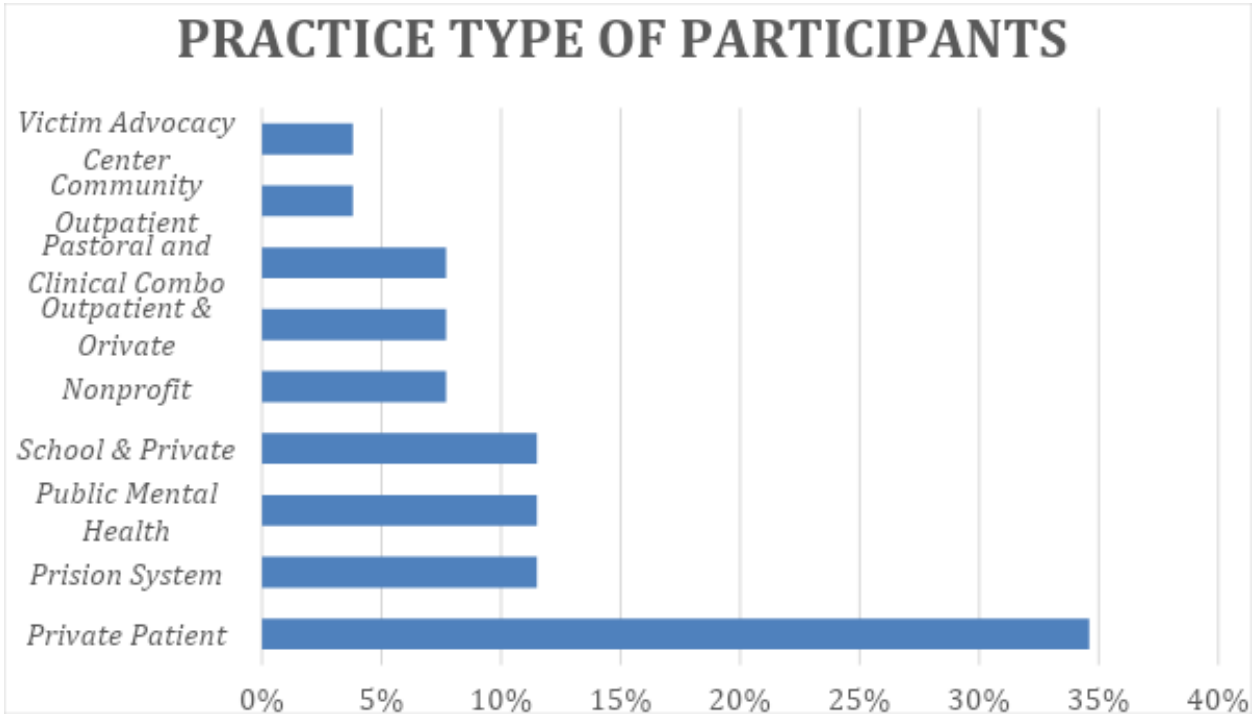

Figure 7

Percentage of Patients Experiencing Trauma