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How domestic violence counselors with personal histories of trauma experience their clients who were victims of domestic violence: a heuristic study

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HOW DOMESTIC VIOLENCE COUNSELORS WITH PERSONAL HISTORIES OF TRAUMA EXPERIENCE THEIR CLIENTS WHO WERE VICTIMS OF DOMESTIC VIOLENCE: A HEURISTIC STUDY

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A

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Acknowledgments

First and foremost, I owe everything to the faith of our clergy. Second, I have the sincerest appreciation for my dissertation committee, Dan Ratliff, Ph.D., Melanie Harper, Ph.D., and Carolyn Tubbs, Ph.D., for helping me understand the true meaning word of the Gethsemane. Third, my heart remains open for everyone, especially the survivors who can live to tell of their lived experiences of victimization and who told those stories with all their might and with grace. Most of all my family helped me focus on the lesson and meaning of aloneness that I have known as "Gethsemane" because they held their faith. My family served a foreign nation for many years, governing a country's politics through martial law. My family is composed of medical doctor (s) and attorney(s), who served their parishes internationally and domestically in the United States of America. I was raised by my maternal aunt, a medical doctor, who served a parish internationally and domestically in the United States of America. She embodied the concept of Warshaw (1996) that clinicians need to address their personal reactions that impact their professional role. I was trained to understand the life of faith-based international public diplomacy and identify human trafficking as well as to determine why a family may speak three languages. The research study of domestic violence counselor with a personal history of trauma who experience clients who were victims of domestic violence is intended to assist counselors in understanding this topic with heuristic inquiry.

Being in a high-profile family's bloodline has produced the most memorable moments and the most heart wrenching. I eventually came to the true meaning of Gethsemane. I came to understand the path of Gethsemane with the help of two clinicians, Austrian psychiatrist Viktor Frankl and American psychologist Clarke Moustakas. Frankl wrote *Man's Search for Meaning*

(1946) about his reflections as an inmate at the concentration camps during World War II. He found it possible to practice the art of living even in the presence of suffering. Frankl (1946, p. 65) stated, “Everything can be taken from a man but one thing; the last of the human freedoms to choose one’s attitude in any given set of circumstances, to choose one’s own way. He formulated logotherapy based on the premise that man’s search for meaning is the primary force in his life. To Frankl, logotherapy is focused on the patients’ futures, specifically in how they will fulfill their meanings to reduce suffering instead of reinforcing it. Similarly, in *Loneliness*, Moustakas (1961) chronicled the pain of loneliness he felt when he had to make a decision regarding surgery for his young daughter, who had become gravely ill. From that personal experience, Moustakas developed the heuristic research methodology after experiencing a crisis in his life.

As a counselor, I truly believe vengeance can never be understood by people who have never been endured the pain of human trafficking or who have never faced religious persecution because the pain of victimization never ends. The pain of religious persecution that followed from my home nation I know of as a counselor. I now understand why my favorite aunt was internationally known as the Steel Butterfly. She helped me blossom from the cocoon with courage and the Gospel’s grace.

Abstract

HOW DOMESTIC VIOLENCE COUNSELORS WITH PERSONAL HISTORIES OF TRAUMA EXPERIENCE THEIR CLIENTS WHO WERE VICTIMS OF DOMESTIC VIOLENCE: A HEURISTIC STUDY

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The heuristic inquiry-based phenomenological approach values focusing on a question or problem that has been a personal challenge in one's quest to understand oneself and the phenomenon. Previous research has shown that counselors with a personal history of trauma who provide services to victims with a similar history report a range of negative consequences. The researcher utilized a heuristic research design to answer the following question: How do domestic violence counselors who have personal histories of trauma experience their clients who were victims of domestic violence? The methodology involved interviewing eight counselors, from whom four themes were identified: awareness of the counselor's own experience, counselor's demonstration of empathy, counselor's self-care, and counselor's countertransference. The counselors who were aware of their own traumatic experience conveyed empathy and demonstrated greater countertransference, which prompted the need for deliberate self-care activities. Four counselors who conveyed empathy demonstrated the overinvolvement form of countertransference, while counselors with low empathy demonstrated the distance or hostility form of countertransference.

Keywords: awareness of the counselor's own experience, clients, counselors, counselor's demonstration of empathy, counselor's self-care, counselor's countertransference, counselors with personal history of trauma, countertransference, domestic violence, effects and management of countertransference, empathy, heuristic inquiry, personal reactions, qualitative research design, survivors, trauma, vicarious traumatization, victim.

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Chapter I

The Problem and Justification of The Study

Introduction

The metaphor of the wounded healer's healing power originates from the ability of a psychotherapist to facilitate the power of healing to help a patient in the therapeutic process. The struggles of the wounded healer could taint the psychotherapy-counseling process. The wounded healer who knows how to cope with his or her problems can help patients to do the same. Although a therapist's wounds may be activated during psychotherapy sessions, they can potentially be used to promote self-healing within the client (Miller & Baldwin, 2000; Sedgwick, 1994).

The wounded healer's countertransference can have a positive influence on therapy by performing counseling with clients who are also victims of trauma (Fauth, 2006; Gelso & Hayes, 2007). Although personal reactions and retraumatization are recognizable and established experiences, Warshaw (1996) stated clinicians who do not confront negative personal reactions could contribute to their clients' retraumatization. The need for public awareness about holding clinicians accountable for their personal reactions. In turn, the decision to carry out the present study is a crucial element that will help increase recognition within the counseling profession of counselors' personal reactions.

If, as Jung (1951, 1963, 1981) suggested, the healer's power originates from the wounds of the psychotherapist, then clinicians and scholars need to understand the ways domestic violence counselors with personal histories of trauma experience clients who were also victims of domestic violence. Counselors with a personal history of trauma are more likely to be affected by their clients' traumatization (Jenkins & Baird, 2002; Pearlman & Mac Ian, 1995).

The predominant focus of research on counselors with a history of domestic violence has been the negative consequences of providing services to victims with a similar history (Jenkins & Baird, 2002; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995). Jenkins and Baird (2002) found that 55% domestic violence counselors with a personal history of trauma who worked with survivors of domestic violence and sexual assault reported higher levels of vicarious traumatization than did counselors who did not report past victimization.

Schauben and Frazier (1995) found that among domestic violence counselors, 70% of the psychologists and more than the 80% of the counselors reported a personal history of trauma. They also reported that counselors with a higher percentage of trauma survivors in their caseload reported views of other people that were more negative. Pearlman and Mac Ian (1995) also found that 60% counselors with a personal history of trauma reported increased disrupted cognitive schemas about themselves or their clients than did counselors who did not report a trauma history.

Research on the management of countertransference has identified counselor qualities of self-insight, integration, empathy, anxiety management, and conceptualizing ability that help counselors manage their personal reactions to clients (Hayes et al., 1991; Hayes et al., 1997; Van Wagoner et al., 1991). Despite the growing body of literature on the subject of counselors' personal reactions to client trauma, no study has examined the experience of counselors with a personal history of trauma who provide counseling to clients with a similar history of trauma. The scope of this study is structured by Moustakas's (1961, 1990) heuristic phenomenology. The outcome of heuristic phenomenology is to understand another's experience through disciplined reflection and exploration of one's experience. Through an internal search, one discovers the meaning and essence of the human experience of others. The first step of the research process,

therefore, is bracketing, in which the researcher reflects on their experience of the phenomena under study (see Chapter IV).

The objective of the present heuristic phenomenological-based dissertation is to examine the way domestic violence counselors who have personal histories of trauma experience their clients who were victims of domestic violence. I conducted interviews with domestic violence counselors with a personal history of trauma about their experiences of providing counseling in domestic violence cases. The best approach to understanding domestic violence counselors with a history of trauma is to walk in the shoes of these counselors; heuristic phenomenology adopts the perspective of these counselors.

Statement of the Problem

The heuristic phenomenological-based research design is a process based on a question or problem that has been a personal challenge in the quest to understand the self and the world in which one lives (Moustakas, 1990). The assumption is that I have successfully addressed my traumatization, allowing this research to portray both the experiences of the self and the experiences of the co-researchers. The objective of the study is to specify a way to examine how domestic violence counselors who have personal histories of trauma experience their clients who were victims of domestic violence based on the process of studying the self and others.

Research Question

Counselors with a personal history of trauma are more likely to be affected by their clients' traumatization (Jenkins & Baird, 2002; Pearlman & Mac Ian, 1995). The impact can include emotional exhaustion (Baird & Jenkins, 2003), disruptions to the counselor's cognitive schemas of safety, trust, intimacy, and control (Jenkins & Baird), or physical effects such as nausea, headaches, and exhaustion (Iliffe & Steed, 2000). Counselors can manage such effects

through self-insight, integration, empathy, anxiety management, and conceptualizing ability (Hayes et al., 1991; Hayes et al. 1997; Van Wagoner et al., 1991). I designed my qualitative heuristic phenomenological-based study to answer the following question:

> How do domestic violence counselors who have personal histories of trauma experience their clients who were victims of domestic violence?

In order to explore the co-researchers' experience of their clients, I utilized open-ended questions that allowed an exploration of the counselors' experience. The interviews attempted to create "an intersubjective space within the researcher—research partner relationship" (Sultan, 2020, p. 72) in which the assumptions and values of both can enter the conversation. The question "How they experienced their clients" could have a variety of assumptions: the counselor may respond with their own internal process, describe the interaction with a client, or assess the client in a more detached, objective diagnostic approach.

Justification for Study

Three studies have identified the personal trauma history of counselors. One study found that among domestic violence counselors 70% of psychologists as counselors and more than 80% of domestic violence counselors reported a personal history of trauma (Schauben & Frazier, 1995). A second study of counselors for domestic violence found that 60% a history of personal trauma (Pearlman & MacIan, 1995). A third study of counselors for domestic violence found that 55% had a personal history of trauma (Jenkins & Baird, 2002). Literature on counseling clients with a history of trauma primarily focuses on the secondary trauma to the counselor (Foreman et al., 2020; Martin-Cuellar et al., 2019; Hensel, 2015; Tosone et al., 2015). There is greater trauma to a counselor with a personal history of trauma. Although a counselor with a history of trauma is

providing counseling services to clients also with a history of trauma, there is no literature that can guide this practice.

The purpose of this study is to explore the ways that domestic violence counselors who have personal histories of trauma experience their clients who were victims of domestic violence. Understanding the experience of their clients is a first step to identifying with them. It is important to understand how counselors with a history of trauma manage the countertransference reactions that arise in response to their clients with a history of trauma. In understanding how these counselors respond, we can design training processes that will develop a counselor's ability to help these clients more effectively.

Limitation

One limitation of this heuristic phenomenological-based study is that the small, purposive-selected sample may not be generalizable to all counselors with a history of trauma. The sample for the present study included five White and three Hispanic female domestic violence counselors and excluded male domestic counselors and counselors from other races and ethnicities. The present study focused exclusively on how domestic violence counselors with personal histories of trauma experience their clients who were victims of domestic violence versus clients who were not.

Definition of Terms

Clients

Clients are defined as individuals "seeking or referred to the professional services of a counselor" (American Counseling Association, 2021, p. 20).

Counselors

Counselors are individuals who are licensed professional counselors (LPCs) or licensed professional counselor–supervisors (LPC–Ss) approved by the Texas Secretary of States' Texas

State Board of Professional Counselors to practice professional counseling if they are appropriately trained and competent in the use of authorized methods, techniques, or modalities as defined by the Texas Administrative Code (2021), which may include but not be restrictezd to as shown:

> Individual counseling, group counseling, couples counseling, family counseling, addictions counseling, rehabilitation counseling, education counseling, career development counseling, sexual issues counseling, referral counseling that uses the processes of evaluating and identifying the needs of clients to determine the advisability of referral to other specialists, informing the client of such judgment and communicating as requested or deemed appropriate to such referral sources; psychotherapy, play therapy, hypnotherapy, expressive modalities utilized in the treatment of interpersonal, emotional, or mental health issues, chemical dependency, human developmental issues, expressive modalities, biofeedback, assessing and appraising, consulting, and crisis counseling.

Counselors With Personal History of Trauma

Counselors with a personal history of trauma refers to counselors who have reported having a personal history of trauma.

Domestic Violence

Domestic violence is defined by Barnett et al. (2005), Bragg (2003), Domestic Violence Resource Center (2010), Knapp & Dowd (1998), National Center for Injury Prevention and Control and Centers for Disease Control (2006), and Tjaden and Theonnes (2000) involves:

> Behavior(s) by a person(s) to gain or maintain power and control over another person(s) through tactics that can involve physical abuse, sexual abuse, emotional that is also

known as psychological abuse, economic abuse, intimidation, or stalking that may occur between persons who are or were in a personal, family, or caregiver relationship.

Trauma

Trauma involves the symptoms and effects caused by traumatic experiences or events.

Victims

Victims are defined as individuals who have experienced or witnessed abusive behaviors as part of domestic violence (Bragg, 2003; Ganley et al., 1998; Tjaden & Theonnes, 2000). Researchers and advocates have also used the term survivor to identify individuals who have experienced abuse as part of domestic violence (Anderson & Saunders, 2003; Dienemann et al., 2002; Neumann & Gamble, 1995). The consensus about which term most accurately or appropriately describes one who has experienced domestic violence is limited (Kohn, 2001).

Chapter II

Review of Literature

Three studies on trauma counseling effects have assessed the counselors' personal histories of trauma. The counselors in these studies reported increased levels of trauma symptoms (Jenkins & Baird, 2002) and disrupted cognitive schemas regarding self and clients (Pearlman & Mac Ian, 1995). One study found a higher percentage of trauma clients predicted greater negative effects, not the domestic violence counselors' personal trauma histories (Schauben & Frazier, 1995).

Studies on personal reaction management have identified active coping strategies to minimize the negative consequences of trauma counseling. Research on the management of countertransference or personal reactions has identified five counselor qualities—self-insight, integration, empathy, anxiety management, and conceptualizing ability—, which help counselors manage their personal reactions to clients (Hayes et al., 1991; Hayes et al., 1997; Van Wagoner et al., 1991). One study found that self-integration and self-insight rated as the most important qualities to manage personal reactions. Another study found conceptualizing ability was the most significant quality. A third study identified empathy and self-integration as the most identified qualities to minimize personal reactions.

The wounded healer metaphor (Jung, 1951, 1963, 1981; Miller & Baldwin, 2000; Sedgwick, 1994) suggests the counselor's personal trauma history can be an impediment to psychotherapy or a source of healing. Existing research has examined only the negative consequences of the counselor's personal trauma history. In this study, I will utilize a heuristic phenomenology method, and the major research question of this heuristic phenomenology

becomes: How do domestic violence counselors who have personal histories of trauma experience their clients who were victims of domestic violence?

Vicarious Traumatization

Trauma is defined as an experience or event that causes extreme upset, temporarily overwhelms an individual's coping resources, and leads to long-term psychological symptoms (Sartor, 2016). The term "trauma" is often used interchangeably to refer to secondary traumatic stress, compassion fatigue, and vicarious traumatization, which are effects counselors can experience when exposed indirectly to traumatic events by working with trauma survivors (Pack, 2013; Tosone et al., 2015). Trauma researchers have focused on assessing the effects of vicarious traumatization, or the cumulative effects of exposure to traumatic material when working with trauma survivors (Baird & Jenkins, 2003; Iliffe & Steed, 2000; Jenkins & Baird, 2002; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995). Counselors who work with trauma survivors are likely to be negatively affected by vicarious traumatization, which can disrupt the counselor's own cognitive schema (Foreman, 2018; Halevi & Idisis, 2017; Jenkins & Baird; Pearlman & Mac Ian).

Furthermore, a number of impairments occur in counselors work predominantly with clients who have experienced trauma; such effects can include emotional exhaustion (Baird & Jenkins, 2003); disruptions to the counselor's cognitive schemas of safety, trust, intimacy, and control (Jenkins & Baird, 2002); and physical effects such as nausea, headaches, and exhaustion (Iliffe & Steed, 2000). Vicarious traumatization of counselors results from empathic engagement with traumatized clients and is correlated with symptoms of posttraumatic stress in the counselor (Jacob & Holczer, 2016; Schauben & Frazier, 1995).

Post-traumatic stress disorder is a medical condition that can occur after an individual experiences a traumatic event. The symptoms of post-traumatic stress disorder fall into three categories: re-experience of the traumatic event, avoidance and numbing symptoms, and increased arousal symptoms (American Psychiatric Association [APA], 2013). In the first category of symptoms, individuals re-experience the traumatic event through intrusive thoughts, nightmares, flashbacks, and emotional and physical reactivity after exposure to reminders of the trauma. The second category of symptoms involves avoidance and numbing behaviors such as avoiding places, events, or objects that are reminders of the trauma and avoiding thoughts and feelings associated with the trauma. The third category of symptoms involves the persistent experience of increased arousal resulting in behaviors that were not present prior to the traumatic event, such as difficulty sleeping, irritability and/or angry outbursts, hypervigilance, and startled responses.

With assessing the personal history of trauma of counselors and non-counseling mental health providers (comprised of clinicians counselor trainees and trauma professionals) researchers have assessed interchangeable compassion fatigue, secondary traumatic stress, shared trauma, and vicarious traumatization, can experience when exposed indirectly to traumatic events by working with trauma survivors associated with: impact of the professional development of counselor trainees with vicarious traumatization and posttraumatic growth (Foreman et al., 2020), effect of vitality against compassion fatigue (Martin-Cuellar et al. (2019), secondary traumatic stress among professionals indirectly exposed to trauma through their therapeutic work with trauma victims (Hensel, 2015), and shared trauma of clinicians exposed to the same community trauma as their clients (Tosone et al., 2015).

Foreman et al. (2020) used a consensual qualitative mixed methods approach to explore the professional development of counselor trainees and assess how providing counseling to clients who have experienced trauma affects them personally and professionally. Nine female counselor trainees agreed to participate in the study. The researchers outlined nine domains gleaned from interviews, including elements of vicarious traumatization (VT) and posttraumatic growth (PTG). The first domain, memorable clients, captured any description the counselor trainees provided about what caused clients to stand out. The second domain, impact, included descriptions of how counselor trainees described their process of working with clients who had experienced direct or indirect trauma. The third domain, coping, encompassed any strategy or behavior the counselor trainees implemented in response to an external problem or professional challenge. The fourth domain, learning curve, included counselor trainees' descriptions of what they learned from clients and their site. For the fifth domain, response to scores, all counselor trainees received information about how their scores for the standardized VT and PTG measures compared to the study's participants' average scores prior to the interview. For the sixth domain, trauma definition, counselor trainees were asked to define trauma during their interviews. The seventh domain, growth, highlighted what counselor trainees shared about personal growth, improvement, or changes resulting from their practicum or internship, work, or personal experiences. The eighth domain, self-care, included descriptions of how counselor trainees cared for themselves personally and what they did to maintain their health. The ninth domain, prior exposure to trauma, emerged as counselor trainees shared their personal experiences related to trauma, as well as current and past stressors. In summary, the counselor trainees shared their personal history with trauma as part of the research process regarding how they experienced elements of the VT and PTG.

Martin-Cuellar et al. (2019) performed a quantitative study to assess vitality, referring to the positive feeling of being alive and energetic, which is an understudied protective mechanism within the psychotherapy literature. The authors explored how vitality influences the relationship between a counselor's past traumatic experiences and their compassion fatigue, defined as fatigue caused by the empathic and compassionate work that encompasses being a counselor. The findings showed that perceived subjective vitality was a significant protective mechanism to prevent the development of compassion fatigue for counselors with a history of trauma. The sample consisted of 113 counselors (of whom 77% were women) and non-counseling mental health providers and represented an international sample. The authors provided the ego-depletion hypothesis as a context with which to describe the importance of vitality and its influence on compassion fatigue. The authors assessed the counselors and non-counseling mental health providers' personal history of trauma yet identified that assessing perceived subjective vitality and self-care practices had an additive effect on building resilience against compassion fatigue.

Hensel (2015) performed a meta-analysis of 38 published studies to examine 17 risk factors for secondary traumatic stress among professionals indirectly exposed to trauma through their therapeutic work with trauma victims. According to the authors, revisions to the posttraumatic stress disorder (PTSD) diagnostic criteria in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013) explicitly clarify that repeated exposure to the aversive details of a traumatic event during the course of one's professional duties qualifies as a Criterion A stressor. In their review, secondary traumatic stress refers to PTSD symptoms associated with repeatedly hearing the details of traumatic events experienced by others over the course of one's professional duties. Professionals who work therapeutically with trauma victims may be at particular risk for

secondary traumatic stress. Small but significant effect sizes were found for trauma caseload volume (r = .16), caseload frequency (r = .12), caseload ratio (r = .19), and having a personal history of trauma (r = .19). Small negative effect sizes were found for work support (r = −.17) and social support (r = −.26). The results showed that a professional's personal history of trauma, whether different from or similar to the client's, was positively related to secondary traumatic stress in all of the included studies; however, the strength of the association varied (r ranging from .05–.36). The role of past trauma may additionally depend on the type of trauma, extent of exposure, and the professional's gender. Demographic factors appeared to be less implicated, although more work is needed that examines gender's role in the context of the type of trauma, given the higher rate of sexual trauma among women along with the recommendation that future work examine how secondary traumatic stress and associated impairment are measured, as well as understudied risk factors and effective interventions and outcomes.

Tosone et al. (2015) discussed that describing secondary trauma phenomena does not adequately capture the profound impact that collective catastrophic events can have on non-counseling mental health providers living and working in traumatogenic environments. Shared trauma, by contrast, contains aspects of primary and secondary trauma, and more accurately describes the extraordinary experiences of clinicians exposed to the same community trauma as their clients. The authors defined shared trauma in relation to existing secondary trauma constructs and described its impact on therapeutic situations, as well as the professional and personal alterations that may result from clinicians' dual exposure to trauma. The authors presented a case vignette from a Manhattan social worker clinician who was a social work intern on 9/11/01 and later went on to work exclusively with survivors of the event. The second case was written by a seasoned academic clinician in Sderot who, along with her students and clients,

has been subjected for years to Quassam rockets on a sporadic, unpredictable basis. Both case vignettes were provided to illustrate the positive transformative changes that clinicians may undergo as a result of dual exposure to trauma involving the importance of articulating one's own trauma narrative and attending to self-care prior to resuming clinical work. They also addressed opportunities for enhanced therapeutic intimacy and caution regarding boundary alterations that may result from clinician self-disclosure. Regarding a clinician's personal history of trauma, the authors discussed the importance of the necessary education, supervision, and support.

Similarly, Cigrang and Peterson (2017) reviewed one assessment of personal history based the composite case depictions on the details and on non-counseling mental health providers veterans' exposure to combat (i.e., PTSD). The authors presented Austern's (2017) three composite veteran case studies using written exposure therapy (WET; Sloan et al., 2013), as a first-level intervention in a larger stepped-care model for posttraumatic stress disorder (PTSD). The relatively minimalist WET intervention (i.e., no written exposure used as homework to encourage uptake among veterans) may be appealing to veterans with PTSD who have opted not to seek treatments that are more time- and therapist-intensive. In addition, writing has been used effectively in other protocols as a method of achieving written exposure to and emotional processing of memories of traumatic experiences. Austern's three cases, although Austern did not provide details, demonstrate a range of success in using WET to engage veterans in evidence-based treatment and to reduce suffering associated with PTSD, beyond normalizing and validating expressed feelings. Additional advantages of the WET and stepped-care approach include the potential for diminishing burnout among trauma therapists and assisting with managing caseloads. The potential value of incorporating motivational interviewing principles

and specific homework tasks into these efforts, explicitly intended to explore ambivalence, could strengthen intrinsic motivation and increase confidence in making changes. This seems like a good fit for work with veterans, similar to Austern's composite cases. The personal history of trauma assessed by the authors came from the composite case depictions, which were limited; in any case, the details were based on the veterans' combat exposure.

Without assessing the personal history of trauma of counselors and non-counseling mental health providers (social workers, child welfare workers, health care providers, and mental health professionals), a number of researchers have assessed interchangeable secondary traumatic stress, compassion fatigue, burnout, vicarious traumatization, and posttraumatic stress disorder (PTSD). When exposed indirectly to traumatic events, counselors and mental health professionals may experience these effects while working with trauma survivors associated with the following: social workers' secondary trauma stress by examining the diagnosis and subdiagnosis for PTSD and the severity of secondary trauma stress levels (Bride, 2007); the summary and review of the most commonly utilized instruments for measuring aspects of compassion fatigue (Bride et al., 2007); secondary traumatic stress among alcohol and other drug service workers (Ewer et al., 2015); the role of counselors as professional chaplains relying on friends and family during difficult times to cope with job demands (Galek et al., 2015); the impact of vicarious trauma on child welfare professionals (Jankoski, 2010); the overlap and differences between the following concepts related to secondary traumatization (e.g., posttraumatic stress disorder, secondary traumatic stress, compassion fatigue, and burnout; Meadors et al., 2009); the impact of the ecological systems approach that can aid in understanding vicarious traumatization for working with survivors of sexual abuse (Pack, 2013);

and the impact on levels of vicarious trauma and high caseloads, which could influence a mental health professional's level of self-efficacy in trauma-counseling services (Sartor, 2016).

Bride (2007) performed a quantitative study on the prevalence of non-counseling mental health providers social workers' secondary trauma stress by examining the frequency of individual symptoms, the frequency with which diagnostic criteria for posttraumatic stress disorder (PTSD) were met, and the severity of secondary trauma stress levels. The researcher found that social workers engaged in direct practice are highly likely to be secondarily exposed to traumatic events through their work with traumatized populations, and many social workers are likely to experience at least some symptoms of secondary trauma stress. Additionally, a significant minority may meet the diagnostic criteria for PTSD; 97.8% of the respondents indicated that their client population experienced trauma, and 88.9% indicated that their work with clients addresses issues related to those clients' traumas. Social workers are indirectly exposed to trauma as a result of their work with clients and, thus, may be at risk of experiencing secondary traumatic stress symptoms. Of the social workers involved, 70.2% had experienced at least one symptom in the previous week, 55% met the criteria for at least one of the core symptom clusters, and 15.2% met the core criteria for a diagnosis of PTSD. The methodology involved 47% (n = 282) master's-level social workers (226 females and 50 males). The study did not assess the social workers' personal history of trauma, and the authors discussed the extent of diagnosis and subdiagnosis rather than the impact on the effectiveness of clinical work.

Bride et al. (2007) provided a summary and review of the most commonly utilized instruments for measuring aspects of compassion fatigue. The goal was to provide a resource for clinicians to assist in choosing an instrument to assess and monitor their own levels of

compassion fatigue. The authors categorized compassion fatigue as the negative effects on clinicians due to work with traumatized clients; they described and evaluated the leading assessments of compassion fatigue in terms of their reliability and validity. The authors discussed three factors involved in selecting a compassion fatigue measure: the assessment domain or aspect of compassion fatigue to be measured, simultaneous measurement, and the time frame of what is being measured. The authors advised caution when interpreting scores, since the measures were developed as screening devices where appropriate, minimizing the possibility that compassion fatigue would not be identified in someone who is experiencing it. The authors did not discuss assessing a clinician's personal history of trauma, with the acknowledgement that no single measure assesses all aspects of the concept of compassion fatigue (i.e., trauma symptoms, cognitive distortions, general psychological distress, and burnout). The authors recommended that more than one measure be utilized to provide a fuller picture of an individual's experience of compassion fatigue.

Ewer et al. (2015) performed a quantitative study to examine the prevalence and correlates of secondary traumatic stress among non-counseling mental health providers alcohol and other drug service workers in Australia. The study was focused on how working with trauma clients impacts these service workers, referred to as secondary traumatic stress or vicarious traumatization. Secondary traumatic stress has been defined as the natural, consequential behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other, possibly meeting the symptoms of posttraumatic stress disorder (PTSD) based on intrusion, avoidance, and hyperarousal. The results indicate that despite the high volume of traumatized clients accessing alcohol and other drug services, less than two-thirds of alcohol and other drug service workers reported having ever received trauma

training. The prevalence of secondary traumatic stress among these workers was 19.9% and was independently predicted by a higher traumatized client workload, fewer hours of clinical supervision, and workers' stress and anxiety levels. The quantitative methodology involved assessing current levels of trauma training, extent of exposure to clients with a history of trauma, workers' history of trauma exposure or PTSD and secondary traumatic stress, and current secondary traumatic stress among 412 (70.5% female) Australian alcohol and other drug services workers. The researchers highlighted the importance of providing adequate trauma training and clinical supervision to alcohol and other drug services workers to maintain their health and welfare and ensure optimal treatment for clients with PTSD. The authors did not assess the personal trauma histories of the workers, stating that the prevalence of trauma exposure, PTSD, and secondary traumatic stress is confounded by other personal and professional characteristics rather than independent predictors.

Burnout and secondary traumatic stress are similar because both result from exposure to emotionally engaging clients via interpersonally demanding jobs and represent debilitation that can obstruct providers' services (Galek et al., 2015; Jenkins & Baird, 2002). Galek et al. performed a quantitative study finding the need for counselors acting as professional chaplains to relate not only to their clients but also to their own inner dynamics, mitigating the possible deleterious effects of their work. The methodology involved a multiple regression performed on responses from 331 professional chaplains (55% male and 45% female). The researchers found that (1) the number of years worked in the same employment position positively related to burnout, but not to secondary traumatic stress; (2) secondary traumatic stress, but not burnout, positively related to the number of hours spent per week counseling patients who had traumatic experiences; and (3) social support negatively related to burnout and secondary traumatic stress.

However, the only specific sources of social support (i.e., supervisory support and family support) negatively related to burnout. The current research did not assess the counselors as professional chaplains with personal trauma histories because it focused on an overall beneficial impact of relying on friends and family during difficult times to cope with job demands.

Jankoski (2010) conducted a qualitative multicase study of non-counseling mental health providers as child welfare professionals (56 women and 13 men) who discussed the changes they experienced due to their work caused by vicarious trauma. This study was grounded in constructive self-development theory, a developmental and interpersonal theory with a trauma focus that explains how trauma affects an individual's psychological development, identity, and adaptation. The term "vicarious trauma" is used most commonly to describe how trauma affects helpers and referred to vicarious traumatization as being most applicable to helpers working for the child welfare system. Jankoski defined five personality traits impacted by trauma that contribute to vicarious traumatization of the organization, the client, and a person's own experiences: frame of reference (how an individual interprets experiences), self-capacities (one's ability to maintain a sense of self), ego resources (self-awareness strategies and interpersonal skills), psychological needs and related cognitive schemas, and memory and perception (physical and emotional responses to trauma). These personality traits negatively impacted by trauma that contribute to vicarious traumatization, and an individual's personality then changes because their original beliefs and thoughts are challenged and questioned due to the trauma experience. The researcher did not research the child welfare workers' personal history of trauma and focused on an increasing knowledge about vicarious trauma and encouraging ways to cope with vicarious traumatization at the organizational, training, higher education, and individual levels to involve the self-care level.

Meadors et al. (2009) performed a quantitative study, primarily to explore the overlap and differences between the following concepts related to secondary traumatization: posttraumatic stress disorder (PTSD), secondary traumatic stress (STS), compassion fatigue (CF), and burnout (BRN). A secondary aim for this research was to examine the effects of secondary traumatization and some of the personal and professional elements that affect how non-counseling mental health providers pediatric healthcare providers experience PTSD, STS, CF, and BRN. Despite previous literature indicating that the terms "STS" and "CF" can be used interchangeably, the two most prominent measures utilized for assessing CF and STS actually captured something unique with the elements. The analyses revealed that a significant overlap existed between the terms "STS," "PTSD," "BRN," "CS," and "CF" at pediatric intensive care units and neonatal intensive care units as well as among pediatric providers (nurses, chaplains, and doctors). However, a hierarchical linear regression revealed a significant number of unique contributions to the variance for CF based on each measured concept. The methodology involved sending an online survey via e-mail to numerous listservs for healthcare providers (N = 167), with 137 women and 24 men participants who had worked in pediatric intensive care, neonatal intensive care, or pediatric units within the past year. The researchers recommended future studies to examine and conceptualize the differences in etiology, prevalence, symptoms, and treatment efficacy for CF and STS as separate but related entities, with a focus on understanding secondary traumatization among healthcare providers. The providers' personal histories of trauma were not assessed.

Pack (2013) performed a review to explore and understand vicarious resilience and vicarious traumatization. The author discussed how an ecological systems approach can aid in understanding vicarious traumatization on several levels and developed a multidimensional

model for working with survivors of sexual abuse. Each level has a central place in the experience of working with sexual abuse survivors. Pack described the level of the individual counselor's responses; the level of the therapeutic relationship between the client and therapist and the resources needed to sustain them in the work; the organizational level; and the level of the societal discourses surrounding sexual violence, which influences the counseling profession as a whole through the intervention approach used to address vicarious traumatization in work with survivors of sexual violence from a practitioner perspective. Vicarious traumatization is the process of disruptive cognitive schemas transforming as a result of the worker's empathetic engagement with traumatic disclosures from clients (Pearlman & Saakvitne, 1995). Pack did not address the counselor's personal history of trauma and instead addressed organizational strategies to help inform practitioners about the risks of working with survivors of sexual violence and to build vicarious resilience among practitioners.

Sartor (2016) performed a quantitative study to evaluate how levels of vicarious trauma and high caseloads could influence a non-counseling mental health provider mental health professional's level of self-efficacy in trauma-counseling services. Efforts and work with traumatized clients can result in counselors entering a state termed "vicarious trauma," if left unmanaged. In turn, this may affect mental health professionals' self-efficacy or perceived ability to counsel clients. Vicarious traumatization affects counselors' decision-making judgment and is defined as changes to one's cognitive schemas and core belief systems. Sartor utilized a quantitative correlational design with mental health professionals (n = 82) to determine if the presence of vicarious trauma could affect their self-efficacy in working with traumatized clients. In this study, a multiple-regression analysis suggested a statistically significant negative correlation indicating that mental health professionals with higher levels of vicarious trauma had

lower levels of self-efficacy. The factors believed to contribute to vicarious traumatization included having a caseload with many traumatized clients. The author did not assess non-counseling mental health providers' personal histories of trauma yet recognized that the impact of vicarious trauma is based on variables such as past experience, training, education, personality, and existing self-care strategies.

Conversely, researchers have assessed the impact involving vicarious traumatization in they did not assess the counselor and non-counseling mental health provider's personal history of trauma related to the experience of other factors involving the assessment of Bowen's family systems theory in an exploration of counselors' vicarious traumatization (Halevi & Idisis, 2017), vicarious traumatization and burnout in professionals treating sex offenders (Kadambi & Truscott, 2003), vicarious traumatization experienced by mental health professionals in the post-Hurricane Katrina New Orleans region (Culver et al., 2011), wellness, exposure to trauma, vicarious traumatization in general (Foreman, 2003), therapeutic bonds, resilience to traumatic client experiences (Hunter, 2012), therapists' experiences of resilience and posttraumatic growth during the COVID-19 pandemic (Aafjes-van Doorn et al., 2021), the supervisory working alliance between two trainee characteristics (i.e., personal distress empathy and trait arousability) as predictors of vicarious traumatization of counseling trainees (Del Tosta et al., 2019), and the effects of supervision on the management of vicarious traumatization among telephone and online counselors (Furlonger & Taylor, 2013) The eight research studies identified vicarious traumatization as disruption to the counselor's and mental health professional's cognitive schemas about the self and others.

Halevi and Idisis (2017) performed a quantitative study using Bowen's family systems theory of intrapersonal differentiation of self to explain and predict vicarious traumatization

among therapists. The findings indicate therapists who are able to maintain a strong emotional balance between a sense of self and a sense of togetherness with others are less likely to experience vicarious traumatization. Vicarious traumatization is identified as the disruption in the cognitive schema about the therapist's self and others (Pearlman & Mac Ian, 1995). The quantitative methodology involved a sample of 134 individual and group therapists (20 male and 114 female) who worked in public and private clinics. Although the researchers did not assess the therapists' personal history of trauma, they identified that exposure to vicarious traumatization can lead to disruption of a therapist's cognitive schemas, leading to accompanying disturbances in thoughts, emotions, and memory systems. These findings suggest the importance of assessing a counselor's personal history of trauma and using coping skills to efficiently and accurately assess the predisposition of vicarious traumatization among counselors. Although the researchers did not assess the therapists' personal history of trauma, they identified that exposure to vicarious traumatization can lead to disruption of a therapist's cognitive schemas, leading to accompanying disturbances in thoughts, emotions, and memory systems. These findings suggest the importance of assessing a counselor's personal history of trauma and using coping skills to efficiently and accurately assess the predisposition of vicarious traumatization among counselors.

Kadambi and Truscott (2003) performed a quantitative research study on vicarious traumatization and burnout on 91 therapists (49 women and 42 men) working primarily with sex offenders. The findings are that therapists did not exhibit significantly higher degrees of vicarious traumatization as compared to a criterion reference group of mental health professionals. Vicarious traumatization is identified as the disruption in the cognitive schema about the sex offender provider's self and others (McCann & Pearlman, 1990). Therapists who

reported having a venue to address the personal impact of their clinical work were more likely to score lower on the measure of vicarious traumatization than those who did not. Other variables theorized to be related to vicarious traumatization were not found to be related or supported by scores on the measure assessing vicarious traumatization. Twenty-four percent of the therapists had a moderate to severe stress response to their work with the sex offenders, and 23% of the sample scored in the high range on the emotional exhaustion and depersonalization subscales as examples of professional burnout. Consequently, despite the strong positive correlations among measures of vicarious traumatization and burnout were also found, the findings call attention to the need to address the appropriateness of generalizing the phenomenon to sex-offender treatment providers. Moreover, the researchers did not assess sex-offender treatment providers' personal history of trauma, which could provide insight into the impact of the clinical work and requires a better understanding of the factors associated with professional burnout.

According to Culver et al. (2011), mental health professionals in a variety of work settings regularly encounter clients who are trauma victims. This secondary exposure to trauma often results in the non-counseling mental health providers as mental health professionals experiencing the effects of trauma themselves, known as vicarious traumatization. The results of this study showed mental health professionals who worked with trauma victims reported many adverse psychological symptoms that included anxiety, suspiciousness, and increased feelings of vulnerability. These mental health professionals also reported that their sense of personal safety as well as their frame of reference were disrupted due to working with trauma victims. Overall, a significant association or correlation was found between the mental health professionals working with trauma clients and their individual level of vicarious traumatization. Vicarious traumatization is identified as the disruption in the cognitive schema about the mental health

professional's self and others (McCann & Pearlman, 1990). The research methodology utilized a quantitative and qualitative mixed-method study that explored vicarious traumatization experienced by mental health professionals in the post-Hurricane Katrina New Orleans region. The researchers did not assess the mental health professional's personal history of trauma, which could be helpful in understanding the impact of vicarious traumatization as it pertains to clinical work with mental health professionals who have experienced natural disasters.

According to Foreman (2018), vicarious traumatization can leave counselors with disrupted cognitive schemas about themselves and how they view the world. With the increased number of traumatized clients seeking counseling, counselors are at a greater risk for developing vicarious traumatization and becoming negatively affected. With the use of a quantitative methods approach, the researchers examined how exposure to client trauma experiences impacted 68 counselors' (80.9% self-identified as female, and 19.1% self-identified as male) wellness and how exposure to client trauma, along with wellness, influenced vicarious traumatization. Vicarious traumatization is identified the disruption in the cognitive schema about the mental health professional's self and others (McCann & Pearlman, 1990). The results indicated that counselors with higher levels of wellness exhibited significantly lower levels of vicarious traumatization when exposed to clients' trauma. The methodology involved participants with an average of 12.9 years of experience, and most of their clients reported a trauma history. A sufficiently high level of counselor wellness has been described as helpful in managing the effects of working with clients who have experienced trauma and mitigating impairment. Despite the study not assessing the counselor's personal history of trauma, future research should be directed at understanding how that trauma could increase awareness of how wellness impacts vicarious traumatization.

Hunter (2012) recognized the therapeutic bond is central to effective therapy, although few studies have examined therapists' experience of this therapeutic bond. The findings of the qualitative study showed walking in sacred spaces with the client was seen as both enriching and challenging for the therapist. The therapeutic bond gave therapists intense satisfaction and posed risks for them, especially when working with traumatic client experiences. However, the findings suggest that the experience of compassion satisfaction and the development of vicarious resilience counterbalanced the intense difficulty of bearing witness to clients' traumatization and the potential to be affected by the vicarious traumatization. Vicarious traumatization is the disruption in the cognitive schema about the therapist's self and others (Pearlman & Mac Ian, 1995). The researchers utilized a qualitative study design to examine the experiences of couple and family therapists in relation to their perceptions of the satisfactions and risks involved in the therapeutic bond. The research was conducted using grounded theory methodology, and eight in-depth interviews (one male and seven female) were conducted with therapists working in five counseling agencies. Therapists described the importance of the three component parts of the therapeutic bond: the empathic connection between therapist and client, the role of investment in the client, and the mutual affirmation experienced by both therapist and client in the therapeutic process. The study did not assess the therapist's personal history of trauma, which could lead to understanding the impact of the negative aspects of workplace factors associated with trauma work regarding the experience of the therapeutic bond.

Aafjes-van Doorn et al. (2021) performed an empirical study to examine therapists' experiences of resilience and posttraumatic growth during the COVID-19 pandemic.

The researchers found that therapists experienced moderate levels of professional self-doubt, more than before the pandemic, and this self-doubt decreased over time, thus showing a resilient

trajectory. The therapists reported resilience during the initial months of the COVID-19 pandemic. Therapists who were relatively more impacted by trauma and more comfortable in their online work during the pandemic experienced more posttraumatic growth. For the study vicarious traumatization is identified as the disruption in the cognitive schema about the therapist's self and others (McCann & Pearlman, 1990). The methodology, a longitudinal study, allowed the researchers to examine the self-reported resilience and posttraumatic growth of 185 (146 female and 39 male) psychotherapists across four time points during the COVID-19 pandemic. Moreover, the research did not assess the therapist's personal history of trauma in addressing the impact of attitudes about performing video therapy since the onset of the COVID-19 pandemic.

Del Tosta et al. (2019) performed a quantitative study of the moderating effects of the supervisory working alliance on two trainee characteristics (i.e., personal distress empathy and trait arousability) as predictors of vicarious traumatization of counseling trainees.
The findings are that as counselor trainee perception of the strength of the working alliance with their current supervisor increased, negative thoughts about self and others decreased.
The researchers identified that a supervisory working alliance does not appear to reduce the association between overall higher personal distress empathy and higher vicarious traumatization. In addition, the researchers found supervision could encourage the use of empathy skills in the context of maintaining personal and professional boundaries. The sample of 206 predominately counseling trainees, the supervisory working alliance did not moderate the relation of personal distress empathy or trait arousability with vicarious traumatization.
The researchers' study did not assess the therapist trainee's personal history of trauma and the perception of the supervisory working alliance that could mitigate vicarious traumatization.

Furlonger and Taylor (2013) utilized a mixed-method analysis and investigated the effects of supervision on the management of vicarious traumatization among telephone and online counselors for a 24-hour national counseling service for young people aged 5–25 as well as a counseling service for parents. The findings from 38 supervised telephone and online counselors showed vicarious traumatization fell within normal limits and the use of positive coping strategies was above average. The size of counselors' trauma-client caseloads proved to be strongly related to both vicarious traumatization and negative coping style. For the study vicarious traumatization is identified as the disruption in the cognitive schema about the online counselor's self and others (McCann & Pearlman, 1990). The study involved counselors who conducted 50,979 counselling sessions in 2008, of which 38,703 were completed over the telephone and 12,276 online. Thirty-eight counselors (13 male and 25 female), of whom approximately 44% were involved with trauma clients, experienced the effect of being at risk of suffering some level of vicarious traumatization. The researchers did not assess the counselor's personal history of trauma to examine the effects of vicarious traumatization of telephone counseling and the impact of supervision.

Five research studies considered vicarious traumatization; three assessed counselors' personal trauma histories, and two did not. Jenkins and Baird (2002), Pearlman and Mac Ian (1995), and Schauben and Frazier (1995) assessed counselors' personal trauma histories. Baird and Jenkins (2003) and Iliffe and Steed (2000) did not assess counselors' personal trauma histories. Researchers have found that counselors with personal trauma histories were more likely to experience vicarious traumatization (Jenkins & Baird, 2002; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995).

In their quantitative study, Jenkins and Baird (2002) examined the symptoms of vicarious traumatization (VT), compassion fatigue, secondary traumatic stress (STS), and burnout associated with post-traumatic stress disorder (PTSD) involving sexual assault and domestic violence present in counselors working with trauma survivors. The researchers identified 55% of counselors for victims of sexual assault and domestic violence as having a history of trauma.

The researchers identified a moderate overlap with burnout, STS, CF and VT due to similarities. Counselors who reported a personal trauma history have increased levels of the symptoms of STS described as psychological distress that mirrors post-traumatic stress responses of intrusion, avoidance, and arousal symptoms VT is identified predominantly as disruptions to cognitive schemas regarding the self and safety, trust, esteem, control, and intimacy. The methodology of the quantitative study of the Jenkins and Baird (2002) involved 99 counselors—95 female and 4 male—who worked with victims of domestic violence and sexual assault

Counselors who have personal trauma histories and who treat trauma survivors share the vicarious traumatization effects that involve disrupted cognitive schemas (Pearlman & Mac Ian, 1995). The researchers' quantitative methodology included questionnaires completed by 188 counselors to detail their exposure to survivor clients' trauma material, as well as their own psychological well-being and the medical symptoms of psychological difficulties. Primarily, the researchers identified that counselors with personal trauma histories reported symptoms of vicarious traumatization, specifically increased disrupted cognitive schemas about themselves or their clients, than did those counselors who did not report trauma histories.

Secondly, Pearlman and Mac (1995) identified that counselors with less longevity and supervision in the profession were more likely to report symptoms of vicarious traumatization, which they identified as disrupted cognitive schemas (about themselves or their clients), than

those counselors who did not report a trauma history. Thirdly, the researchers identified that performing trauma work effected those without personal trauma histories in relation to other-esteem (i.e., the belief that others are valuable). The researchers advised that future research should classify symptoms of vicarious traumatization as a risk factor.

Schauben and Frazier's (1995) research did not substantiate that counselors with personal victimization histories had more vicarious trauma than those counselors who had trauma-client workloads did. The researchers researched how vicarious traumatization was a consequence of providing trauma counseling. In their qualitative and quantitative study, the researchers assessed the counselors' psychological functioning, work-related vicarious traumatization, and personal trauma histories in relation to the extent of their work with sexual violence victims. The researchers performed their research with 148 female counselors (comprised of 118 psychologists and 30 sexual violence counselors). The qualitative and quantitative methodology involved the participants completing questionnaires; 70% of the counselors (psychologists) and more than 80% of the counselors reported personal trauma histories. Counselors who had higher percentages of survivors in their caseloads reported more disrupted beliefs involving negative other-esteem; thus, the trauma work-related stress did not relate to the counselors' own victimization histories.

In contrast to Jenkins and Baird (2002), Pearlman and Mac Ian (1995), Schauben and Frazier (1995), Baird and Jenkins (2003), and Iliffe and Steed (2000) did not assess the domestic violence counselors' personal trauma histories and identified that vicarious traumatization symptoms impacted these counselors, regardless of the counselors' personal trauma histories. Baird and Jenkins performed a quantitative study with a sample of 101 (96 females and four males) participants comprised of 35 counselors (sexual assault counselors), 17 were counselors

(domestic violence counselors), and 49 dual role employees for the sexual assault and domestic violence agency. The researchers identified sexual assault and domestic violence counselors who had more education and saw more clients reported fewer vicarious traumatization symptoms. Younger or less experienced sexual assault and domestic violence counselors reported more emotional exhaustion because of working with trauma victims.

Similarly, Iliffe and Steed (2000) assessed work-related vicarious traumatization symptoms in domestic violence counselors and service providers who worked with victims of domestic violence. They identified that the long-term effects of trauma impact physical health, including emotional and physical exhaustion, feelings of hopelessness, and viewing others in a negative way. The researchers performed a qualitative study examining 18 (13 female and five male) domestic violence counselors who treated female victims of domestic violence without assessing whether the counselors had personal trauma histories. Moreover, the counselors and providers' vicarious traumatization symptoms were a result of hearing the clients' traumatic experiences. The impact of vicarious traumatization symptoms resulted in counselors and service providers identifying decreased confidence, increased responsibility for clients, and challenges to remain respectful toward clients' decisions and the perpetrators. The vicarious traumatization symptoms also extended to changes in cognitive schemas related to safety, worldview, and gender power issues.

Effects of Countertransference and Management of Countertransference

The management of personal reactions is the ability of a counselor to reduce or minimize. the negative impact of personal reactions. Researchers have assessed the management of personal reactions based on counselor's behaviors and outcomes (Cartwright & Read, 2011; Fatter & Hayes, 2013; Hayes et al., 2018; Jiyoung & Gabsook, 2013; Metcalf, 2003; Pakdaman,

2015; Williams et al., 2003a; Williams et al., 2003b). Some researchers have proposed that countertransference management involves the five attributes of self-insight, conceptualizing skills, empathy, self-integration, and anxiety management skills (Hayes et al. 1991; Hayes et al., 1997, and Van Wagoner et al (1991). Conversely, mental health professionals have provided fundamental recommendations for counselors to manage the stress of being a trauma provider with specific behavioral activities and self-care (Barnett & Cooper, 2009; Coster & Schwebel, 1997; Meichenbaum, 1994).

Latts and Gelso (1995) performed a quantitative study to examine personal reaction management among 47 counselors (14 males and 33 females) working with survivors of sexual assault. Male counselors exhibited more avoidant responses toward clients than female counselors did, and female counselors exhibited more empathy than male counselors did. The researchers utilized a two-step model of countertransference management. The two-step model teaches an awareness of the counselor's countertransference behaviors and then suggests a theoretical framework to decrease the level of behavior. They found that counselors who used a theoretical framework facilitated personal reaction management.

Robbins and Jolkovski (1987) suggested that counselors who are open to their personal reaction feelings were more likely to manage their personal reactions before they manifested into behavior. The research paradigms of Hayes et al. (1991), Hayes et al., (1997), and Van Wagoner et al. (1991) are the basis for the counselor qualities that facilitate person reaction management. Hayes et al. (1991) utilized the Countertransference Factors Inventory (CFI), a 50-item, five-point Likert instrument to measure the five counselor qualities theorized to help counselors with their personal-reaction management. They surveyed 33 counselors regarding the five factors of self-insight, integration, empathy, anxiety management, and conceptualizing ability. Although all

five qualities were important, the counselors rated self-integration and self-insight as the most significant qualities in managing personal reactions.

Van Wagoner et al. (1991) also utilized the CFI to measure the five counselor qualities. A sample of 122 experienced counselors rated selected counselors as having excellent qualities as compared to other counselors. Excellent-rated counselors had more insight into their feelings and bases for their feelings; greater capacity for empathy to intellectually understand their clients' emotions; greater ability to differentiate the clients' needs from their own; less anxiety with clients during the sessions; and better conceptualization within the context of the client dynamics, therapeutic relationship, and the client's past (p. 418). Counselors perceived as having excellent qualities are likely to have a theoretical framework to facilitate personal-reaction management.

Hayes et al. (1997) utilized the CFI to determine how personal reaction management impacts the therapy outcome. Their study included 20 cases of therapy conducted by doctoral counseling psychology students. The doctoral students' former clinical supervisors rated their personal-reaction management (i.e., self-insight, anxiety management, empathy, and self-integration) on the CFI, and their current supervisors observed therapy sessions and rated personal-reaction behavior. Former supervisors rated the doctoral students as having qualities of empathy and self-integration to facilitate personal-reaction management. Conversely, in the majority of cases, the observed personal-reaction behavior did not relate to the therapy outcome.

Subsequent research has shown support for the five qualities of personal-reaction management. Rosenberger and Hayes (2002) found that counselors' self-reported personal-reaction management was quite strong across sessions, indicating that personal-reaction management can play a small role, perhaps fostering therapeutic alliance. Strong working

alliances could consistently endure low levels of personal reactions in the form of behavior. Other researchers indicated that the counselors' theoretical skills positively associated with personal-reaction management. Personal-reaction management associated with positive treatment outcomes, as rated by counselors' supervisors (Gelso et al., 2002). Robbins and Jolkovski (1987) found that a two-step model, in which the counselor became aware of their personal feelings and then theoretically or cognitively interpreted those feelings, supported personal-reaction management.

Furthermore, Gelso and Hayes (2007) provided a more detailed discussion about the five counselor qualities theorized to help with personal-reaction management. The first factor, self-insight, involves the counselors' awareness of their personal feelings and the basis for their feelings. Self-insight is particularly essential for counselors because their understanding of clients is limited to the extent to which the counselors understand themselves. Therapy is a naturally subjective experience, and it requires the counselors' familiarity with their internal processes. Self-insight is an extremely difficult process; however, the discomfort of unpleasant experiences can serve an opportunity for insight. A counselor should value and seek self-insight to manage his or her personal reactions through reflection. Counselor self-insight as a critical component of personal-reaction management (Gelso et al., 1995, 2002; Hayes et al., 1997). However, one study found that counselors' self-ratings of their self-insights did not relate to their supervisors' ratings (Hayes et al.). Gelso and Hayes discussed that counselors' self-insights might have limited significance with their awareness.

The second factor, self-integration, refers to the counselor's ability to maintain effective therapeutic boundaries. Counselors are less likely to experience problematic personal reactions if they experience fewer internal conflicts. Self-integration involves the counselor's intact character

to effectively maintain the therapeutic boundaries. Counselors who possessed qualities of self-integration were less likely to exhibit personal-reaction behavior (Gelso et al., 1995; Hayes et al., 1997; Rosenberger & Hayes, 2002).

The third factor, empathy, is recognized as the counselors' ability to view the world as the client does and to convey that understanding, as well as the ability to reflect a client's emotions (Hayes et al. (1997; Rogers, 1957, 1980; Sultan, 2020; Van Wagoner et al., 1991). The fourth factor, anxiety management, involves the counselor's ability to recognize, tolerate, and learn from anxiety. Anxiety is a critical component of personal reaction because it is an element of avoidant behavior. Personal reactions management involved the counselor's self-integration and anxiety management. A number of studies have found that anxiety is a predictor of personal reactions (Gelso et al., 1995; Hayes & Gelso, 1991, 1993; Hayes et al., 1998; Yulis & Kiesler, 1968). Counselors who managed their anxiety were less likely to have their internal conflicts or vulnerabilities triggered (Fauth & Williams, 2005; Gelso et al.; Gelso et al. 2002; Hayes & Gelso; Hayes et al., 1997; Yulis & Kiesler). A counselor's ability to manage their anxiety decreased their personal reaction-based anxiety. Anxiety management is about managing anxiety so that it does not negatively impact the therapeutic relationship. Anxiety is usually a factor of avoidant behaviors. Freud (1959) suggested that anxiety was a primary motivator for much of an individual's behavior. Existential theory holds that anxiety is the threat of absence, nothingness, or a general all-encompassing dread of an uncertain threat. The general message that anxiety delivers is that one is experiencing fear, panic, or doom.

The fifth factor, the ability to conceptualize, involves the counselor's ability to process stressful emotions cognitively, to draw on the theoretical framework, and to understand the patient's dynamics in terms of the therapeutic relationship (Hayes et al. 1991; Hayes et al. 1997;

Van Wagoner et al. 1991). Conceptualization ability involves understanding the clients within the therapeutic relationship. Self-insight involves becoming aware and understanding the sources of personal reactions. Self-integration involves effectively managing internal conflicts.

Conversely, researchers have examined various factors different from those proposed by Hayes et al. (1991), Hayes et al. (1997), and Van Wagoner et al.'s (1991) that facilitate person-reaction management for counselors (comprised of art therapists, counselor trainees, psychologists, psychotherapists, therapist trainees, and supervisors). These factors involve a five-step method to facilitate the therapeutic understanding and management of personal reactions (Cartwright & Read, 2011); therapists' meditation, mindfulness, and self-differentiation to facilitate the management of personal reactions (Fatter & Hayes, 2013); meta-analyses of how reactions based on unresolved personal conflicts affect patient outcomes and how these reactions can be managed effectively (Hayes et al., 2018); commonalities between narcissistic personality traits, interpersonal relationship tendencies, and the ability to cope with personal reactions (Jiyoung & Gabsook, 2013); personal reaction management among play therapists; (Metcalf, 2003); personal reactions management to determine the effects of a supervisory alliance on trainees' self-reported comfort and likelihood of personal reactions disclosure (Pakdaman, 2015); strategies for managing personal reactions and the methods by which counselor trainees' mindfulness and psychological flexibility are positively associated with counseling self-efficacy (Williams et al., 2003a), and novice and experienced therapists' experiences of and strategies for managing distracting self-awareness (Williams et al., 2003b).

Cartwright and Read (2011) performed a qualitative study based on a five-step method designed to facilitate the therapeutic understanding and management of personal reactions. The qualitative data analysis demonstrated an improved understanding of personal reactions by the

end of the training course, along with the participants' abilities to manage their personal reactions using the strategies. The methodology involved 28 psychologists (26 female and 2 male). The five steps of the researchers' program proved useful as strategies for the participants to manage their personal reactions. The five steps for therapists are to (a) monitor and be aware of cognitive, affective, and physical sensations related to the client; (b) recognize one's own reaction to the client's experiences; (c) theorize about the interpersonal processes occurring between therapist and client; (d) utilize a calming strategy to manage reactions and utilize imagining and coaching by shifting out of the personal reaction to respond as a therapist, and (e) retain one's initial personal reaction for later reflection on the clinical value in working with the client. The authors discussed the implication that the instinct to address the management of countertransference yields caution on the impact of therapeutic emphasis on subjective countertransference rather than on the therapeutic relationship.

In their quantitative research study on personal reactions management, Fatter and Hayes (2013) studied 92 therapist trainees (60 female, 30 male, and 2 transgender) and their 78 (53 female and 25 male) supervisors, who rated the trainees' personal reactions management qualities of mindfulness, differentiation of self, and personal reactions. The purpose of their study was to examine the roles that therapists' meditation, mindfulness, and self-differentiation might play in helping them develop qualities to facilitate the management of personal reactions. Both the longevity of a meditation experience and the nonreactive component of mindfulness facilitated better personal reactions management. The authors found that mindfulness, self-differentiation, and meditation help counselors with their personal reactions management abilities.

In their review of the history and definition of personal reactions and their empirical research on personal reactions, the management of personal reactions, and the relationship between both psychotherapy outcomes, Hayes et al. (2018) presented three meta-analyses studying how psychotherapists' reactions based on their unresolved personal conflicts affect patient outcomes and how these reactions can be managed effectively. The first meta-analysis indicated that personal reactions are related inversely and modestly to psychotherapy outcomes regarding working alliance, session depth, session smoothness, and client improvement, $r = .16$, $p = -.02$, 95 CI [.30, .03], $d = -0.33$, $k = 14$ studies, $N = 97$. A second meta-analysis supported the notion that personal reactions management factors attenuate personal reactions, $r = -.27$, $p = -.001$, 95% CI [.43, .10], $d = -0.55$, $k = 13$ studies, $N = 1{,}065$. The final meta-analysis revealed that better or improved personal reactions management is related to positive or better therapy outcomes, $r = .39$, $p = .001$, 95% CI [.17, .60], $d = -0.84$, $k = 9$ studies, $N = 392$ participants. Hayes et al. found that personal reactions are typically harmful, though not necessarily irreparably so, and that personal reactions management typically proves beneficial to patient outcomes.

In their quantitative personal reactions management research, Jiyoung and Gabsook (2013) studied 181 art therapists (172 female and 9 male) to find commonalities between narcissistic personality traits, interpersonal relationship tendencies, and the ability to cope with personal reactions. The findings indicated the art therapists who possessed a high drive for achievement, research, demonstration, and dominance had more negative personal reactions. The art therapists who rated higher on the defiant–distrusting generally lacked the ability to deal with personal reactions. Conversely, the art therapists who rated higher on managing personal reactions also rated higher in self-sufficiency, lower on dominant–superior, and lower on

defiant–distrusting. The authors suggested that art therapists who possess a positive self-image and are independent and responsible in their interpersonal relations have the ability to manage their personal reactions.

In a quantitative research study on personal reactions management, Pakdaman (2015) studied 331 counselor trainees (268 females and 60 males and 3 who identified as other, transgender, intersex, or androgynous) to determine the effects of a supervisory alliance on the trainees' self-reported comfort and likelihood of personal reactions disclosure. They found positive associations between the supervisory alliance and the respondents' reported comfort and likelihood of personal reactions disclosures. The researchers' results indicated the importance of the relationship between a working alliance and personal reactions disclosure as a critical component in supervision and in the development of clinical competence in counselor trainees.

Williams et al. (2003a) performed a quantitative study of 301 counselor trainees to identify the ways counselors assess their strategies for managing personal reactions and the strategies by which counselor trainees' mindfulness and psychological flexibility are positively associated with counseling self-efficacy. The results indicated two subscales for hindering self-awareness (i.e., Anxiety and Distraction scales) and five subscales of management strategies (Self-Care, Relaxation, Returning to Focusing on the Client, Suppression, and Returning to Use of Basic Techniques). In other words, the principal components involved using multiple strategies such as practicing self-reflection (processing reactions after the session); focusing on self-care (e.g., nutrition, sleep, and exercise); seeking supervision or consultation; working on personal issues in personal therapy; preparing before sessions (e.g., centering oneself or clearing one's head); trying to understand one's self-awareness and to use it to understand one's client; performing relaxation techniques (e.g., deep-breathing techniques); employing self-coaching or

positive self-talk; taking a break or time-out; using thought-stopping techniques; and using basic techniques (e.g., open-ended questions, reflection, and paraphrasing) to manage the counselors' personal reactions.

In their qualitative personal reactions management research to identify counselors' experiences of and strategies for managing personal reactions, Williams et al. (2003b) studied novice and experienced therapists' experiences of and strategies for managing distracting self-awareness. They found that the novice counselors were more aware of their anxiety and negative self-talk, whereas the experienced counselors were more aware of boredom and outside distractions. Specifically, the experienced counselors managed distracting self-awareness in sessions. It was common for both the novice and experienced counselors to use self-coaching, focus on the client, and utilize basic techniques such as asking open-ended questions and seeking outside consultation. In addition, although the experienced counselors were able to manage distracting self-awareness through self-coaching and refocusing on the client, the novice therapists specifically mentioned managing problematic self-awareness through self-disclosure. In contrast, the experienced therapists tended to manage problematic self-awareness by using thought-stopping techniques. Furthermore, the experienced counselors typically relied on taking a break (e.g., pausing for a long time or even leaving the room), including using their personal therapy, as a way to help themselves manage their personal reactions. The study participants were six novice (three male and three female) counselors (aged 22–42) and six experienced (three male and three females) counselors (aged 35–60). The results provide new avenues for examining the personal reactions counselors experience in their sessions when researching the effectiveness of various management strategies.

Considering the focused attention of personal reactions management, the noted specific behavioral activities for counselors to manage their personal reactions are parallel to Meichenbaum's (1994) encouragement for counselors to engage in personal, professional, and organizational activities to manage their emotional and personal distress from working with trauma survivors. He (1994) suggested ways for counselors to manage distress in working with trauma survivors. First, counselors should recognize that vicarious traumatization most likely occurs when health care persons work with trauma clients. The second suggestion was for counselors to engage in personal, professional, and organizational activities.

Next involves Meichenbaum's (1994) recommended eight personal interventions to manage the stress of vicarious exposure. First, the counselor should recognize and increase the self-awareness of the emotional, cognitive, and physical signs of incipient stress reactions within oneself and colleagues. Second, counselors should not limit their clinical practices to trauma clients. Third, counselors should monitor and limit caseloads in terms of size and number of trauma cases.

Michenbaum's (1994) fourth personal intervention noted that counselors should engage in self-care behaviors (i.e., relaxation activities and/or exercise). Barnett and Cooper (2009) recommended counselors to perform continuing practices of self-care. Coster and Schwebel (1997) described self-care as the "enduring quality in one's professional functioning over time in the face of professional and personal stressors" (p. 5). Smith and Moss (2009) emphasized the need for counselors to confront signs of distress, burnout, and impaired professional competence actively with preventative and self-care techniques. Counselors who participate in self-care fulfill a component of their ethical responsibilities. The American Counseling Association (ACA, 2021) makes very clear the need for counselors to "engage in self-care activities to maintain and

promote their emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities" (p. 8). Section A.4 included avoiding harm and imposing values; counselors also must "act to avoid harming their clients … [and] minimize or … remedy unavoidable or unanticipated harm" (p. 4). According to Norcross and Barnett (2008), the ethical standards show that self-care is a necessity to avoid negative outcomes and is a prerequisite for competent care.

Meichenbaum's (1994) fifth personal intervention noted the counselor should recognize that he or she is not alone in facing the stress of working with traumatized clients. Sixth, counselors should engage in healing activities that renew the meaning of life in and out of the therapeutic setting, as well as ensuring physical and mental well-being. Seventh, the counselors should adopt a philosophy or religious outlook to remind themselves that they cannot take responsibility for the client's healing and to recognize limitations. Finally, a counselor should share the stress reaction with the client to foster the therapeutic alliance, emphasizing the counselor's empathy and humanity.

Meichenbaum (1994) recommended four professional interventions to manage stress from vicarious exposure. First, counselors should maintain collegial on-the-job support to limit the sense of isolation. This includes seeking consultation and supervision. Second, counselors should undergo debriefings with other counselors to explore emotions and experiences and to identify the traumatic events their clients experienced. Third, counselors who have their own histories of trauma should adopt time-limited group approaches to assist with their memories and emotions that treatments evoke. Finally, the counselor should develop and maintain knowledge, skills, and abilities to work with a trauma-based population.

Meichenbaum (1994) recommended three organizational interventions to manage the stress of vicarious exposure. First, counselors should perform social justice and advocacy work for victims at the local, organizational, or national level. Counselors should encourage and advocate for legislative reform efforts and social actions for clients. Second, counselors should encourage the local, state, and national organizations to educate professionals and nonprofessionals about trauma populations. Counselors should engage in endorsement of prevention activities (i.e., speaking at community events and distributing educational materials). Third, counselors should join a professional network for social support. A counselor can obtain enhanced knowledge and maintain collaborative efforts with other professionals who work with populations suffering from traumatic experiences.

In consideration of the behavioral strategies and the character qualities, another aspect of personal-reaction management is the prevention of adverse effects from personal reactions. Gelso and Hayes (2007) found that, to prevent negative consequences from personal reactions, counselors should stop seeing clients or transcend their personal reactions. Although counselors can believe they are self-actualized, the lack self-awareness and the knowledge about the impact of personal reactions increases any vulnerability. For those counselors who experience infrequent, chronic personal reactions, they could pursue alternative careers; alternatively, counselors could choose to not see specific kinds of patients until, perhaps, they have sufficiently resolved the basis for their personal reactions. On the other hand, the decision to stop seeing clients could be involuntary. Personal reactions might be the reason for the unethical behavior that resulted in counselors having their licenses suspended or revoked.

The overview of personal-reaction management has covered the specific qualities, as well as behavioral and prevention strategies. The process of personal-reaction management also

involves strategies to remediate the negative effects of personal reactions. Furthermore, Gelso and Hayes (2007) considered the remediation of the negative effects of personal reactions as part of personal-reaction management. They (2007) highlighted the results of Baehr's (2004) qualitative study of factors that help remediate the negative effects of personal reactions. Baehr found that personal and professional relationships were important to counselors and served a number of functions. These relationships served as containers for counselors' emotional reactions toward clients, facilitated a deeper understanding of the counselors' personal reactions toward clients, and trusted others could serve as sounding boards and feedback sources for counselors as they sorted through difficult and confusing reactions toward clients. Colleagues and loved ones helped counselors make connections between their personal reactions and personal histories, their needs, interpersonal tendencies, client–counselor similarities, similarities between clients and significant others in counselors' lives, and a variety of patient factors. Close relationships could provide unconditional support to the counselors, who then could internalize and offer the same to their clients.

Summary

The present heuristic phenomenological-based research design study describes and explains how experienced domestic violence counselors manage their personal reactions toward clients who are victims of domestic violence to help me better understand my own personal reactions as an experienced domestic violence counselor. The Chapter II provided the literature review. The Chapter III discussed the research methodology. The Chapter IV included the bracketing of bias and assumptions of the researcher. The Chapter V provided the results of the heuristic phenomenological-based research design, and the Chapter VI concluded with the summary, implications, and recommendations.

Chapter III

Methods

Heuristic Research Design

In the contextual sense, this heuristic-based, qualitative, phenomenological study follows Moustakas's (1990) heuristic phenomenological-based research paradigm whereby the researcher attempts to understand the intensity and complexity of a personal experience that could not be well understood. The essence of the heuristic research design is that the researcher is in a process of self-discovery that is actually a heuristic inquiry. First, the focus that is emphasized is the researcher's internal frame of reference, self-searching, intuition, and indwelling (p. 12). The seven processes involved in the researcher's journey to arrive at a deeper understanding of the central question through heuristic inquiry that is demonstrated with the six phases of the heuristic research design. The seven processes as the identification with the focus of inquiry, self-dialogue, tacit knowing, intuition, indwelling, focusing, and internal frame of reference paired with six phases of the heuristic research design of initial engagement, immersion, incubation, illumination, explication, and culmination of the findings in a creative synthesis.

Seven Processes of Heuristic Research Design

Focus of Inquiry

The first process is the identification of the focus of inquiry, which is when a researcher has experienced what is identified as the component being researched (Moustakas, 1990). The identification of the focus of inquiry in a heuristic study is an autobiographical connection to the primary researcher. The identification of the focus of inquiry involves the primary researcher

immersing the self in the exploration to understand the self and others by orientating and interacting while performing the research (Sultan, 2020).

Self-Dialogue

The second process is self-dialogue, in which the researcher enters a dialogue with the phenomenon being studied (Moustakas, 1990). The researcher performs a search of the self through personal and subjective tacit knowledge that is based on the individual researcher. Self-dialogue involves the researcher oscillating from concept to experience, from part to whole, from individual to universal and back, communicating with the self and the phenomenon under heuristic inquiry (Sultan, 2020). Ultimately, self-dialogue brings the researcher face-to-face with the self. The primary purpose of self-dialogue is for the researcher to attain a holistic comprehension of the phenomenon between self-exploration and self-disclosure with the core purpose of determining the focus of the inquiry.

Tacit Knowing

The third process is the tacit knowing that is the foundation of the discovery of heuristic inquiry (Moustakas, 1990). Tacit knowledge is a deep structure that involves the unique perceptions, intuitions, beliefs, and judgements of the internal frame of reference of an individual that governs behaviors and interpretations of an experience. Tacit knowledge is known as the universal experience of the known and unknown or direct or implicit that provides a process of making meaning out of the research process to understand deeply based on knowledge or comprehension (Sultan 2020). Tacit knowledge is information that could be presented and understood as vague and ambiguous but that allows the same concept to be become clear and concise to implement in the process of knowing reality.

Intuition

The fourth process is intuition, which is the essential feature of seeking knowledge that bridges the explicit and tacit, allowing the increase of awareness and understanding (Moustakas, 1990). The intuitive process involves testing the process of both logic and reasoning combined with perception and observation (Sultan, 2020). The intuition process is an act of subjective and objective experience, observation, and perception that emphasizes the dimension of heuristic inquiry (Sultan, 2020). Intuition is commonly known as an existential and humanistic dimension of heuristic inquiry that allows an integration of guidance to understand encounters as patterns and themes and the creation of new knowledge.

Indwelling

The fifth process involves indwelling, which allows a holistic and deeper understanding of a particular facet of human experience with the aim of comprehending it (Moustakas, 1990). Indwelling involves the dialogue and relational interaction between the researcher and co-researchers. The process of indwelling involves the tacit and intuitive as well as explicit dimensions of a human experience by exploring every nuance of it (Sultan, 2020). The subject of an observation is felt and experienced as an entity that is as much a part of our world as we are of its or theirs. The concept of indwelling is how the reality and meaning being cocreated.

Focusing

The sixth process involves focusing, in which the researcher clears an inner space wherein thoughts and feelings are needed to clarify a question or its constituents or to make contact with and illuminate core themes that could arise (Moustakas, 1990). To avoid blurring understanding, focusing allows the heuristic researcher to declutter their inner world by opening a space for elements of an experience to surface (Sultan 2020). Focusing attunes the researcher's

senses, feelings, and thoughts to facilitate movement through the research process. Focusing is an inward experience that is transformative within the researcher to gain knowledge and grow with a felt sense rather than truth imposed by another.

Internal Frame of Reference

The seventh process involves the internal frame of reference that requires the researcher to comprehend his or her experience deeply (Moustakas, 1990). The internal frame of reference serves as the catalyst for the various processes of heuristic inquiry as I return, again and again, to seek an internal and deeper understanding of my perceptions, feelings, thoughts, decisions, and actions (Sultan, 2020). The emphasis is on the importance of maintaining a balance of being attuned to being a researcher and to the empathy, trust, and intersubjective experience that unfolds between the researcher and co-researcher. The integrity of the study is enhanced when the nature of the methodology is "we-orientated".

Six Phases of Heuristic Data Research Design

The heuristic research design is a subjective journey a researcher employs through successive stages of deeper understanding that results in a full description of the experience that has been studied. With that purpose in mind, Moustakas (1990) developed six phases of the heuristic process: initial engagement, immersion, incubation, illumination, explication, and culmination of the findings in a creative synthesis.

Initial Engagement

The initial engagement is the first phase of the heuristic phenomenological-based research design wherein I identified a research question that is personally meaningful. According to Moustakas (1990), initial engagement focuses on the research question related to the primary researcher's self-searching process. Initial engagement is when a climate of freedom and trust is

created, and the core theme or problem is determined. Sultan (2020) described initial engagement as an internal exploration to develop the tacit knowledge and awareness that facilitates the development of the research question. The initial engagement involves the researcher engaging in the topic in a numerous way, such as by reading research on trauma and domestic violence. The process also involves the researcher's interactions with other health care professionals and counselors and participated in conversations that helped with the comprehension of trauma and domestic violence. These experiences have the potential to confirming a successful approach in addressing the primary traumatization, which is known as the period of immersion in heuristic phenomenological-based research.

Immersion

Immersion is the second phase in heuristic phenomenological-based research involving living the question and seeking all opportunities to connect with it (Moustakas, 1990). The second phase of immersion involves a complete, intense focus of the topic being studied involving one's experience by looking within the experience rather than at it. Immersion is the complete immersion into a person's world without judgment to understand the nature of the problem as well as the texture, tone, mood, range and content. This means the researcher immerses the self into the other person's world to understand their human presence completely. As part of the immersion process, I performed research interviews with the eight co-researchers. The immersion process also involved the examination of the interview transcriptions, audio recordings of interviews, and field notes to gain an understanding of the co-researchers' experiences. I read and reread the transcripts of field notes of the eight co-researchers to understand their experiences as a whole and the sum of its parts. The process of immersion

resembled the ebb and flow of life intermixed with the challenges of being questioned about successfully addressing my primary traumatization.

Incubation

The third phase, known as incubation, requires that I detach from the topic by retreating from the intense and concentrated focus on the question (Moustakas, 1990). In summary, this is a timely and appropriate retreat from the intensity of the study. Once the researcher has come to the realization of the parameters of the world of the others that are critical, the researcher is then able to arrive at the period of incubation to achieve an essential understanding of the core meanings. This process is the beginning of the emergence of the problem, the texture, tone, mood, range, and content wherein the researcher connects with who the other person is. During this phase, I required myself to cease considering any additional information about the topic that would contribute to an increased understanding of the phenomenon. This allowed me to utilize the inner workings of the tacit dimension and intuition to continue to clarify and extend understanding to levels outside immediate awareness. The process of discovery takes place after a period of rest or distraction to which the incubation phase will allow the discovery of a new understanding of or perspective on the phenomenon. After conducting the initial and follow-up interviews and examining interview transcriptions, audio recordings of interviews, and field notes, I put aside time to postpone the review of information for one month, until the time arrived to perform the final written perspectives.

Illumination

After immersing myself in the phenomenon month after month, I entered a period of illumination (Moustakas, 1990). Illumination is the fourth phase in the heuristic research method. Illumination occurs naturally and spontaneously, and it requires a passionate, disciplined

commitment to remain with a question intensely and continuously until it is illuminated or answered, regardless of the time involved. Illumination is performed with timely and appropriate participation through conversations, dialogues, and self-exploration of texture, detail, and structure that is revealed of the other's world. All of the major facets have been understood through the awareness and deepening meaning to reach a bond between the researcher (counselor) and the other, which leads to the next step of the process.

Although the process requires a degree of self-reflection, this phase represents insights breaking through into the conscious awareness via the discovery of new knowledge, the uncovering of meaning, or the modification of meaning based on the understanding of the research question (Moustakas, 1990). I had to become open and receptive to tacit knowledge and intuition for illumination to occur. Yet, the process of illumination involved being sidetracked and having many major fundamental revelations. Months of deep reflection, called indwelling, led to another phase called the explication phase of what came into my consciousness.

Explication

From illumination comes explication, which is the fifth phase in heuristic phenomenological-based research. Explication involves the identification of the core themes of the experience for the creative synthesis (Sultan, 2020). Moustakas (1990) identified this phase as the full explication of the themes and parameters of the problem. Explication involves the process of explaining and clarifying the information acquired. The researcher becomes immersed in focusing, self-exploration, and self-disclosure, which allows the researcher to recognize the core themes of the experience.

The world of the other is delineated and explored to portray the situation as a whole and develop a creative synthesis. The process of explication requires the researcher to attend to the

awareness, feelings, thoughts, beliefs, and judgments that prelude the understanding that is derived from conversations and dialogues with others (Moustakas, 1990, p. 31). The accumulation of data is the sixth phase. Data accumulation leads to "a story that portrays the qualities, meaning, and essences of universally unique experiences" (p. 13). According to Sultan (2020), the essences of the experience are refined in preparation for the creative synthesis phase. First, the researcher prepares an individual depiction of the core themes illuminated from each co-researcher's raw data that provide a holistic explication that serves to present the findings of the study. From the collection of the individual depictions, a composite depiction is created representing a holistic rendition of the illuminated themes. Then, two or more exemplary portraits are generated using the unique data of select co-researchers to characterize universal themes of the study individually.

Creative Synthesis

The final phase of my heuristic process is creative synthesis that involves a framework of the various strands of the experiences and understanding gleaned from the research process, which are integrated into a whole using tacit knowledge and intuition (Sultan, 2020). The creative synthesis is a personal undertaking of the researcher that includes consideration of all the data and findings to generate an interpretation that accurately represents the experience as a whole. The researcher returns to the various depictions that were generated to seek inspiration for the final phase expressed in form. The process of creative synthesis involves successfully addressing my primary traumatization to ask what my experience has been like.

The heuristic research design conveys the voice of the researcher and the participants as co-researchers in heuristic inquiry found in literature, art, and holistic traditions. Journaling and using alternative forms of expression of the experience that could involve journal entries and any

form of expression that facilitates self-discovery, awareness, and understandings were the initial steps of the process (Moustakas, 1990). In similar fashion, co-researchers were asked to provide the narratives of their experiences in dialogue interviews that would deepen the understanding of what is expressed in the individual depictions, composite depiction, exemplary portraits, and creative synthesis. The data of the experience that has been investigated are presented in a vital and unified way. A new reality is comprised of within.

Qualitative Framework

The qualitative framework of the data collection involves gathering words and analyzing them using inductive reasoning, by focusing on the participants' meaning and describing sthat is meaningful and persuasive in language (Creswell, 2008). The qualitative framework involves inducing an understanding of the meanings that people attach to things in their lives, such as their own frames of reference and how they experience reality (Taylor & Bogdan, 1998). It involves developing concepts, insights, and understandings based on patterns derived from the data, rather than collecting data to understand preconceived models, hypotheses, or theories. The focus of the framework and researcher must stay on the participants in the contexts of their pasts and the situations in which they found themselves. The researcher must adopt strategies that could be considered parallel to how the participants think and act in daily life, typically by interacting with the participants in a natural and unobtrusive manner. The framework involves examining the participants' points of view from various angles and recognizing the meaningfulness of the many facets of qualitative research.

Qualitative Paradigm Assumptions

A qualitative researcher utilizes their worldview, or cognitive schema, which comprises a set of values and beliefs through which the individual interprets the world (Creswell, 2008;

Guba, 1990). Qualitative research is based on different paradigm assumptions: ontological, epistemological, methodological, axiological, and rhetorical. The ontological assumption refers to the nature of reality wherein participants in a study see reality subjectively and in multiple ways. The epistemological assumption refers to the nature of the relationship between the knower and the known in which qualitative researchers interact with those being researched. The methodological assumption concerns how the inquirer goes about finding knowledge.

Qualitative research encompasses the inductive process and the simultaneous shaping and verification of factors, emerging design categories identified during the research process, context-bound patterns, theories developed for understanding, and accurate and reliable information. The axiological assumption involves the nature of values, in which qualitative researchers must acknowledge that every aspect of the research process is value laden. One's theoretical stance and sociocultural norms play significant roles in the research process. The rhetorical assumption refers to researchers' use of language in the research process.

Rationale for Qualitative Methodology

I employed four questions other qualitative researchers have utilized in selecting this framework to answer their research questions (Crotty, 1998):

1. What theory of knowledge is embedded in the theoretical perspective?
2. What is the theoretical perspective informing the methodology?
3. What methodology will inform the data collection procedures?
4. What methods of data collection and analysis will be used?

To perform qualitative research, I had to understand the foundation of the theoretical knowledge that provided the guidance and originated in epistemology, which refers to the nature of how people acquire knowledge. In working from an epistemological framework, I performed

the research based on an engagement with interactive and contextual connections in the construction of knowledge. The aforementioned has been considered intersubjective epistemology (Caelli et al., 2003; Cohen & Omery, 1994; Creswell, 2008; Laverty, 2003). Intersubjectivity is the relational connection that occurs during successful communication in which shared understanding is experienced (Crossley, 1996). The core concept of intersubjectivity is that it prompts individuals, regardless of their differences, to convene and exchange thoughts, feelings, and beliefs without fear or the need to be defensive.

Theoretical Perspective of Research Design

The theoretical perspective that guided me in this study was the constructionist epistemology, which allows the exploration of research participants' realities or meanings based on their social relationships (Creswell, 2008; Crotty, 1998). In performing the qualitative research, I came across three assumptions that were based on elements of the constructionist epistemology and involved the socially constructed knowledge of participants. The first assumption is that participants develop meaning based on their social interactions with others. The second assumption is that humans engage with their world and make sense based on their historical and social perspectives. The third assumption is that the essence of meaning is based on social interactions. Within the framework of the constructionist epistemology, the research process uses a largely inductive approach, with the researcher generating meaning from the data based on their research. Within the context of the constructionist epistemology, theoretical perspectives, methodology, and data collection procedures, I anticipated my outcomes would be interpreted to answer the research questions as part of my exploration of the study's results. Furthermore, I decided not to claim the results as the ultimate truth but as part of a journey of exploration.

Participants

After receiving approval from the Institutional Review Board, I used the snowball method to recruit potential participants co-researchers. The following were inclusion criteria for participants co-researchers: (a) are certified as a licensed professional counselor (LPC) or licensed professional counselor–supervisor (LPC–S) by the Texas State Board of Examiners of Professional Counselors, (b) are victims of trauma and willing to share their experiences, (c) have 5 or more years of experience as an LPC or LPC–S performing professional counseling with clients who were victims of domestic violence, and (d) are willing to share their experiences about one client who did not demonstrate psychotic features, was at least 18 years old, was a victim of domestic violence, and for whom they provided a minimum of five face-to-face counseling sessions. This study utilized a snowball recruitment strategy, starting with organizations with which the researcher had a professional membership, such as the Texas Association of Addiction Professionals, and relevant professional Facebook pages. The researcher emailed counseling professionals whom she knew worked in domestic violence settings and asked them to forward information about the study to other counselors working in domestic violence settings.

Eight counselors met the inclusion criteria and participated in the study. They were informed that their participation was voluntary and that they would receive no remuneration for participating in the study; however, most importantly, the potential for advancing knowledge about the counseling profession would provide a meaningful venue for them to give back to the community. The participants co-researchers were advised that by participating in this study, they faced the potential of revealing personal and historical information, which might evoke cognitive

and emotional discomfort. They were encouraged to seek mental health services should they wish to pursue resolution concerning their experiences.

The participants co-researchers were informed that they had several choices regarding participation in this project: (a) They may decide not to participate at all, (b) they may decide not to answer some of the questions, or (c) they may decide to terminate their participation even after they had begun. In addition, they were advised that should they withdraw from the study, which they could do at any time, or should they refuse to participate in the study, their decisions would have no penalties or cause no loss of benefits to which the participants co-researchers were otherwise entitled. The participants co-researchers were advised that at any time during the interview, should they experience symptoms of their trauma or desire to end the interview, they could inform me. I also advised them that I could end the interview if in my judgment, they are experiencing symptoms of trauma. Finally, the participants co-researchers were advised that I would end the interview if they described any client who was under 18 years old.

I maintained confidentiality throughout the qualitative research process. After reading and signing the informed consent (see Appendix B) and receiving a copy of it, each participant–co-researcher was assigned a random number that I used to label my interview notes and transcriptions, the audio recordings of the two research interviews, and the demographic questionnaire (see Appendix C). The participants co-researchers were advised that I would remove or change all direct and indirect identifiers that were disclosed during the interviews. The information provided by the domestic violence counselors were gathered by audio recordings, transcribed interviews, and field notes from their work and were in first person to describe the participants co-researchers' experiences. To preserve confidentiality and anonymity, direct and indirect identifiers were removed, and the transcripts were redacted. I implemented a system of

name substitution before the interviews began, applied the appropriate safeguards to protect the written records and electronic media containing my research information, and utilized safeguards to ensure the confidentiality of the participants co-researchers.

The participants co-researchers were LPCs or LPC–Ss licensed by the Texas State Board of Examiners of Professional Counselors; were victims of trauma and willing to share their experience; had 5 or more years of experience as LPCs or LPC–Ss performing professional counseling with clients who were victims of domestic violence; and were willing to share their experiences about one client who did not demonstrate psychotic features, was at least 18 years old, was a victim of domestic violence, and for whom they provided a minimum of five face-to-face counseling sessions.

Data Collection Procedures

The purpose of this qualitative study was to examine how domestic violence counselors who have been victims of trauma experienced their clients who also were victims of domestic violence. I performed the eight initial face-to-face interviews with each of the participants–co-researchers. The participants co-researchers were asked to select either a face-to-face or telephone follow-up interview. One participant co-researcher selected a face-to-face interview and seven selected follow-up interviews by telephone.

The data collection process involved asking questions to address my research question (see Appendix D). I utilized semistructured interviews based on open-ended questions that emphasized an exploration of the counselors' experiences. Every effort was made to create a relaxed and informal atmosphere to help the participants co-researchers feel comfortable sharing their experiences. The goal of a qualitative interview is to create a situation in which participants feel free to express their feelings, thoughts, and experiences (Josselson, 2013). The conceptual

framework of the goal is based on the psychology of creating an attentive, nonjudgmental, empathic area for such as interview conversation. A qualitative interview allows for a personal interview to gather a research participant's experiences. Correspondingly, to stay focused on the interview process, I maintained awareness that subjectivity could affect the interview process yet could be utilized in every way to enhance the qualitative research (Patton, 1990).

Strengths and Weaknesses of Data Collection

Qualitative research is often criticized for lacking reliability and validity; however, it has numerous strengths when properly conducted (Anderson, 2010). I have considered both the strengths and weaknesses of the heuristic, phenomenological-based research process. The first strength is that it helps domestic violence counselors with a personal history of the trauma experience of clients who are victims of domestic violence. This history can best be examined in detail and in depth through qualitative methodology. I have understood that the process of qualitative research can provide a better understanding of the nature of trauma counseling.

The second strength is that although heuristic, phenomenological-based research data cannot be generalized to a larger population, it can be relevant to a similar population. A third strength is that the collection of qualitative data can be performed in natural settings; the sampling takes into account the characteristics of individuals within the context of the study (Anderson; Marshall, 1996).

The primary guideline is that although the heuristic, phenomenological-based research process facilitates creative freedom, the method can lead to irresponsible, undeveloped research (Djuraskovic & Arthur, 2010; Frick, 1990). I have remained mindful of the rigor of qualitative research, which can be more difficult to maintain, assess, and demonstrate; moreover, interpretation of the volume of data derived from the analysis can be time consuming. I have

found it helpful to remain mindful of maintaining a role as primary researcher and not as a counselor when meeting with another counselor for clinical consultation. This has allowed me to understand that my own bias may lead to an increase in subjectivity during the process of heuristic, phenomenological-based research. Furthermore, I have recognized that qualitative research is heavily dependent on the individual skills of the researcher, which the researcher's personal biases can easily influence. I have remained aware of capturing the eight participants' experiences from their points of view.

Ethical Consideration of Qualitative Research

I have followed all ethical principles to ensure that I have conducted the qualitative research in an appropriate and accurate manner (Elmes et al., 1995). I have advised the eight participants about the research procedure, and the eight participants have given consent to participate in the research before data collection took place. I have avoided deceiving the participants. I have provided the ability for the eight participants to withdraw from participation in the study without fear of being penalized. I have provided the eight participants with information about the objectives of the research from the initial onset of the study. I have advised the eight participants of their rights to privacy and ensured that confidentiality will be maintained during the entire research process.

Chapter IV

Bracketing The Researcher's Assumptions

The researcher applied bracketing or epoch as part of the heuristic-based phenomenological inquiry (Sultan, 2020). Bracketing means that the researcher critically assessed, recognized, and set aside his or her knowledge, beliefs, and motives related to assumptions about the topic to examine the studied phenomenon in an unbiased manner by maintaining a neutral position. The researcher utilized a heuristic approach involving her own personal experience, rather than suspending it (Moustakas, 1990), alongside bracketing. Written and enclosed is the bracketing and suspension of any theoretical and experiential assumptions to take on a fresh perspective of the phenomenon that has become the focus of the research inquiry. Bracketing fulfills emic and etic points of view. The emic point of view allows the presentation of the participants of the research, also known as co-researchers' perspectives. The etic point of view fulfills the researcher's point of view of the sense of self. The heuristic inquiry method requires a direct, personal encounter with the phenomenon being researched, which has been known to be profound and transformative through self-healing and forgiveness (Moustakas, 1961, 1990).

The following personal narrative is written in the primary researcher's first person point of view. The bracketing is my family's cultural influence. I come from a high-profile family that ran a foreign nation. This most definitely came with a burden, which I tend to not disclose at all. I am a daughter and granddaughter of a high-profile family involved in a foreign nation's politics. I had spent most of my time studying abroad, mostly in the United Kingdom and other sovereign monarchies, before relocating to the United States. Journaling, poetry, photography, and music remain important to me because mastering English has been difficult, and my

maternal family had tasked me with learning English in various ways. My family learned to communicate in three languages, and if I studied abroad, I learned that country's language, if the language was not English. As far back as my childhood, I had been educated on foreign public diplomacy, and I remain quite well versed on international political economy and foreign relations.

Due to my family's high-profile political status in our home nation, all women, including me, who were close in age were educated on how to identify human trafficking. I was also educated on how to seek medical assistance and use medical terminology by my grandparents, who were medical doctors, especially when I traveled abroad. I used to read news media articles about my family that I knew never to believe as true—that is, until graduate school, when I read about how my family had contributed to our home country's poverty and conflict, which increased my awareness and understanding. During college, I also attended a public lecture about ending world hunger, and I learned about the ways my family was seen as helpful, yet I understood the undertone that my family had contributed to the problems.

I once expressed an interest in having a career in international public diplomacy to follow in my family's footsteps. I was interviewed to be recruited by a United States government agency to protect the interest national security while studying as an undergraduate and declined. The more I learned about the effects of civil unrest of my home country, the more that I realized I would be better equipped for another profession, which resulted in me being becoming a counselor. What remains unspoken is the level of compassion about my family, which made me change my mind and become a counselor. Therefore, I acknowledge that domestic violence counselors with personal histories of trauma who do not come from high-profile families that have run foreign nations understand survivors of domestic violence at a different level. Another

level exists to be comprehended when one's family member has become a victim of human trafficking, which some counselors will never understand. This experience is parallel to understanding the amount of grit that my family had in rising from the phoenix's ashes.

The timeline of my family's victimization must never be disclosed, but I had been told that a close family member had been victimized of human trafficking by being kidnapped. I had been given the less truthful version at first but was given the ultimate truth later, when I came of age. This does not include the other numerous attempts that I had been informed about and read about in the media, only to be instructed that it would happen to me and that I needed to be prepared. My family had to endure a process that only survivors of human trafficking understand and that will remain a lifetime memory. The vengeance by the perpetrators of human trafficking can never be understood by people who have never been trafficked. In studying foreign public diplomacy, I am, and I remain, aware of the causes of and the unrest resulting from poverty within a civil society in a former war-torn nation and how perpetrators use these to justify illegal activities such as human trafficking involving the distribution of narcotics and sexual slavery.

A counselor should never have to experience victimization and doing so more than once has been a nightmare. I recognize the lesson of protection that my family had given me. As part of the bracketing, I understand that as a counselor, I must set aside being a survivor. I must separate being a survivor from being a counselor and from my family's political status. I had been informed about the reason why the crime was committed against me. As part of this process, what remains will never exist for me to justify the human trafficking, sexual slavery, and narcotics use, especially against others and then at me. As a counselor, my professional experience has allowed for me to truly understand how survivors of human trafficking and sexual slavery ask for assistance.

No counselor should ever have to endure what I have experienced as a counselor. The pain of political retribution one type of pain. The pain of victimization as a counselor is another form of pain. One time as a counselor, law enforcement had contacted me to say that I was the intended victim of a perpetrator who had been arrested. I had been informed by law enforcement of the unimaginable terror that more than one victim has experienced as an attempted murder witness and kidnapping victim by this one perpetrator. This one victim had experienced family violence from enduring the horror of a stranger initially stalking her and then having to marry that same perpetrator.

I was shown numerous photographs of me obviously taken from my public social media posts that had been defaced with words involving the perpetrator's intent to take my life. I also had been shown pages with words expressing how this perpetrator had gone to great lengths to find out every bit of information about my friends, my family, and me. I was aware of the level of disgust I would experience from seeing one photograph after another with calls for my death by the perpetrator. Because I come from a high-profile and politically devout family, I am aware of dangers ranging from lower levels of harassment to extreme threats. My mother had worked at a United States embassy abroad, and everyone who worked there had to learn to deal with threats. As a young adolescent, I was allowed to travel unaccompanied because I had been trained to identify how to not be taken to hostage by human traffickers; thus, I had been educated to see how this perpetrator began stalking me as a stranger.

When I had to be contacted, the impact of seeing me how the perpetrator viewed me was at the level shown in the movie *The Silence of the Lambs* (Demme, 1991) when law enforcement learns of the next victim. A victim like me will experience a level of discomfort upon being contacted by law enforcement. I reached the next level of discomfort when I was contacted by

one victim and the perpetrator's family about their hatred towards me. I had been educated at a young age to recognize warning signs or red flags and still do so, similar to the movie *Taken* (Morel, 2008), where the kidnapper initially defers kidnapping the daughter of an ex-special forces officer with whom he attempts to shares a cab at the Paris airport. Victim advocates see female counselors at another level of victim advocacy because of their ability to ask for help. Thus, I must practice what I preach as a counselor, and I always will. In another realm, I truly comprehend their experience as a survivor. I also understand the political ramifications of the axis of evil with which my family had to deal while leading a country.

To complete the process, I, as the primary researcher, utilized a reflexive bracketing process of consulting with peers and supervisors as well as journaling, poetry, photography, and music. My family had to help me the most in the ways that political families must deal with trauma privately. I also consulted with peers daily and with supervisors weekly about staying focused and asking for help. I have a background in performing piano music and practiced almost every day as a form of journaling. In addition, I also enjoy practicing my English language skills by reading poetry and classic literature, which I have studied over the years by writing literary interpretations of them. I originally sought to document my process of bracketing being photographed by a photographer colleague. Then, I attempted to improve my nature and street photography as a form of journaling and had submitted my work to public photography forums. This led me to be photographed for the book *Humans of San Antonio* because of the level of compassion I gained from what I had learned that kept me alive

Chapter V

Results

The results of the dissertation research design of this heuristic inquiry have been based on Moustakas (1990) defined seven processes involved in the researcher's journey to arrive at a deeper understanding of the central question through heuristic inquiry that is demonstrated with the six phases of the heuristic research design. The seven processes involve the identification with the focus of inquiry, self-dialogue, tacit knowing, intuition, indwelling, focusing, and internal frame of reference paired with six phases of the heuristic research design of initial engagement, immersion, incubation, illumination, explication, and culmination of the findings in a creative synthesis. In this section, the results will be described using Sultan's (2020) analytic approach of the heuristic design. The question that has been a personal challenge focused exclusively on how domestic violence counselors who have personal histories of trauma experience their clients who were victims of domestic violence?

Explication

Explication of the phenomenon, the fifth phase in heuristic phenomenological-based research, involves the individual depictions and composite depictions (Sultan, 2020). The individual depictions before the composite depictions contain experiences of the domestic violence counselors used in this study are based on audio recordings, transcribed interviews, and field notes, are in first person to describe the co-researchers' experiences. Moustakas (1990) discussed that the researcher recognizes core themes of the phenomenon (p. 31). The individual depictions contain the experiences of the domestic violence counselors of the experience investigated. The composite depictions involve how the participants as a group experienced what they experienced.

Individual Depictions

The individual depictions from each of the participants are the identified themes of the living the experience investigated. Within the collection of individual depictions, composites were created that represent a holistic rendition of the identified themes (Sultan, 2020). The composite depictions are the group's overall experiences of the individual themes of each of the eight participants co-researchers. The primary researcher transcribed the interviews at a professional transcription service. The primary researcher deidentified the recordings provided to the transcription service as the primary researcher asked the participants to use only pseudonyms in the interview. The primary researcher conducted the subsequent analysis on 1,000 pages of transcription. The experiences of the domestic violence counselors are based on audio recordings, transcribed interviews, and field notes; they are in first person to describe the co-researchers' experiences. To preserve confidentiality and anonymity, the primary researcher removed direct and indirect identifiers and redacted the transcripts. The individual depiction listed by the primary researcher of the eight domestic violence counselor is as follows:

> Becky is a master's-level licensed professional counselor in the state of Texas. She is Hispanic/Latina. Becky discussed her experience providing face-to-face counseling for Dawn, a female client who was a victim of domestic violence.
>
> Maya is a master's-level licensed professional counselor in the state of Texas. She is White. Maya discussed her experience providing face-to-face counseling for Autumn, a female client who was a victim of domestic violence.
>
> Olivia is a master's-level licensed professional counselor in the state of Texas. She is White. Olivia discussed her experience providing face-to-face counseling for Veronica, a female client who was a victim of domestic violence.
>
> Ruby is a master's-level licensed professional counselor in the state of Texas. She is White. Ruby discussed her experience providing face-to-face counseling for Angela, a female client who was a victim of domestic violence.

Sofia is a master's-level licensed professional counselor in the state of Texas. She is Hispanic/Latina. Sofia discussed her experience in providing face-to-face counseling for Michelle, a female client who was a victim of domestic violence.

Stella is a master's-level licensed professional counselor in the state of Texas. She is Hispanic/Latina. Stella discussed her experience providing face-to-face counseling for Lilly, a female client who was a victim of domestic violence.

Vivian is a master's-level licensed professional counselor in the state of Texas. She is White and identified her trauma as emotional abuse in childhood. Vivian discussed her experience providing face-to-face counseling for Gabriela, a female client who was a victim of domestic violence.

Zoey is a master's-level licensed professional counselor in the state of Texas. She is White. Zoey discussed her experience providing face-to-face counseling to Sylvia, a female client who was a victim of domestic violence.

In response to the open-ended interview questions, co-researchers responded with depictions of their own internal recollections of their personal trauma history and depictions of their interactions with their clients.

Composite Depictions

From the eight individual textural depictions, the composite textural depictions have been developed (Moustakas, 1990). The composite depictions are how the participants as a group experienced what they experienced. The primary researcher identified four composite depictions (see Table 1):

Table 1

Four Composite Depictions

First Composite Depiction	The awareness of the counselor's own experience.
Second Composite Depiction	The counselor's demonstration of empathy.
Third Composite Depiction	The counselor's self-care.
Fourth Composite Depiction	The counselor's countertransference.

Awareness of Counselor's Own Experience

The first of the four themes are the awareness of the counselor's own experience. Main point of theme number one is four out of the eight participants/co-researchers Becky, Maya, Vivian, and Olivia are aware of their own personal trauma history and seemed more able to empathize with their clients' emotional responses. In contrast, the four of eight participants/co-researchers Sofia, Zoey, Ruby, and Stella seem to view their personal history of trauma as an aspect that interferes with performing counseling with their clients expressed aspects of their personal history that were similar to their client. Furthermore, four participants/co-researchers Sofia, Zoey, Ruby, and Stella do not appear to use their personal history of trauma to understand their client's emotional responses.

Co-researcher Becky's own experience of domestic violence gave her an understanding of the client's situation that allowed her to ask difficult questions. While helping a coworker to pack her belongings, they were confronted by the coworker's husband who held them at gunpoint. This was similar to her client's experience of the husband confronting the client with a gun.

> I was held up at gunpoint during a domestic violence dispute between a husband and wife. My client's husband held her a gunpoint when she arrived home from work making statements that he wanted her to die. I would feel frustrated in the sense that I, and I would never say it to her, just because I didn't want to feel as though I was really conniving. But I always asked why? Why would you stay? Why didn't you leave? Why wouldn't you seek help? Why would you let someone abuse you to that level? I think about it and I say to myself, why do I always feel like I'm asking people? Did I not learn from my traumatic experience that I could have been killed.

Co-researcher Becky's own traumatic experience allowed her to ask difficult questions about why a victim of domestic violence would stay with her abuser.

In a similar way, co-researcher Maya's experience of growing up in an alcoholic family and her own abuse of alcohol to cope with an abusive relationship formed her understanding of how and why a client might self-medicate as a result of one's trauma.

> I grew up with an alcoholic father and a very co-dependent mother; I was emotionally neglected. I used alcohol, drugs, sex to cope with my then psychologically abusive husband. I felt frustration with my client because my client would not provide the clear picture about her problem drinking alcohol. I can understand when people are medicating trauma symptoms.

Co-researcher Maya's own traumatic experience led her to understand why her client would self-medicate.

Moreover, co-researcher Vivian recognized that her irritation with the client was a product of her own traumatic experience.

> My client was sexually abused by her father and that came out fairly early during our counseling sessions as the father sexually abused her and her sisters and my client's brothers. I would work pretty hard to recognize that was my own annoyance. In general, I see things in triangles, the perpetrator, victim, rescuer triangle. When I find myself becoming annoyed or in that persecutor, perpetrator, bad guy, villain role I'm aware pretty quickly that's my dad happening because he took his anger out on the entire family because he was truly a homosexual.

Despite what co-researcher Vivian felt toward the client, co-researcher Vivian was able to manage her emotional response.

In similar way, co-researcher Olivia's own experience of being physically abused by her father and watching her husband abuse her children allowed her to understand her emotional response of the client.

> My father was an alcoholic who would physically abuse my younger brother in which my mom did nothing to stop that. My husband would physically abuse one of our 3 children to get to me and blame me for not intervening on my younger brother's behalf…When my female client begins to talk about the internal feelings of worthlessness, of the betrayal on the part of her parents who were supposed to love and protect her, I can connect with that.

Co-researcher Olivia's own traumatic experience led her to identify the emotional response that occurred when performing counseling with the client.

Co-researcher Sofia acknowledged some similarity with the client, but simply said that she did not allow her awareness to interfere with the therapy process.

> I think my feelings sided with my client Michelle ... Even though I saw myself a little bit in that, and some of her story reminded me of my husband's infidelity as Michelle had been unfaithful during her marriage which was the result of the physical and emotional abuses, the remorse, regret, I still didn't allow it to interfere in our sessions. I was still very attentive with her, so I definitely did not let that interfere.

Although this could be understood as similar to bracketing, her assumption is that her personal experience would interfere with counseling. Co-researcher Sofia's experience indicates she saw her personal experience as a potential obstacle to counseling.

Co-researcher Zoey acknowledged the similarity with the client on the basis of her financial struggle.

> My mother saw what my husband was doing and gave me a credit card to use because still to this day I have struggled to support myself and two children and when I was married to my husband. I have had had a credit card of my mom's forever. Most of my clients had money problems and lacked financial stability.

Co-researcher Zoey experience indicates she saw her personal experience as a potential obstacle in counseling.

Counselor's Demonstration of Empathy

The second of the four themes is the counselors' demonstration of empathy. Some counselors can demonstrate empathy with their clients because of personal experiences. In contrast, other counselors convey low empathy concerning their clients' distress. The eight participants co-researchers interviewed were Becky, Maya, Olivia, Ruby, Sofia, Stella, Vivian, and Zoey. Four of them (i.e., Becky, Maya, Vivian, and Olivia) demonstrated empathy with their clients because of personal experiences. In contrast, the other four (i.e., Sofia, Zoey, Ruby, and

Stella), who viewed their personal history as something that could interfere with the therapeutic process and therefore conveyed low empathy concerning their clients' distress. In contrast, the other four participants/co-researchers (i.e., Sofia, Zoey, Ruby, and Stella) conveyed low empathy toward their client's distress because it made them recall their own experiences.

Co-researcher Becky conveyed empathy when she spoke of her client. Both Becky and her client had been threatened with a firearm during domestic violence disputes.

> She shared that even her parents, they had turned on her. I know that exact experience because I was isolated from orders of my military chain of command to not speak of what had occurred until the court martial; this felt like I had been turned against when I was the victim.

Becky's traumatic experience led her to demonstrate empathy by conveying that she was free of judgment because she understood the exact experience of isolation.

Co-researcher Maya demonstrated empathy when she spoke of her client. Maya's father was an alcoholic, and Maya had become the alcoholic of her family. She also the coupled problematic drinking with promiscuous behavior outside of her marital relationship. Maya's client had been the alcoholic of her family.

> My client would not provide the clear picture about her problem drinking alcohol. I too lied about my drinking and did nothing to listen to anyone else especially my spouse and my young children at the time.

Maya's traumatic experience led her to demonstrate empathy by recognizing similarities with her client. This facilitated Maya to take a non-judgmental approach.

Co-researcher Vivian also demonstrated empathy when she spoke of her client. Vivian's father had been sexually abusive and identified as homosexual. Vivian felt an older sister's protectiveness toward her client because of the client's family dynamics.

> The turning point for her to seek help had been when a brother told the entire family he identified as transgender that upset the entire family and I know the exact dysfunction because my father came out to the family saying he is a homosexual. My client's father was physically and sexually abusive with the boys. In particularly picked on the one that came out of the closest years later as transgender. The whole family dynamic was loaded with emotional, physical, and sexual abuses.

Vivian's traumatic experiences led her to demonstrate empathy, as the client's traumatic experiences and family dynamics mirrored her own.

In similar way, Co-researcher Olivia demonstrated empathy when she spoke of her client. When Olivia witnessed her then-husband physically abusing one of her three children, she felt the same sense of worthlessness she experienced as child when witnessing her alcoholic father's physical abuse of her younger brother.

> When my female client begins to talk about the internal feelings of worthlessness, of the betrayal on the part of her parents who were supposed to love and protect her, I can connect with that.

The pain of witnessing the husband's actions and of her younger brother's abuse Olivia identified painfully equal of the client.

Co-researcher Sofia conveyed low empathy when speaking of her client because Sofia saw her own experiences in the client's.

> All I could think about was how my husband was doing me wrong with him cheating on me. I think my feelings sided with my client Michelle ... Even though I saw myself a little bit in that Michelle had been unfaithful during her marriage which was the result of the physical and emotional abuses and how I became emotionally abusive towards my husband. The more that I worked with Michelle I was able to understand how my husband needed my forgiveness to make our marriage work. I had worked with my client to work with communicating with her partner.

Sofia's traumatic experiences led her to demonstrate low empathy when speaking of her client because the counselor–client relationship mirrored her own marriage.

Co-researcher Zoey conveyed low empathy when speaking of her client's financial stress.

> I'm privileged and my mother always gave me a credit card to use because I struggled to support myself and two children when I was married to my husband. I have had a credit card of my mom's forever. My mother purchased a house for me when I left and divorced my husband. All could and have ever think about I how my mother is always going to help me financially. My client could barely keep a job and one time she needed hangers and I just gave her a box of hangers. What angered me is that my client would smoke marijuana and curse, because my husband would curse at me and battled a behavior addiction that he blamed me for.

Zoey's traumatic experience led her to convey low empathy and difficulty in understanding the client's financial situation because Zoey's was so different.

Co-researcher Stella's traumatic experiences led her to demonstrate no empathy when speaking of her client because the client's traumatic experiences mirrored her own.

> I became upset with Lily at Lily's perpetrator as well as with the experiences she had with other men on the street and the comments they made to her. At times, I would cry with her because I just felt her pain. Everything about this client is me. Everything about how she could not leave her abusive situation even as an adult I had to endure.

Stella's traumatic experiences caused her to focus on her emotional response toward the client's perpetrators and men. This led her to make comments to the client that did not demonstrate empathy.

Co-researcher Ruby's resolution of her own trauma led her to have unrealistic expectations for her client to leave her abuser. Ruby demonstrated the most lack of empathy regarding her client's reluctance to make changes.

> I have higher expectations of her being able to make changes since I did. My client was like a dead tree that's just a waste of space. This. client had her young toddler aged son in filthy and drug infested household with access to abusive men. Everything about her that I could not view her as a victim triggered me to no end because of the hell I had to go through to leave my abusive relationship.

Ruby demonstrated the greatest lack of empathy by displaying a judgmental attitude toward her client, whom she called "a dead tree that's just a waste of space."

Counselor's Self-Care

The fourth theme refers to a counselor's self-care. The eight participants/co-researchers—Becky, Maya, Olivia, Ruby, Sofia, Stella, Vivian, and Zoey—described a variety of counselors' self-care activities and the self-care they used to prevent impairment in their work with trauma survivors. All eight participants/co-researchers utilized coping strategies to focus on their well-being. The main forms of self-care that all eight participants/co-researchers utilized

outside of the counseling sessions are personal, professional, and organizational activities. The forms of self-care are meant to reduce the social isolation of working with a trauma population and to reduce the demonstration of personal reactions. On the other hand, the three most predominant forms of self-care as a whole were the coping skills of clinical consultation, peer support, and supervision. The coping skills of clinical consultation, peer support, and supervision involve counselors being supportive of other counselors in professional roles.

- Co-researcher Becky utilized clinical consultation, left a difficult job, and utilized the support of various sorority sisters, a female cousin, her mother, peer support, and supervision.
- Co-researcher Maya utilized Alcoholics Anonymous meetings, clinical consultation, peer support, and supervision.
- Co-researcher Olivia used clinical consultation, living her religious faith, peer support, supervision, and three mindfulness activities of meditation, breathing, and progressive muscle relaxation.
- Co-researcher Olivia described utilizing her religious faith as effective because she knows the scripture of the Bible and found healing through repentance.
- Co-researcher Ruby utilized clinical consultation, physical fitness, peer support, and supervision.
- Co-researcher Sofia utilized clinical consultation, peer support, the support of her three biological sisters, her relationship with a male friend, and supervision.
- Co-researcher Stella attended Alcoholics Anonymous and Al-Anon meetings of a specific sexual orientation and utilized clinical consultation, debriefing, peer support, and supervision.

- Co-researcher Vivian utilized what she described as clinical consultation, peer support, supervision, and spiritual practices for self-care such as tarot card reading and spell casting. Co-researcher Vivian also utilized personal therapy and three mindfulness activities of meditation, breathing, and progressive muscle relaxation, as well as the support of her male husband.
- Co-researcher Zoey used clinical consultation, her debriefing with colleagues, social support of her biological mother, peer support, religious faith, and supervision. She also utilized religious faith that could be described as somewhat effective because she knows the scripture of the Bible; however, she continued to relive and stay in her trauma by seeing herself in her clients.

Counselor's Countertransference

The third theme is the counselors' countertransference, which is a reaction of overinvolvement or underinvolvement with the client. The term "countertransference" has been defined as the counselor's reaction(s) toward a client (Freud, 1959; Satir et al., 2009). Positive countertransference occurs when a counselor is overly friendly or supportive toward the client (Friedman & Gelso, 2000). Negative countertransference occurs when a counselor's actions involve underinvolvement and withdrawal, which the counselor demonstrates by being excessively critical, punitive, or rejecting of the client and by serving the counselor's own needs in a negative form (Friedman & Gelso, 2000). Six of the eight participants/co-researchers—Becky, Olivia, Sofia, Stella, Vivian, and Zoey—demonstrated countertransference of overinvolvement. Two of the eight participants/co-researchers—Maya and Ruby—demonstrated countertransference of underinvolvement.

Overinvolvement manifested as positive countertransference occurs when the counselor is overly involved in identifying with the negative emotion experienced from the client. Six of the eight participants/co-researchers—Becky, Olivia, Sofia, Stella, Vivian, and Zoey—demonstrated overinvolvement that could be identified as excessive and nontherapeutically oriented self-disclosures.

- Co-researcher Becky demonstrated countertransference of over-involvement due to feeling a negative emotion. She described constantly crying outside of work because of the pain she felt she had to take on as a counselor and how a colleague once found her crying in the bathroom.
- Co-researcher Olivia also demonstrated countertransference of overinvolvement due to feeling a negative emotion. She discussed feeling incapacitated, crying for hours, and canceling plans with her family after one intense session with a female client about the client's rape and sodomy with guns after being taken out to a field.
- Co-researcher Sofia demonstrated countertransference of overinvolvement by focusing on her similarity to her client. She discussed how when her client discussed being sexually abused by her brother at a younger age, Sofia always thought about her husband and sometimes about herself due to Sofia's own brother having sexually abused Sofia and her sisters.
- Co-researcher Stella had demonstrated countertransference of overinvolvement by focusing on her own needs over those of her client while in the session. She described how her client's trauma stayed with her after their counseling session,

especially when the client was suicidal, to the point that Stella had cried with the client.

- Co-researcher Vivian demonstrated countertransference of overinvolvement by becoming annoyed and battling her own overinvolvement. She discussed doing therapy with that female client and sometimes having to fight within herself with what causes her to lose presence in sessions while she tried to get herself under control.
- Co-researcher Zoey demonstrated countertransference of overinvolvement by focusing on her similarity to her client. Specifically, she spoke about how her client reminded her of her abusive husband. The client would use profanity during their counseling sessions that would upset Zoey.

Underinvolvement refers to the negative countertransference demonstrated with withdrawal, with the counselor minimizing their discomfort in the counseling session by being overly critical, punitive, or rejecting of the client.

- Co-researcher Maya demonstrated countertransference of emotional detachment by rejecting the client because of Maya's own frustration with her client, due to her client not providing a clear picture of her alcohol problem.
- Co-researcher Ruby demonstrated countertransference of emotional detachment by rejecting the client through being excessively critical. She discussed that her client was like a dead tree—a waste of space.

Creative Synthesis

The wounded healer paradigm allows the focus to be on the wounded healer's ability to promote the patient's healing. The essence of this analysis is that the process of wounded healing

requires that we all become aware of our woundedness and practice self-care so that we can best serve our similarly wounded clients. All co-researchers and myself have been wounded through painful experiences. While each one's trauma is unique, one cannot say that one person is more traumatized than another. However, we are all in different places when it comes to the process of healing.

The co-researcher who appeared to be least healed was Stella. A victim of sexual abuse from child- to adulthood, she performed counseling with female clients who had problems that mirrored her own history. Stella seemed overwhelmed by her own personal history of trauma, sometimes reserved, and other times over-disclosing.

In contrast, three co-researchers, Olivia, Vivian, and Becky appeared to use their traumatic history to become more empathic with their clients, an example of the wounded healer. Vivian also suffered from sexual abuse, but seemed to be resilient choosing to focus on her children and husband. Vivian enjoyed being a counselor. Olivia coped with the pain endured in a violent relationship by using her faith to heal. Olivia performs couples counseling with those who have ongoing domestic violence, using her religious faith as a tool of counseling. Becky experienced abuse in in her family, in the military, and in an abusive relationship. Becky's self-care included accepting that the people important to her are not going to change, so she had to protect her child from toxic family members.

As for myself, I believe the role of the wounded healer is founded on the realization that inner strength must be recognized and fostered without reluctance. The paradigm of the wounded healer is the most sensitive to the core of the self, where meaning can be achieved with a balanced representation that seems inherently unclear and impossible. Counselors must better understand the woundedness and the personal healing to understand the complexities of the

nature of humanity from some inevitable element. This involves time and energy that involves an emotional dimension of hope and personal well-being.

Chapter VI

Summary, Implications, and Recommendations

Given the findings of the study, the influence appears that the metaphor of the wounded healer that originates from the ability of a psychotherapist to facilitate the power of healing can be viewed as the continual revisitation of recognizing the difficulties faced by clients who are trauma survivors. The process of the phenomenon of the wounded healer demonstrates that wounded healers experience the opportunity regarding unaddressed issues that remain when the woundedness has been disclosed. The struggles or difficulties of the wounded healer that could impact psychotherapy should facilitate the importance of the wounded healer who knows how to cope with his or her problems to help patients to do the same. The process to address the woundedness is an integral part of psychotherapy with clients who are survivors of trauma. With the focus of the constant recognition of the clinician's personal reactions and retraumatization, this highlights that clinicians can become aware and address their personal reactions to prevent any retraumatization of the client. There is a need for public awareness about holding clinicians accountable for their personal reactions. The contribution to the meaning of the wounded healer involved the decision to carry out the present study to foster an increased recognition highlighting the importance of the counselor's clinical ability.

Summary of Clinical Implications

The paradigm of the wounded healer may offer a unique and valuable perspective on how to create a trauma-informed counselor education program. The wounded healer represents the growth that comes from one's own posttraumatic growth for healing (Zerubavel & Wright, 2012). The more wounded healers can understand their own wounds and journeys of recovery, the better position they are in to guide others through such a process. Importantly, being

wounded in itself does not produce the potential to heal; rather, healing potential is generated through the process of recovery through self-care. The approach of this dialogue would be from a place of resilience with the acknowledgment that wounded healers require on-going support and guidance.

The recognition is that wounded healers are more likely to validate and normalize therapist stressors and countertransference issues, encourage the seeking of consultation and personal therapy, and integrate attention to compassion fatigue, counselor well-being, and self-care (Zerubavel & Wright, 2012). The attention to self-care (e.g., regular exercise, yoga, eating well and getting enough sleep, spending time with friends, establishing boundaries between one's personal and professional life, and making time for fun activities) is critical to the wounded healer's psychological health. Wounded healers have recognized the value of self-care practices in preventing a reemergence of burnout by acknowledging that self-care does not come easily. The act of self-care takes time to accomplish and incorporating these the goals and activities into a busy professional life has been, for many, an ongoing challenge to integrate into their lives.

Summary of Research Implications

The end of the journey of this research brings the researcher to realize how it may contribute to the benefit of society. How does this study contribute to the clinical knowledge, skills, and abilities with which domestic violence counselors who have their own personal histories of trauma experience clients who were victims of domestic violence? The first implication is that follow-up research should include a more diverse sample. To expand awareness and critical thinking in the area of trauma and domestic violence, the knowledge of difference, intersectionality, and relevance across diverse populations should be implemented

equally. Follow-up research should introduce a more diverse sample from the cultural population.

The counselor's reaction to the trauma of a client from the same ethnic or cultural group and with the same personal history of trauma should be researched. The counselor's reaction to the trauma of a client of a different ethnic or cultural group and with a different personal history of trauma should also be researched. Other factors that researchers should consider include socioeconomic status, immigration status, and the level of acculturation, along with other cultural, occupational, social, psychological, environmental, and historical factors that can influence a personal history of trauma.

Finally, the impact on the counselor of repeated exposure to traumatic client imagery and material depends on what has been defined as trauma. How trauma is defined depends on the set of symptoms and how lives have been impacted physically and emotionally. This approach depends on the construction of meaning in the face of trauma resulting from either a specific event or from events or conditions occurring over time. Trauma can be defined as arising from a natural disaster such as a hurricane or flood, an industrial disaster, a manmade disaster such as terrorism, or other traumatic events such as an accident involving a loss of a life. The victim of trauma shows signs of stress after exposure to a disaster or other traumatic event. Counselors can also recognize trauma through vicarious traumatization—the experience of symptoms parallel to those experienced by the victims. The definition of trauma primarily depends on the cognitive schema regarding the psychological factors at the levels of trust, safety, power, self-esteem, and frame of reference, all of which are fundamental to the potential factors of healing from the traumatic event.

A dominant theme in the interviews was that counselors who are aware of their own traumatic experiences are able to show greater empathy and experience greater countertransference. Future research should involve utilizing a quantitative study of three variables: a personal history of trauma; empathy with client; countertransference, and countertransference management. Subjects should be counselors providing a significant amount of trauma counseling, such as rape crisis counselors, domestic violence counselors or child sexual abuse counselors. Researchers should measure a counselor's personal history of trauma in a way similar to Jenkins and Baird's (2002) and Pearlman and Mac Ian's (1995) assessment of the behaviors and emotions associated with vicarious traumatization identified as psychological well-being and the symptoms of psychological difficulties. Researchers should measure the counselor's empathy for clients using the counselor's empathy scale (Decker et al., 2014). They should measure the counselor's countertransference according to Friedman and Gelso's (2000) Inventory of Countertransference Behavior, a 21-item Likert scale measuring the therapist's over-involvement, under-involvement, or withdrawal. This test measures the counselor's counter-behavior on two types of subscales, one for positive countertransference and one for negative countertransference. Researchers should further measure the counselor's countertransference management through the Countertransference Factors Inventory (CFI; Hayes et al., 1997), a 50-item, five-point Likert instrument measuring the five counselor qualities theorized to help counselors with the management of their personal reaction.

References

Aafjes-van Doorn, K., Békés, V., Luo, X., Prout, T. A., & Hoffman, L. (2021). Therapists' resilience and posttraumatic growth during the COVID-19 pandemic. *Psychological Trauma: Theory, Research, Practice, and Policy*. Advance online publication. https://doi.org/10.1037/tra0001097.supp

American Counseling Association. (2021). *Code of ethics*. https://www.counseling.org/resources/aca-code-of-ethics.pdf

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author. https://doi.org/10.1176/appi.books.9780890425596

Anderson, C. (2010). Presenting and evaluating qualitative research. *American Journal of Pharmaceutical Education, 74,* 1–7. https://doi.org/10.5688/aj7408141

Anderson, D. K., & Saunders, D. G. (2003). Leaving an abusive partner: An empirical review of predictors, the process of leaving, and psychological well-being. *Journal of Trauma, Violence, and Abuse*, *4*(2), 163–191. https://doi.org/10.1177/1524838002250769

Baehr, A. (2004*). Wounded healers and relational experts: A grounded theory of experienced. therapists' management and use of countertransference* [Unpublished doctoral dissertation]. Pennsylvania State University, State College, Pennsylvania. *https://etda.libraries.psu.edu/catalog/6313*

Baird, S., & Jenkins, S. R. (2003). Vicarious traumatization, secondary traumatic stress, and burnout in sexual assault and domestic violence agency volunteer and paid staff. *Journal of Violence and Victims, 18,* 71–86. https://doi.org/10.1891/vivi.2003.18.1.71

Barnett, J. E., & Cooper, N. (2009). *Creating a culture of self-care. Clinical Psychology: Science and Practice, 16,* 16-20. https://doi.org/10.1111/j.1468-2850.2009.01138.x

Bragg, L. H. (2003). *Child abuse and neglect manual series: Child protection in families experiencing domestic violence*. U.S. Department of Health and Human Services. https://www.childwelfare.gov/pubpdfs/domesticviolence.pdf

Bride, B. E. (2007). Prevalence of secondary traumatic stress among social workers. *Social Work, 52*(1), 63–70.

Bride, B. E., Radey, M., & Figley, C. R. (2007). Measuring compassion fatigue. *Clinical Social Work Journal, 35*, 155–163.

Caelli, K., Ray, L., & Mill, J. (2003). "Clear as mud": Toward greater clarity in generic qualitative research. *International Journal of Qualitative Methods*, *2*(2), 1–9. https://doi.org/10.1177/160940690300200201

Cartwright, C., & Read, J. (2011). An exploratory investigation of psychologists' responses to a method for considering "objective" countertransference. *New Zealand Journal of Psychology*, *40*(1), 46–54.

Cigrang, J. A., & Peterson, A. L. (2017). Stepped-care approaches to posttraumatic stress disorder: Sharpening tools for the clinician's toolbox. *PCSP: Pragmatic Case Studies in Psychotherapy*, *13*(2), 142–153. https://doi.org/10.14713/pcsp.v13i2.2004

Cohen, M. Z., & Omery, A. (1994). Schools of phenomenology: Implications for research. In J. M. Morse (Ed.), *Critical issues in qualitative research methods* (pp. 136–156). Sage.

Coster, J. S., & Schwebel, M. (1997). Well-functioning in professional psychologists. *Professional Psychology: Research and Practice, 28*, 5–13. https://doi.org/10.1037/0735-7028.28.1.5

Creswell, J. W. (2008). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research* (3rd ed.). Pearson Education.

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. Sage.

Crossley, N. (1996). *Intersubjectivity*: *The fabric of social becoming*. Sage.

Culver, L. M., McKinney, B. L., & Paradise, L. V. (2011). Mental health professionals' experiences of vicarious traumatization in post-Hurricane Katrina New Orleans. *Journal of Loss and Trauma*, *16*(1), 33–42. https://doi.org/10.1080/15325024.2010.519279

Decker, S. E., Nich, C., Carroll, K., & Martino, S. (2014). Development of the therapist empathy scale. *Behavioural and Cognitive Psychotherapy, 42*(3), 339–354. https://doi.org/10.1017/S1352465813000039

Del Tosta, J. E., Ellis, M. V., & McNamara, M. L. (2019). Trainee vicarious traumatization: Examining supervisory working alliance and trainee empathy. *Training and Education in Professional Psychology*, *13*(4), 300–306. https://doi.org/10.1037/tep0000232

Demme, J. (Director). (1991). *The Silence of the Lambs* [Film]. Strong Heart Productions.

Dienemann, J., Campbell, J., Landenburger, K., & Curry, M. A. (2002). The domestic violence survivor assessment: a tool for counseling women in intimate partner violence relationships. *Patient Education and Counseling*, *46*(3), 221–228. https://doi.org/10.1080/01612840701493493

Domestic Violence Resource Center. (2010). *Domestic violence*. http://www.dvrc-or.org/domestic/violence/resources/C39/

Djuraskovic, I., & Arthur, N. (2010). Heuristic inquiry: A personal journey of acculturation and identity reconstruction. *The Qualitative Report, 15*(6), 1569–593. https://doi.org/10.46743/2160-3715/2010.1361

Elmes, D. G., Kantowitz, B. H., & Roediger, H. L. (1995). *Research methods in psychology* (5th ed.). Wadsworth.

Ewer, P. L., Teesson, M., Sannibale, C., Roche, A., & Mills, K. L. (2015). The prevalence and correlates of secondary traumatic stress among alcohol and other drug workers in Australia. *Drug & Alcohol Review*, *34*(3), 252–258. https://doi.org/10.1111/dar.12204

Fatter, D. M., & Hayes, J. A. (2013). What facilitates countertransference management? The roles of therapist meditation, mindfulness, and self-differentiation. *Psychotherapy Research*, *23*(5), 502–513. https://doi.org/10.1080/10503307.2013.797124

Fauth, J., & Hayes, J. A. (2006). Counselors' stress appraisals as predictors of countertransference behavior with male clients. *Journal of Counseling and Development*, *84*(4), 430–439. https://doi.org/10.1002/j.1556-6678.2006.tb00427.x.

Fauth, J., & Williams, E. N. (2005). The in-session self-awareness of therapist-trainees: Hindering or helpful? *Journal of Counseling Psychology*, 52, 443–447. https://doi.org/10.1037/0022-0167.52.3.443

Foreman, T. (2018). Wellness, exposure to trauma, and vicarious traumatization: A pilot study. *Journal of Mental Health Counseling*, *40*(2), 142–155. https://doi.org/10.17744/mehc.40.2.04

Foreman, T., Tangen, J., Fickling, M., & Wester, K. L. (2020). The impact of trauma exposure: Vicarious traumatization and posttraumatic growth among counselor trainees. *Journal of Counselor Practice*, *11*(2), 21–43. https://doi.org/10.22229/tio1122020

Freud, S. (1959). Future prospects of psychoanalytic psychotherapy. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 20, pp. 87–172). Hogarth. (Original work published 1910)

Frick, W. B. (1990). The symbolic growth experience: A chronicle of heuristic inquiry and a quest for synthesis. *Journal of Humanistic Psychology*, *30*(1), 64–80. https://doi.org/10.1177/0022167887274003

Friedman, S., & Gelso, C. (2000). The development of the inventory of countertransference behavior. *Journal of Clinical Psychology*, *56*(9), 1221–1235. https://doi.org/10.1002/1097-4679(200009)56:9<1221::AID-JCLP8>3.0.CO;2-W

Furlonger, B., & Taylor, W. (2013). Supervision and the management of vicarious traumatisation among Australian telephone and online counsellors. *Australian Journal of Guidance and Counselling*, *23*(1), 82–94.

Galek, K., Flannelly, K., Greene, P., & Kudler, T. (2011). Burnout, secondary traumatic stress, and social support. *Pastoral Psychology*, *60*(5), 633–649. https://doi.org/10.1007/s11089-011-0346-7

Ganley, A. L., Fazio, J., Hyman, A., James, L., & Ruiz-Contreras, A. (1998). *Improving the health care response to domestic violence: A trainer's manual for health care providers*. Family Violence Prevention Fund. http://www.futureswithoutviolence.org /userfiles/file/HealthCare/improving_healthcare_manual_intro.pdf

Gelso, C. J., Fassinger, R. E., Gomez, M. J., & Latts, M. G. (1995). Countertransference reactions to lesbian clients: The role of homophobia, counselor gender, and countertransference management. *Journal of Counseling Psychology, 42*(3), 356–364. https://doi.org/10.1037/0022-0167.42.3.356

Gelso, C. J., & Hayes, J. A. (2007). *Countertransference and the therapist's inner experience: Perils and possibilities*. Lawrence Erlbaum.

Gelso, C. J., Latts, M. G., Gomez, M. J., & Fassinger, R. E. (2002). Countertransference management and therapy outcome: an initial evaluation. *Journal of Clinical Psychology*, *58*, 861–867. https://doi.org/10.1002/jclp.2010

Guba, E. G. (1990). *The paradigm dialog*. Sage.

Halevi, E., & Idisis, Y. (2018). Who helps the helper? Differentiation of self as an indicator for resisting vicarious traumatization. *Psychological Trauma*, *10*(6), 698–705. https://doi.org/10.1037/tra0000318

Hayes, J. A., & Gelso, C. J. (1991). Effects of therapist-trainees' anxiety and empathy on countertransference behavior. *Journal of Clinical Psychology, 47*, 284–290. https://doi.org/10.1002/1097-4679(199103)47:2<284::AID-JCLP2270470216>3.0.CO;2-N

Hayes, J. A., & Gelso, C. J. (1993). Male counselors' discomfort with gay and HIV-infected clients. *Journal of Counseling Psychology*, *40*(1), 86–93. https://doi.org/10.1037/0022-0167.40.1.86

Hayes, J. A., Gelso, C. J., Goldberg, S., & Kivlighan, D. M. (2018). Countertransference management and effective psychotherapy: Meta-analytic findings. *Psychotherapy*, *55*(4), 496–507. https://doi.org/10.1037/pst0000189

Hayes, J. A., Gelso, C. J., Van Wagoner, S. L., & Diemer, R. A. (1991). Managing countertransference: What the experts think. *Psychological Reports, 69*(1), 139–148. https://doi.org/10.2466/pr0.1991.69.1.139

Hayes, J. A., McCracken, J. E., McClanahan, M. K., Hill, C. E., Harp, J. S., & Carozzoni, P. (1998). Therapist perspectives on countertransference: Qualitative data in search of a theory. *Journal of Counseling Psychology*, *45*(4), 468–482. https://doi.org/10.1037/0022-0167.45.4.468

Hayes, A., Riker, J., and Ingram, K. (1997). Countertransference behavior and management in brief counseling: A field study. *Psychotherapy Research*, *7*, 145–153. https://doi.org/10.1080/10503309712331331933

Hensel, J. M., Ruiz, C., Finney, C., & Dewa, C. S. (2015). Meta-analysis of risk factors for secondary traumatic stress in therapeutic work with trauma victims. *Journal of Traumatic Stress*, *28*(2), 83–91. https://doi.org/10.1002/jts.21998

Hunter, S. V. (2012). Walking in sacred spaces in the therapeutic bond: Therapists' experiences of compassion satisfaction coupled with the potential for vicarious traumatization. *Family Process*, *51*(2), 179–192. https://doi.org/10.1111/j.1545-5300.2012.01393.x

Iliffe, G., & Steed, L. (2000). Exploring counselors' experience of working with perpetrators and survivors on domestic violence. *Journal of Interpersonal Violenc*e, *15*, 393–412. https://doi.org/10.1177/088626000015004004

Jankoski, J. A. (2010). Is vicarious trauma the culprit? A study of child welfare professionals. *Child Welfare*, *89*(6), 105–120.

Jenkins, S. R., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validational study. *Journal of Traumatic Stress*, *15*, 423–432. https://doi.org/10.1023/A:1020193526843

Jiyoung, L., & Gabsook, K. (2013). Effects of narcissistic personality traits and interpersonal relationship tendencies of art therapists on their countertransference management ability. *The Arts in Psychotherapy*, *40*(3), 298–305. https://doi.org/10.1016/j.aip.2013.05.008

Jung, C. G. (1951). Fundamental questions of psychotherapy. In H. Read, M. Fordham, G. Adler, and W. McGuire (Eds.), *The collected works of C. G. Jung* (Vol. 16). Princeton University Press.

Jung, C. G. (1963). *Memories, dreams, reflections*. Pantheon.

Jung, C. G. (1981). *The development of personality* (R. F. C. Hull, Trans.). Princeton University Press. (Original work published 1954)

Kadambi, M. A., & Truscott, D. (2003). Vicarious traumatization and burnout among therapists working with sex offenders. *Traumatology, 9*(4), 216–230. https://doi.org/10.1177/153476560300900404s

Knapp, J. F., & Dowd, M. D. (1998). Family violence: Implications for the pediatrician. *Pediatrics in Review, 19*(9), 316–321. https://doi.org/10.1542/pir.19-9-316

Kohn, L. S. (2001). Why doesn't she leave: The collision of first amendment rights and effective court remedies for victims of domestic violence. *Hastings Constitution Law Quarterly*. http://ssrn.com/abstract=2182802

Latts, M. G., & Gelso, C. J. (1995). Countertransference behavior and management with survivors of sexual assault. *Psychotherapy,* 32, 405–415. https://doi.org/10.1037/0033-3204.32.3.405

Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative*

Methods, *2*(3), 21–35. htttp://www.ualberta.ca/~iiqm/backissues/2_3final/html /95averty.html

Marshall, M. N. (1996). Sampling for qualitative research. *Family Practice*, 13, 522–525. https://doi.org/10.1093/fampra/13.6.522

Martin-Cuellar, A., Lardier, D. T., Atencio, D. J., Kelly, R. J., & Montañez, M. (2019). Vitality as a moderator of clinician history of trauma and compassion fatigue. *Contemporary Family Therapy: An International Journal*, *41*(4), 408–419. https://doi.org/10.1007/s10591-019-09508-7

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, *3*(1), 131–149. https://doi.org/10.1007/BF00975140

Meadors, P., Lamson, A., Swanson, M., White, M., & Sira, N. (2009). Secondary traumatization in pediatric healthcare providers: Compassion fatigue, burnout, and secondary traumatic stress. *Omega: Journal of Death & Dying*, *60*(2), 103–128. https://doi.org/10.2190/OM.60.2.a

Meichenbaum, D. (1994). *Clinical handbook of treatment of post-traumatic stress disorder*. Institute Press.

Mehrabian, A. (1977). A questionnaire measure of individual difference in stimulus screening and associated difference in arousability. *Environmental Psychology & Nonverbal Behavior*, *1*, 89–103. https://doi.org/10.1007/BF01145458

Mehrabian, A. (1994). *Manual for the Revised Trait Arousability Scale*. Monterey, CA: Author.

Metcalf, L. M. (2003). Countertransferance among play therapists: Implications for therapist development and supervision. *International Journal of Play Therapy, 12*(2), 31–48. https://doi.org/10.1037/h0088877

Miller, G. D., & Baldwin, D. C. (2000). The implications of the wounded healer paradigm for the use of self in therapy. In Baldwin, M. (Ed.), *The use of self in therapy* (2nd ed., pp. 243–261). Haworth Press.

Morel, P. (Director). (2008). *Taken* [Film]. EuropaCorp.

Moustakas, C. E. (1961). *Loneliness*. Prentice-Hall.

Moustakas, C. E. (1990). *Heuristic research: Design, methodology, and applications*. Sage.

National Center for Injury Prevention and Control and Centers for Disease and Control and Prevention. (2006). Fact sheet: Understanding intimate partner violence. www.cdc.gov /ncipc/dvp/ipv_factsheet.pdf.

Neumann, D. A., & Gamble. S. J. (1995). Issues in the professional development of psychotherapists: Countertransference and vicarious traumatization in the new trauma therapist. *Psychotherapy,* 33, 341–47. https://doi.org/10.1037/0033-3204.32.2.341

Norcross, J. C., & Barnett, J. E. (2008). Self-care as ethical imperative. National Register of Health Service Providers in Psychology, 34, 21–27. http://www.nationalregister .org/trr_spring08_norcross.html.

Office of the Secretary of State. (2021). Texas administrative code, Texas State Board of Examiners of Professional Counselors. http://liaison.sos.state.tx.us/pls/pub/readtac$ext .ViewTAC?tac_view=4&ti=22&pt=30&ch=681

Ortlepp, K., & Friedman, M. (2002). Prevalence and correlates of secondary traumatic stress in

workplace lay trauma counselors. *Journal of Traumatic Stress*, *15*(3), 213. https://doi.org/10.1023/A:1015203327767

Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Sage.

Pérez-Rojas, A. E., Palma, B., Bhatia, A., Jackson, J., Norwood, E., Hayes, J. A., & Gelso, C. J. (2017). The development and initial validation of the Countertransference Management Scale. *Psychotherapy*, *54*(3), 307–319. https://doi.org/10.1037/pst0000126

Pearlman, L. A. (2003). *Trauma and Attachment Belief Scale*. Western Psychological Services.

Pearlman, L., & Mac Ian, P. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology, Research and Practice*, *26*(6), 558–565. http://doi.org/10.1037/0735-7028.19.6.624

Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. W.W. Norton.

Robbins, S. B., & Jolkovski, M. P. (1987). Managing countertransference feelings: An interactional model using awareness of feeling and theoretical framework. *Journal of Counseling Psychology*, *34*(3), 276–282. https://doi.org/10.1037/0022-0167.34.3.276

Rogers, C. R. (1951). *Client-centered counseling*. Houghton Mifflin Harcourt.

Rogers, C. R. (1980). *A way of being*. Houghton Mifflin Harcourt.

Rosenberger, E., & Hayes, J. (2002). Therapist as subject: A review of the empirical countertransference literature. *Journal of Counseling & Development*, *80*(3), 264–270. https://doi.org/10.1002/j.1556-6678.2002.tb00190.x

Satir, D. A., Thompson-Brenner, H., Boisseau, C. L., & Crisafulli, M. (2009). Countertransference reactions to adolescents with eating disorders: Relationships to

clinician and patient factors. *International Journal of Eating Disorders*, *42*(6), 511–21. https://doi.org/10.1002/eat.20650

Sartor, T. A. (2021, August 20). *Vicarious Trauma and its Influence on Self-Efficacy*. Ideas and Research You Can Use: VISTAS 2016. https://www.counseling.org/docs/default-source/vistas/article_2721c024f16116603abcacff0000bee5e7.pdf?sfvrsn=6

Schauben, L. J., & Frazier, P. A. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly*, *19*, 49–64. https://doi.org/10.1111/j.1471-6402.1995.tb00278.x

Sedgwick, D. (1994). *The wounded healer*. Brunner Routledge.

Smith, P. L., & Moss, S. B. (2009). Psychologist impairment: What is it, how can it be prevented, and what can be done to address it? C*linical Psychology: Science and Practice, 16,* 1–15. https://doi.org/10.1111/j.1468-2850.2009.01137.x

Sultan, N. (2020). *Heuristic inquiry, researching human experience holistically*. Sage. https://doi.org/10.1002/johc.12142

Taylor, S. J., & Bogdan, R. (1998). I*ntroduction to qualitative research methods: The search for meaning*. Wiley.

Tjaden, P. & Theonnes, N. (2000). *Extent, nature, and consequences of intimate partner violence*. U.S. Department of Justice. www.ncjrs.gov/pdffiles1/nij/181867.pdf

Tosone, C., Nuttman-Shwartz, O., & Stephens, T. (2012). Shared trauma: When the professional is personal. *Clinical Social Work Journal, 40*, 231–239. https://doi:10.1007/s10615-012-0395-0

Van Wagoner, S. L., Gelso, C. J., Hayes, J. A., & Diemer, R. A. (1991). Countertransference and the reputedly excellent therapist. *Psychotherapy: Theory, Research, Practice, Training*, *28*, 411–421. https://doi.org/10.1037/0033-3204.28.3.411

Warshaw, C. (1996). Domestic violence: Changing theory, changing practice. *Journal of American Medical Women's Association, 51*(3), 87–91.

Williams, E. N., Hurley, K., O'Brien, K., & de Gregorio, A. (2003). Development and validation of the Self-Awareness and Management Strategies (SAMS) scales for therapists. *Journal of Psychotherapy, 40*, 278–288. https://doi.org/10.1037/0022-0167.44.4.390

Williams, E. N., Polster, D., Grizzard, B., Rockenbaugh, J., & Judge, A. (2003). What happens when therapists feel bored or anxious? A qualitative study of distracting self-awareness and therapists' management strategies. *Journal of Contemporary Psychotherapy, 33,* 5–18. https://doi.org/10.1023/A:1021499526052

Yulis, S., & Kiesler, D. J. (1968). Countertransference response as a function of therapist anxiety and content of patient talk. J*ournal of Consulting and Clinical Psychology,* 32, 414–419. https://doi.org/10.1037/h0026107

Appendix A

Invitation To Participate In A Research Project

Dear Colleague,

My name is Janis April Edralin and I am a student in the Department of Counseling and Human Services at St. Mary's University pursuing a doctorate in Counselor Education and Supervision. For my dissertation, I am conducting a study entitled "How Domestic Violence Counselors with Personal Histories of Trauma Experience Clients Who Were Victims of Domestic Violence: A Heuristic Study." At this time, there has been no research in this area of interest. For this reason, information from this study is intended to assist counselors in understanding this topic. Your participation is critical to learning more about this process. I would like to request your participation if you meet the following criteria:

- You are a Licensed Professional Counselor (LPC) or Licensed Professional Counselor-Supervisor (LPC-S) licensed by the Texas State Board of Examiners of Professional Counselors;

- As an LPC or LPC-S you have 5 or more years of experience in performing face-to-face professional counseling with clients who were victims of domestic violence;

- You have experienced trauma personally and are willing to share your personal history of trauma; and

- You are willing to share your counseling experience about one client who has not demonstrated psychotic features, was at least 18 years old, was a victim of domestic violence, and for whom you have provided at least five face-to-face counseling sessions as an LPC or LPC-S.

Trauma is bodily or mental injury, usually caused by an external agent. Domestic violence is behavior to gain or maintain power and control over another person through harmful tactics. It can involve physical abuse, sexual abuse, emotional or psychological abuse, economic abuse, entitlement, intimidation, and/or stalking. It involves a current or former personal, family, or caregiver relationship. Domestic violence is also known as domestic abuse, family violence, or intimate partner violence. Victims, also known as survivors, are those who have witnessed or experienced abusive behaviors.

Your anticipated time commitment for the initial face-to-face interview should be no more than 3 hours. If you agree to participate in this study, it will involve completing a demographic questionnaire prior to the initial face-to face interview. The initial face-to-face interview will entail me asking you about your personal history of trauma and how you experience a client who was a victim of domestic violence. You will be asked to provide a pseudonym for the client. All direct and indirect identifies will be removed or changed. Another face-to-face or telephonic interview will follow. You will be asked to about your preference to have a follow-up face-to-face interview of telephonic interview with me.

Your responses will remain confidential. You will be assigned a participant identification number and pseudonym so your identifying information will never be kept with the audio or transcript files. Your initial face-face interview will be recorded, transcribed, and sent to you for review. The interview transcript will be sent by email in a password-protected computer file. No one will be able to identify you or your answers, and no one will know if you participated in the study. The informed consent form will be stored separately from other research study material.

There will be no remuneration for this endeavor; however, most importantly, the potential for advancing knowledge about our profession provides a meaningful venue for giving back to the community. Your participation is voluntary. You have several choices regarding nonparticipation in this project: (a) you may decide not to participate at all; (b) you may decide not to answer some of the questions; or (c) you may decide to terminate your participation even after you have begun. At any time during the interview should you experience symptoms of your trauma or would like to end the interview you may let me know. I may end the interview if in my judgment you are experiencing symptoms of trauma. I will end the interview if you describe any client who is under 18 years old.

Each is available to you, and you will not suffer any penalty. If you agree to participate in the study, please review the consent form. There are no physical s to participants in this study. The potential associated with participating in this study relates to revealing personal and historical information. Participation may evoke cognitive and emotional discomfort. You are encouraged to seek mental health services should you wish to pursue resolution concerning your experiences.

Every effort will be made to maintain the confidentiality of the data you provide. I am a mandated reporter under Texas law. I am mandated to report child, elder, and disabled person abuse or neglect of identifiable individuals.

The data collected from this inquiry will be used for education and publication purposes; however, it will not be identified with you personally. Any questions about this research, or any related problems, may be directed to the principal investigator, Janis April Edralin, MA, LCDC, LPC-S, NCC, Department of Counseling and Human Services, at (210) 535-7155. If you have any questions about your rights as a research subject or concerns about this study, please contact the chair of the Institutional Review Board, St. Mary's University, at 210-436-3736 or email at IRBCommitteeChair@stmarytx.edu

ALL RESEARCH PROJECTS CARRIED OUT BY INVESTIGATORS AT ST. MARY'S UNIVERSITY ARE GOVERNED BY THE REQUIREMENTS OF THE UNIVERSITY AND THE FEDERAL GOVERNMENT.

Thank you for considering participation in this study. Your response is very important to this study. Please contact me at jedralin@mail.stmarytx.edu if you have questions or would like to join in the research.

Sincerely,
Janis April Edralin,
MA, LCDC, LPC-S, NCC

Study Participants Needed

You are invited to participate in a research study about
How Domestic Violence Counselors Who Have Personal Histories of Trauma Experience Their Clients Who Were Victims of Domestic Violence.

What would you need to do?

- The study involves two interviews.
- The first is a face-to-face interview that should last no more than 3 hours.
- The second interview will be your preference of a face-to-face or telephonic interview.

What is required to participate?

- Be a Licensed Professional Counselor (LPC) or Licensed Professional Counselor-Supervisor (LPC-S) licensed by the Texas State Board of Examiners of Professional Counselors;
- As an LPC or LPC-S have 5 or more years of experience in performing face-to-face professional counseling with clients who were victims of domestic violence;
- Have experienced trauma personally and are willing to share your personal history of trauma;
- Be willing to share your counseling experience about the following:
    - one client who did not demonstrate psychotic features,
    - was at least 18 years old,
    - was a victim of domestic violence, and
    - for whom you provided at least five face-to-face counseling sessions as an LPC or LPC-S.

If you are interested in participating or you would like more information, please contact Janis April Edralin, MA, LCDC, LPC-S, NCC by email at jedralin@mail.stmarytx.edu or telephone at (210) 535-7155. Contacting me in no way commits you to participate. If you decide to participate, you are completely free to stop participating at any time.

Appendix B

Informed Consent Form

ST. MARY'S UNIVERSITY OF SAN ANTONIO, TEXAS
CONSENT BY PARTICIPANT FOR PARTICIPATION
IN A RESEARCH PROJECT

Title:	How Domestic Violence Counselors with Personal Histories of Trauma Experience Clients Who Were Victims of Domestic Violence: A Heuristic Study.
Principal Investigator:	Janis April Edralin, MA, LCDC, LPC-S, NCC Department of Counseling and Human Services (210) 535-7155
Faculty Sponsor:	Ray Wooten, PhD Department of Counseling and Human Services

I am being asked to participate in the above-mentioned project. My participation in this study is voluntary, and I may refuse to participate or I may decide to cease participation once begun. Should I withdraw from the study, which I may do at any time, or should I refuse to participate in the study, my decision will involve no penalty or loss of benefits to which I am otherwise entitled. At any time during the interview should I experience symptoms of my trauma or would like to end the interview I will let the researcher know. I understand the researcher may end the interview if in the researcher's judgment I am experiencing symptoms of my trauma. The researcher will end the interview if I describe any client who is under 18 years old.

I am being asked to read the consent form carefully and will receive a copy of it to keep, if I decide to participate in this study. The purpose of this study is to examine how domestic violence counselors who have personal histories of trauma experience their clients who were victims of domestic violence. Information from this research study is intended to assist counselors in understanding this topic.

I understand the following research procedures:

The researcher will perform face-to-face interviews with participants who are Licensed Professional Counselors (LPC) or Licensed Professional Counselor Supervisors (LPC-S) licensed by the Texas State Board of Examiners of Professional Counselors.

As an LPC or LPC-S, the participants must have at least 5 years of experience in performing face-to-face counseling with clients who were victims of domestic violence.

The participants have experienced trauma personally and are willing to share their personal histories of trauma.

As an LPC or LPC-S, the participants are willing to share their counseling experiences about one client who did not demonstrate psychotic features, was at least 18 years old, was a victim of domestic violence, and for whom they have provided at least five face-to-face counseling sessions.

I understand that the total anticipated time commitment for the initial face-to-face interview should be no more than 3 hours. Participants will be asked to complete a demographic questionnaire prior to the initial face-to-face interview. The initial face-to-face interview will entail the researcher asking participants questions about their experiences of a client who was a victim of domestic violence. I understand that I will be asked to provide a pseudonym for the client.

I understand that I will be assigned a participant identification number and pseudonym so my identifying information will never be kept with the audio or transcript files. I understand that all direct and indirect identifiers will be removed or changed. I understand that my initial face-face interview will be recorded, transcribed, and sent to me for review. I understand the interview transcript will be sent by email in a password-protected computer file. The informed consent form will be stored separately from other research study material.

The researcher will perform a follow-up face-to-face or telephonic interview with me. The researcher will ask about my preference to have a follow-up face-to-face interview or telephonic interview with me. I understand that while there are no physical s associated with participation in this project, the potential associated with participating in this study relates to revealing personal and historical information. The participation may evoke cognitive or emotional discomfort. I have been encouraged to seek mental health services should I wish to pursue resolution concerning my experiences.

I understand that I will receive no direct benefit from my participation in this study, but my participation will have the potential for advancing knowledge about how domestic violence counselors who have personal histories of trauma experience their clients who were victims of domestic violence.

I understand that in order to preserve confidentiality, the researcher will make every effort to maintain the confidentiality of the data I provide. I understand that the data collected from the study will be used for educational and publication purposes; however, I will not be identified by name. Such confidentiality will remain within allowable legal limits. I understand that the researcher is a mandated reporter under Texas law. I understand that the researcher is mandated to report child, elder, and disabled person abuse or neglect of identifiable individuals.

I understand there will be no remuneration for this endeavor; however, most importantly, the potential for advancing knowledge about the counseling profession provides a meaningful venue for giving back to the community.

I understand that the investigator has the right to withdraw me from this study at any time. The principal investigator has offered to answer all my questions. If I have additional questions during the course of this study about the research or any related problem, I may contact the

principal investigator, Janis April Edralin, Department of Counseling and Human Services, at (210) 535-7155.

In the event of injury resulting from this research, St. Mary's University is not able to offer financial compensation or absorb the costs of medical treatment; however, necessary facilities, emergency treatment, and professional service will be available to research participants, just as they are to the public. My signature below acknowledges my voluntary participation in this research project. Such participation does not release the investigator(s), institution(s), sponsor(s), or granting agency(ies) from their professional and ethical responsibility to me.

I HAVE READ THE INFORMATION PROVIDED ABOVE AND HAD MY QUESTIONS ANSWERED TO MY SATISFACTION. I VOLUNTARILY AGREE TO PARTICIPATE IN THIS STUDY. I WILL RECEIVE A COPY OF THIS CONSENT FORM.

If you have any questions about your rights as a research subject or concerns about this research study please contact the chair of the Institutional Review Board, St. Mary's University, at (210) 436-3736 or email at IRBCommitteeChair@stmarytx.edu

ALL RESEARCH PROJECTS THAT ARE CARRIED OUT BY INVESTIGATORS AT ST. MARY'S UNIVERSITY ARE GOVERNED BY THE REQUIREMENTS OF THE UNIVERSITY AND THE FEDERAL GOVERNMENT.

_____ _____

Name of Research Participant (Please Print) Date

_____ _____

Signature of Research Participant Date

_____ _____

Signature of Witness Date

_____ _____

Signature of Principal Investigator Date

The IRB has approved the study, approved the study, *How Domestic Violence Counselors with Personal Histories of Trauma Experience Clients Who Were Victims of Domestic Violence: A Heuristic Study* (Wooten, Faculty sponsor) for the period of 02/17/2017 to 02/01/2018.
If research participants have any questions about their rights as a research subject or concerns about this research study please contact the Chair, Institutional Review Board, St. Mary's University at 210-436-3736 or email at IRBCommitteeChair@stmarytx.edu.

Dan Ratliff, Ph.D.
IRB Chair
St. Mary's University

Appendix C

Demographic Questionnaire

Please do not write any identifying information on this form. Please make a check mark or fill in the blanks in the appropriate space below.

Are you a Licensed Professional Counselor (LPC) or Licensed Professional Counselor-Supervisor (LPC-S) licensed by the Texas State Board of Examiners of Professional Counselors?
[ ] Yes
[ ] No

Do you have at least 5 years of experience as an LPC or LPC-S in performing face-to-face professional counseling with clients who were victims of domestic violence?
[ ] Yes
[ ] No

Have you experienced trauma personally and are willing to share your personal history of trauma?
[ ] Yes
[ ] No

As an LPC or LPC-S, are you willing to share how you experienced one client who was a victim of domestic violence, demonstrated no psychotic features, was at least 18 years old, and for whom you have provided at least five face-to-face counseling sessions?
[ ] Yes
[ ] No
Note: You will be asked about your experiences of this work and should not provide any identifying information about the client.

Which one of the following best describes the agency setting in which you work as a counselor?

[ ] Private practice/independent contractor	[ ] Federal agency
[ ] State agency	[ ] County agency
[ ] Municipal agency	[ ] Health insurance company
[ ] Educational institution	[ ] Hospital or clinic
[ ] Nonprofit organization	[ ] Other_____

Which one of the following best describes your race/ethnicity?

[ ] White	[ ] Black/African American
[ ] Middle Eastern	[ ] Hispanic/Latin
[ ] Asian	[ ] Pacific Islander
[ ] American Indian/Alaskan Native	
[ ] Other _____	

Which one of the following best describes your gender?
[ ] Male [ ] Female [ ] Other _____

Appendix D

Initial Face-To-Face Interview Questions

1. Tell me what you think about being a domestic violence counselor who has a personal history of trauma.
2. How have you managed to cope given everything you have been through?
3. How have you been impacted in performing counseling with clients who were victims of domestic violence?
4. Tell me more about a specific client who was a victim of domestic violence who had an impact on you.
5. How were you negatively impacted during the counseling sessions?
    a. How did you manage the negative impact during the counseling sessions?
6. How were you negatively impacted outside of the counseling sessions?
    a. How did you manage the negative impact outside of the counseling sessions?
7. How were you positively impacted during the counseling sessions?
    a. How did you manage the positive impact during the counseling sessions?
8. How were you positively impacted outside of the counseling sessions?
    a. How did you manage the positive impact outside of the counseling sessions?
9. What would you advise domestic violence counselors to do in a similar situation?
10. What do you think domestic violence counselors in a similar situation would advise you to do?
11. What have learned about yourself, both personally and professionally?

Vita

CENSUS

Janis April Edralin was born and then raised by adoption with her maternal aunt and grandmother internationally and domestically in the United States of America.

EDUCATION

Master of Arts in Counseling, The University of Texas, San Antonio, Texas.

Master of Arts in International Relations, Saint Mary's University, San Antonio, Texas.

Bachelor of Arts in Criminal Justice, The University of Texas, El Paso, Texas.

RESEARCH EXPEREINCE

Research assistant at the Legal Psychology Department at The University of Texas, El Paso, Texas.

LICENSES

Licensed Chemical Dependency Counselor.

Licensed Professional Counselor.

ADDRESS:

PO Box 100-106

San Antonio, Texas 78201