

Working with refugee survivors of torture and trauma: An opportunity for vicarious post-traumatic growth

Allysa J. Barrington* and Jane Shakespeare-Finch

*School of Psychology and Counselling, Institute of Health and Biomedical Innovation,
Queensland University of Technology, Brisbane, Australia*

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Clinical work with people who have survived trauma carries a risk of vicarious traumatisation for the service provider, as well as the potential for vicarious post-traumatic growth (VPTG). Despite a growing interest in this area, the effects of working with survivors of refugee-related trauma have remained relatively unexplored. In this study, we examined the lived experiences of people working on a daily basis with survivors of torture and trauma who had sought refuge in Australia. Seventeen clinical, administrative and managerial staff from a not-for-profit organisation participated in a semi-structured interview that was later analysed using interpretive phenomenological analysis. Analysis of the data demonstrated that the entire sample reported symptoms of vicarious trauma (e.g. strong emotional reactions, intrusive images and shattering of existing beliefs) as well as VPTG (e.g. forming new relationships, increased self-understanding and gaining a greater appreciation of life). Moreover, effortful meaning-making processes appeared to facilitate positive changes. Reduction in the risks associated with this work, the enhancement of clinician well-being, and improvement of therapeutic outcomes for clientele are responsibilities shared by the organisation and clinicians. Without negating the distress of trauma work, clinicians are encouraged to more deeply consider the unique positive outcomes that supporting survivors can provide.

Keywords: trauma; refugee; vicarious trauma; vicarious post-traumatic growth; meaning making

Trauma literature has predominately focused on the impacts of experiencing a highly distressing or traumatic event and limited attention has been paid to mental health professionals who assist or support trauma survivors in their recovery. As such, investigators are only beginning to understand the effects of trauma work on the mental health of service providers. One increasingly recognised idea is that clinicians involved in such work are at risk of experiencing negative outcomes, like compassion fatigue (e.g. Figley, 1995; Steed & Downing, 1998). Clinicians are not immune to the distressing and potentially traumatising stories they hear, even when they are highly qualified or extensively trained (Illiffe & Steed, 2000).

The notion of vicarious trauma first appeared in the emergency services literature when rescue workers showed signs of post-traumatic stress disorder (Moulden & Firestone, 2007). Researchers then broadened their focus to include the possible

*Corresponding author. Email: allysa.barrington@qut.edu.au

adverse impact on clinicians of working with sexual and physical abuse survivors (e.g. Moulden & Firestone, 2007; Schauben & Frazier, 1995; Steed & Downing, 1998), survivors of military combat (e.g. Linnerooth, Mrdjenovich, & Moore, 2011; Voss Horrell, Holohan, Didion, & Vance, 2011), survivors of domestic and family violence (e.g. Ben-Porat & Itzhaky, 2009; Iliffe & Steed, 2000) and survivors of single traumatic accidents (Sabin-Farrell & Turpin, 2003). However, the potential consequences for clinicians of working with people who have migrated as refugees remain relatively unknown.

Due to conflict, poverty and human rights abuses, the number of people seeking asylum or refuge is constantly increasing. The traumatic experiences of refugees are many and often include illness, injury, starvation, rape, torture, or concentration camp experiences (Oktikpi & Aymer, 2003). As such, research concerning the effects on clinicians of working with this growing and sometimes highly traumatised population is warranted. We hope that further research will help to improve clinical effectiveness through enhanced clinician well-being. The limited research available in this area claims that clinicians feel bombarded by the stories told to them by refugees, and that working with this population can foster feelings of hopelessness, helplessness, impotence and fear (Eleftheriadou, 1999).

Vicarious traumatisation

The impact of trauma can be far-reaching because of its ability to shatter the global beliefs that people hold. Typically, people believe that they have control over their lives, the world is reasonably fair and bad things do not happen to good people. These global beliefs (i.e. core schemas through which people interpret their experience of the world) are violated in the face of trauma (Janoff-Bulman, 1989). Traumatic events often raise questions regarding the purpose and meaning of life, or questions about the fairness and controllability of the world (Janoff-Bulman, 1989; Park, 2010; Park & Ai, 2006). When clinicians are repeatedly exposed to traumatic material, they can experience a phenomenon known as vicarious traumatisation (VT; McCann & Pearlman, 1990). McCann and Pearlman (1990) defined VT as the painful and disruptive psychological effects of trauma-based work. Symptoms can include strong emotional reactions, intrusive images and the disruption of beliefs about the self, others, and the world (McLean, Wade, & Encel, 2003).

VT is considered a natural and almost inevitable response to working with trauma survivors (Pearlman & MacIan, 1995; Pearlman & Saakvitne, 1995). VT is neither a reflection of pathology in the clinician nor an intentional act of the client (Pearlman & MacIan, 1995). McCann and Pearlman (1990) conceptualise VT as pervasive (i.e. affecting all realms of life), cumulative (i.e. each story reinforcing gradually changing schemas) and arising from repeated empathic engagement with traumatic material. The level of distress experienced by clinicians is commensurate with the degree of discrepancy between their appraised meaning of the traumatic story and existing global meaning (Park & Folkman, 1997). A large discrepancy creates discomfort that reflects a loss of predictability or comprehensibility of the world. Clinicians will engage in an effortful process of meaning making to reduce this discrepancy and ameliorate the shattering of their assumptions (Janoff-Bulman, 1989; Park & Folkman, 1997). Cognitive processing or mentally reworking beliefs

allow clinicians to incorporate their personal narrative around the experience of hearing about trauma and to reduce their psychological distress (Park & Ai, 2006).

Vicarious post-traumatic growth

A growing body of literature indicates that once survivors are able to make sense of their experience, positive post-trauma changes can occur (see Tedeschi, Park, & Calhoun, 1998). Post-traumatic growth (PTG) is defined as positive psychological change that results from engaging in the struggle associated with traumatic or highly challenging circumstances (Calhoun & Tedeschi, 2001). More recent research has demonstrated that behavioural changes (e.g. spending more time with family or friends, changes in study or career path, increased use of prayer) can accompany this psychological change (Shakespeare-Finch & Barrington, 2012). Implicit in the traditional notion of growth is that it is beyond mere survival; PTG is reflective of greater psychological and cognitive development, emotional adjustment and life awareness (Tedeschi & Calhoun, 2004; Tedeschi et al., 1998). Tedeschi and Calhoun (1996) have grouped positive change into three broad categories of growth – changes in self-perception, changes in interpersonal relationships and changes in life philosophy.

Theorists argue that growth can occur as a result of vicarious trauma, through similar meaning-making processes that follow direct trauma; that is, creating and infusing meaning with existing global beliefs (Janoff-Bulman, 1989; Linley, Joseph, & Loumidis, 2005). Trauma workers have reported important work-related benefits or rewards including gains in relationship skills, increased appreciation for the resilience of people, satisfaction from observing growth, and being part of the healing process (Herman, 1995; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995; Shakespeare-Finch, Smith, Gow, Embelton, & Baird, 2003). However, such positive outcomes are often mentioned tangentially in the context of more comprehensive explorations of negative outcomes (e.g. McCann & Pearlman, 1990; Steed & Downing, 1998). Little is known about the process of psychological growth that can follow vicarious exposure to trauma, which has been labelled vicarious PTG (VPTG; Arnold, Calhoun, Tedeschi, & Cann, 2005).

From the limited research available, evidence suggests that perceived growth amongst clinicians reflects gains made in the same three areas as survivors (Arnold et al., 2005). In a study of vicarious trauma, Herman (1995) reported that clinicians' second-hand exposure to traumatic material enriched their self-understanding and their ability to understand others; enabled them to form new relationships or deepen existing relationships; and, enhanced their appreciation of life. However, it appears that only two published studies have explicitly examined VPTG. In their landmark article, Arnold et al. (2005) examined how a sample of trauma therapists ($N=21$) had been affected by their work. As expected, all the therapists reported some type of negative response to their work (e.g. intrusive thoughts and images; emotional reactions; physical exhaustion and concerns about therapeutic effectiveness). Yet, all the therapists simultaneously reported some positive outcomes such as gains in empathy, compassion, tolerance and sensitivity; improved interpersonal relationships; deepened appreciation for human resilience; greater appreciation of life; a desire to live more meaningfully; and, positive spiritual change. Splevins, Cohen, Joseph, Murray, and Bowley (2010) later explored the concept of VPTG in a sample

of interpreters ($N=8$) who worked with refugees. Consistent with the findings of Arnold et al. (2005), the interpreters reported both negative and positive consequences of their work (e.g. feelings of joy, hope, admiration and inspiration; witnessing client recovery; and, a desire to live a deeper and more purposeful life).

In both of these studies, perceptions of growth for trauma workers were consistent with the three domains of growth identified by Tedeschi and Calhoun (1996). Moreover, Splevins et al. (2010) found support for the way in which people attempt to reduce cognitive dissonance pre- and post-trauma by accommodating new trauma-related material. Therefore, if a trauma worker engages in similar processes to that of the survivor they might also successfully integrate and transform their vicarious trauma experience to maximise the possibility of growth (McCann & Pearlman, 1990). An increased understanding of how trauma workers can foster such positive outcomes has important clinical implications (e.g. enhanced clinician well-being, role retention, and improved therapeutic outcomes).

Given the paucity of research examining post-trauma outcomes in those who treat the traumatised, our purpose in this study was to explore the lived experiences of people working with survivors of refugee-related trauma. Our questions of interest included: What are the impacts of supporting refugees in their recovery from torture and trauma? Do clinicians experience any positive outcomes from this work? If so, do meaning-making processes lead to these positive outcomes?

Method

Participants

The sample ($N=17$) was comprised of frontline clinical ($n=13$) and administrative or managerial staff ($n=4$) from the Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT). This is a not-for-profit organisation that provides services to people who have suffered refugee-related torture and trauma prior to migrating to Australia. The sample was recruited via a snowballing method that resulted in 43% of all staff taking part in the project. The sample contained two males and 15 females who ranged between 31 and 60 years of age ($M=42$, $SD=7.79$). Most participants identified as Australian (29%), South American (24%), or European (24%). Almost half of the sample had completed a psychology degree (47%); a smaller proportion had completed a social work degree (20%). The sample reported working in the trauma field for an average of 6.3 years ($SD=5.60$, 95% CI [3.20, 9.40]). The typical amount of time, on a weekly basis, that individuals in this sample had contact with the refugee population, was 26 h ($SD=11.52$, 95% CI [19.62, 32.38]).

Interviews

All participants engaged in a semi-structured interview that spanned 45–60 min. The aim of the interview was to examine the lived experience of working with refugee survivors, with a particular focus on how clinicians made sense of the distressing stories they heard and whether they experienced any positive outcomes as a result of their work. Each interview began with a neutral, open-ended question related to the clinician's role at QPASTT (i.e. 'Tell me a little bit about what you do here at QPASTT, what is your role?'). As is typical with qualitative semi-structured designs,

the unique interaction between the researcher and clinician shaped the course of the interview.

Procedure

Following human subjects approval, we informed all QPASTT staff members of the project via e-mail. We attached to the e-mail a participant information sheet that contained a brief project description, the potential risks and benefits of the project, inclusion criteria, a statement on confidentiality, and a consent form. Those staff members who were interested in participating contacted the researchers (via e-mail or phone) and forwarded to us the signed consent form. The interviews were audio-recorded and later transcribed verbatim, but special care was taken to remove any potentially identifying information from the final data set used in the analysis.

Data analysis

The data were explored using interpretative phenomenological analysis (IPA; Smith, 1996). The aim of this approach was to *give voice* to participants and the meaning they assigned to their experience. IPA allowed for salient domains of the lived experience of working with refugees to emerge. Existing research was used to inform, rather than drive the analysis or impose a priori assumptions on the data. Interpretation was adherent to a contextual constructionist view that highlights reality as subjective, dynamic in nature and informed by personal and social constraints (Smith, 1996; Splevins et al., 2010).

In line with IPA methodology, the analysis involved five separate stages. First, constructions of meaning were prioritised. Each interview was transcribed verbatim and analysed in accordance with an idiographic and iterative approach. Second, emergent constituent themes were coded following several readings of the transcripts. Third, the codes that comprised constituent themes were clustered into superordinate themes. These superordinate themes were reflective of the overarching dimensions of the interview narratives. Fourth, the data were interrogated nomothetically. Finally, the themes identified within each transcript were merged to create a master table of exemplary quotes, constituent themes and superordinate themes (Smith, 1996). For the purposes of this article, the themes of vicarious trauma, meaning making and VPTG were examined in depth. In addition, exemplary quotes were extracted from the master table to show evidence of these phenomena. The quotes presented below are followed with a unique identifying number that was assigned to each participant.

Allysa J. Barrington performed the initial analysis but to ensure the validity and reliability of the identified themes, Jane Shakespeare-Finch analysed a subset of transcripts. Jane Shakespeare-Finch, an experienced qualitative researcher, followed the same procedure outlined above. A high inter-rater agreement was obtained adding to the rigour of interpretation. Evidence of this inter-rater reliability was in the independence of identifying the same constituent and superordinate themes regarding domains of growth and meaning making. In addition, internal coherence and presentation of evidence, two methods specific to IPA, were used to ensure the integrity and credibility of the data. Internal coherence refers to whether the argument presented in a study is internally consistent and supported by the

qualitative data. Presentation of evidence refers to presenting sufficient qualitative data to enable readers to evaluate the interpretations (Smith, 1996).

Results

Vicarious trauma

As mentioned above, vicarious trauma acts as a precursor to vicarious growth. It is impossible for a trauma worker to experience significant growth without first feeling somewhat traumatised by their work. All the participants reported some element of VT as a result of their work with refugee survivors. One clinician disclosed,

... It's (VT) just something that you can't avoid when you work with people who have had such trauma in their lives. (12)

Most clinicians referred to an initial difficulty adjusting to the work. For example, one participant said,

Initially, I got affected; it took me a while to actually deal with it. (17)

Although a number of issues reportedly caused distress amongst the clinicians (e.g. working with interpreters and dealing with government bodies), hearing the traumatic stories was the primary instigator of VT symptoms. One participant stated,

It is hard because you get swallowed up very easily in this work because you are hearing all the stories and worrying about clients... The only probably negative, more difficult part here is dealing with the stories. (8)

A number of clinicians indicated that hearing such stories moved them to tears and carried a high emotional toll. One participant stated,

I would leave a client after hearing their story and just burst into tears. (1)

Some clinicians reported more severe post-traumatic stress symptoms that were akin to those of direct trauma survivors (e.g. intrusive images, flashbacks and dissociation). For instance, one person said,

One client was talking about feeling blood on his hands and I could see the blood, in my mind, on his hands. (15)

Another person said,

Not dreams, but I [get] flashbacks... Sometimes I am at home and I just have this [bad feeling] come back. (12)

One clinician was quite descriptive in her experience and said,

I used to go to the supermarket and feel like I had bubble wrap, like Glad Wrap, just around me, like this kind of coating. I would go there and I just felt like I was going from this horror world into normal land, and then I didn't feel connected to people in normal land. Like I was going, 'You don't get it; you didn't hear what I heard!'... It sounds very dramatic, but it's like you kind of walk around and on the inside you're just constantly churning through this information. (9)

Meaning making

The shattering of beliefs associated with vicarious trauma acts as an impetus for meaning making and other positive outcomes. To reduce the psychological distress

of trauma work, clinicians can adjust existing beliefs to incorporate the traumatic stories and make meaning of their experience. Ten clinicians reported engaging in this meaning-making process as a part of their work at QPASTT. For instance, one participant said,

You think, how could this happen? That's all the time! How can someone just, you know, chop off something or do something physically to someone? It sends shivers to my skin. (17)

Another clinician said,

There are things that you hear that you actually go like, how can that happen to someone? How can you survive? How can you, like how can you cope and keep living? You see the depression or you see the sadness, but the person keeps going and you wonder how. (5)

The entire sample described the strategies they relied on to make sense of their experiences and move from a position of vulnerability to a position of growth. Some strategies occurred at an organisational level, whereas some occurred at an individual level. A portion of the clinicians made sense of the traumatic stories by changing their way of thinking. One person reported,

I'm trying to see things from another perspective; that this is something that has been happening probably from the beginning of humankind and that still the war is going on and then everybody seems to be, not that it's not important, but the show must go on or something like that. (14)

Another person reported,

I look at the way human beings are and what causes us to do evil things. Looking at more of a Buddhist perspective around human behaviour is, it helps with that kind of thinking around that people are just doing the best they can given the circumstances that they were born into . . . and that if you were in their shoes you would probably, you would, you would not probably do exactly the same thing, you would do exactly the same thing. (3)

Other participants relied on increasing their self-awareness or considering how they might have coped in similar situations. One stated,

I'm constantly doing that reflection about what do I think about this, how does it affect me, how does it change my idea of the world? (9)

Another stated,

I suppose you think about, you know, how would I have coped in that situation. I think to myself, you know, what would I have done? Would I have just kind of, you know, jumped in the nearest river? (7)

Some reported reaching out for additional support to help make sense of the stories. One clinician said,

I ended up having some counselling sessions just around, you know, the nature of evil. Not that I believe in evil but why, how this could, how can a human being do this to another human being. (3)

Undergoing personal counselling was one of many self-care strategies that clinicians utilised as a way of making meaning. One of the participants indicated,

[Self care strategies] are more important. They're things I have used before . . . but they've become vital . . . If I didn't do these things for a few months, I would probably have to leave the job. (1)

The most commonly reported self-care strategies were: (a) meditation; (b) practicing mindfulness; (c) eating healthily; (d) exercising regularly; (e) limiting exposure to violent or dramatised material outside of work; (f) spending more time outdoors; (g) developing a healthy work–life balance; and, (h) speaking to friends or family about work-related stress.

The sense of purpose received from their work also helped participants to make meaning of their experience. A number of clinicians described feeling honoured or privileged to be working with refugees and hearing their stories. For instance,

It feels like an absolute privilege to sit with [these] people and hear their stories, to be the person that they are willing to trust when they don't trust anybody else. You know, to be the person that they trust with that level of information, that depth of trauma and horror. (1)

Another participant said,

To be able to help such vulnerable people, I just feel privileged to be in this job, to be sitting and listening to their stories . . . to see them opening up and talk about things. I just feel quite privileged to be sitting there and listening to their stories. (2)

For others, it was witnessing growth in their clients that helped them to make meaning of their work. One clinician said,

Even though it is going to take time, even though it is going to take years, even though the healing is not always going to be complete, there is something that you can see in clients when you work here. You can see how life changes in ways that you never thought would happen. If you can see that, you have the motivation to continue to work. (12)

And another said,

Sometimes change is very, very small, but if you're skilled and know what you're looking for, you do actually see very small change and that's enough to keep you going. (7)

At an organisational level, participants reported using supervision as a way of making sense of the stories. For example,

The good thing within the QPASTT organisation is [that] they offer supervision. That helps a lot . . . you won't keep something inside you and take it home. (13)

However, speaking to colleagues seemed to carry additional benefits because colleagues had personally experienced similar situations or reactions. One clinician said,

It's good just to hear and normalise [our] experiences and maybe share the ideas, like if something works for us it might work for others and vice versa. And sharing the frustrations, you know, like we do the best we can and yet we have the same frustrations. (11)

An empathic work environment and good collegial support was reportedly vital in helping participants to make meaning of their work. One participant said,

Peer support is very strong here at QPASTT. Even if you're not able to see the supervisor right away, you know that there are people around who are able to listen and understand. (4)

Post-traumatic growth

Research has shown that a found sense of meaning can lead to other positive outcomes for the trauma worker, such as VPTG. Although the clinicians experienced

symptoms of VT, they also reported elements of VPTG. All participants reported changes in one or more of the three domains of growth outlined below.

Changes in life philosophy

The entire sample experienced some philosophical shift as a result of making sense of their work with refugees. The clinicians frequently reported an ‘opening of their mind’ or growing sense of awareness. For example,

Your idea about what the world is like just develops and it kind of crumbles and it grows and it blooms in all these weird ways. My understanding of our earth and people has just, you know, it just grows everyday like with every phone call, with every interaction like its constantly growing and the understanding is constantly getting bigger. (9)

Another participant said,

I think that we learn everyday something new and it’s for us! What we learn is making us a bigger, not bigger [i.e. physically bigger], but our minds or our views are broadened. (15)

For other clinicians, making sense of their work positively impacted their way of thinking. One person reported,

I used to be really strict and I used to be a right or wrong person, and this place has changed me 100% in that way. I try to avoid saying right or wrong, even to say that, you know, because now, I don’t believe there is a right or wrong. (12)

Another person said,

I only used to see things [in] black and white, but working in here makes you more understanding. (17)

Some of the participants reported a change in their values or priorities for life. One clinician said,

Its changed the values that you want, to live more simply, even if that was maybe my philosophy always [this work] probably enhances that more. (8)

Another said,

It just helped bring it more to home on a personal level, to want to do so much more, to bring equality to this earth. (2)

Some of the participants reported being more understanding or less judgemental of other people since starting this work. One clinician said,

What I just also learn is respect that everybody has different experiences and what is hard for you maybe is not for me; this is another thing that I learn from my clients. As a person working in this area [I learned] to avoid judging people for what they say or how they appear to be because they come from different, you know, places where they need to learn to survive. (12)

A number of participants indicated an increased sense of gratitude. One clinician said,

Knowing that these people are not having even one per cent of, you know, what we have in our life, it helps you to appreciate what you have, to be grateful, and not to whine about things. (4)

The participants were particularly appreciative of their loved ones, freedom and safety. For instance,

I appreciate everything and everybody a lot more. I appreciate things like having my family, you know, having my children here, my mother here, and just all the opportunities that we have, and the freedom that we have. We have the freedom to do anything, go anywhere. (1)

Another clinician stated,

I think, the thing that I do think about is that if someone broke into my house or assaulted me or one of my family, you know, we would just go to the police. Like you would go there and it would be expected that they would do something to help you. I can't imagine what it's like living in a country where if you present yourself at the police station, no matter what terrible thing has happened to you, you're more likely to be targeted and punished than helped. (7)

For one clinician, this increased appreciation manifested behaviourally.

... I might finish a session and I'll just send a message home to my partner about how much I care about him and for him being in my life because of something that, you know, I've talked about with a client. (3)

After making sense of their work, some participants reported positive change related to their religiosity or spirituality. However, issues of spiritual change tended to be mixed. For instance, some found their religiosity or spirituality had deepened since starting this work. One person said,

My faith has kept growing and it isn't like before. (16)

For some, this work awakened a sense of spirituality they had not previously known. One clinician stated,

I'm an atheist but I notice sometimes, I feel like something is happening to me more on a spiritual level. Something about engaging with [the client's] belief about it and appreciating it and not just doing it as an exercise but really feeling something about that with [the client], about what it means to pray or something. I had that thought the other day – that I feel like praying – and I don't believe in anything. It's that kind of feeling. (15)

In contrast, others indicated that this work had caused them to question their religious or spiritual beliefs. One participant reported,

I have to say I used to be a very Catholic person. When I started to work here and I saw people coming from different religions, you see that there is not one God, or probably there is one God but we have different names [for Him] and worship Him in a different way. But nobody has the right to say that this is the wrong religion and this is the right one. I started to think that there is something bigger than just the Catholic religion. I do believe in God and Jesus but not the way that I used to. (14)

Regardless of the direction of spiritual change (i.e. increased or decreased faith), the clinicians viewed the change as a positive outcome of their work.

Changes in self-perception

After experiencing a shift in their worldview, clinicians experienced a shift in their perception of self. Twelve participants reported increased personal strength as a result of making sense of their work. For some, this change manifested as an

increased confidence in their abilities as a mental health professional. One clinician stated,

After working here I think I feel much, much more comfortable when working with people from different backgrounds. (10)

Another clinician stated,

It has been really good for me in terms of my confidence, I think, working with refugees. (6)

Other participants noticed changes in their level of personal strength outside of work. One reported,

Although there are challenges [in life], I normally take challenges as a learning situation and think that they, like, make me stronger. (16)

Another said,

It makes you strong, [I'm] a stronger person than I used to be. (17)

Changes in interpersonal relationships

With a change in self-perception comes a change in how a person relates to others. Twelve participants reported positive change in their interpersonal relationships as a result of their work. Most clinicians talked about limiting their social circles to those they truly connected with and shared similar beliefs or values. For instance, one participant said,

I think I spend more time with the people that I'm closest to, and you know, who I have really meaningful relationships with and very little time with other people that was just for socialising. (1)

Other clinicians mentioned that their interactions with people had changed since starting this work. In particular, clinicians began advocating for the refugee population within their own interpersonal relationships. One clinician stated,

I've had friends and family talk about refugee people, people on the news, and all those sorts of people, and it's like, well hang on, and I'm able to articulate it in a way so it helps them understand the difference, you know, in what's happening. So just the way I interact with people and communicate [is different], I'm able to help them understand the situation of refugees more. (2)

Another clinician said,

I feel very proud that I can actually stand up for people and say 'wait', and challenge people on things that they might not know about because they haven't [had] the opportunity to meet people like this or because they don't have a desire to learn. Or, they have those judgements and I love breaking them, I love challenging them. (9)

Discussion

These findings demonstrate that clinicians who support refugees in recovering from trauma are both positively and negatively affected by their work, which is consistent with existing literature (e.g. Arnold et al., 2005; Splevins et al., 2010). Despite choosing such work, clinicians are not immune to the horrifying traumas that refugees divulge (Illiffe & Steed, 2000). This sample reported strong emotional

reactions and intrusive images, both of which have been conceptualised as symptoms of VT (McLean et al., 2003). Concepts like VT remind us of the potential for clinicians to be psychologically harmed by their work. Clinicians who do not adequately cope with VT are more likely to experience a disruption in their empathic abilities and this can reduce their overall clinical effectiveness (Neumann & Gamble, 1995; Pearlman & Saakvitne, 1995; Sexton, 1999).

Splevins et al. (2010) found that interpreters working with refugees were more likely to report negative outcomes during their initial adjustment to the role. Similarly, VT appeared to be a natural response for our sample of clinicians in the early stages of their work (Pearlman & MacIan, 1995; Pearlman & Saakvitne, 1995). This is largely inconsistent with prevailing conceptualisations of VT. According to McCann and Pearlman (1990), VT is cumulative and the result of *repeated* engagement with traumatic material. However, the initial shock of the work was more impactful for our sample of clinicians and their level of distress reduced over time. It appears that the initial shattering of their beliefs was quickly ameliorated because clinicians were able to process the stories, rework their beliefs and effectively incorporate the traumatic material. In other words, the psychological distress of these workers seemingly dissipated because they were able to make meaning of their experience and grow from it. Many theorists argue that meaning-making processes only lead to adjustment if some end product or meaning is made (e.g. Joseph & Linley, 2005; Park & Folkman, 1997). Linley and Joseph (2011) noted that *found* meaning was associated with greater positive outcomes, whereas the *search* for meaning, without finding a coherent sense of understanding, was associated with greater negative outcomes.

Despite the inherent stressors of working with refugees, all the participants in this study were pre-occupied with the positive impacts they experienced. The fact that they preferred to talk about the benefits of their work indicates that theories of VT fail to represent the total vicarious experience of clinicians who support refugee survivors. Both VT and VPTG theories postulate that distress is inevitable because trauma challenges fundamental beliefs whether it is experienced directly or vicariously. However, VPTG theories expand on this notion and argue that trauma acts as an impetus for effortful meaning-making processes and subsequent positive outcomes (Joseph, 2011; Joseph & Linley, 2005; Tedeschi & Calhoun, 2004). It is through the accommodation of new trauma-related material that clinicians can experience growth (Park, 2010; Park & Ai, 2006). As Splevins et al. (2010) argued, a theory of VPTG better accounts for the experiences of trauma workers, remembering that VPTG does not discount enduring distress.

The known impacts of experiencing a potentially traumatic event have been useful in guiding research on vicarious trauma (e.g. Arnold et al., 2005; Herman, 1995). The same three foundational domains of growth purported by the PTG researchers Tedeschi and Calhoun (1996, 2004) have been found in studies of clinicians who conduct trauma work (e.g. Arnold et al., 2005; Splevins et al., 2010). Moreover, the data from our study revealed similar results. The staff reported positive changes in their life philosophy, self-understanding and interpersonal relationships as a result of their work with refugees. As the majority of participants reported that their work had changed their lives in profound and positive ways, it seems the potential benefits of trauma work may be more powerful and far-reaching than earlier studies indicated (Splevins et al., 2010). Increasing awareness of the possibility of VPTG might hold positive consequences for clinicians and clients alike.

A more inclusive and less pathologising conceptualisation of trauma work might help clinicians to view themselves, their clients and their work in new and empowering ways (Arnold et al., 2005). In turn, this could help to improve clinicians' effectiveness, foster more desirable therapeutic outcomes, and increase their longevity as trauma workers.

Clinical implications

Given the potential impact of VT and VPTG on both organisational and individual levels, understanding how to effectively minimise negative outcomes and maximise the potential for positive outcomes associated with trauma work becomes important. The data from our study suggest that effortful meaning-making processes facilitate positive change. Our participants described the ways in which they made meaning of their experiences, many of which have been supported by existing literature (e.g. Park, 2010; Park & Ai, 2006). A number of the clinicians consciously changed their way of thinking, sought out additional support, or developed self-care strategies to make meaning of their work with refugees.

In a similar vein, clinicians reported turning to their colleagues for help to process and make sense of their vicarious trauma. Colleagues function as an important social network for clinicians and can validate feelings and offer support (Sexton, 1999). Supervision can also provide clinicians with a safe space to process the horrific stories and graphic imagery that are an inherent part of trauma work (Pearlman & McJan, 1995). A large portion of our sample reported utilising supervision as a way of making sense of their work. Therefore, best practice involves alerting supervisors to this potential for growth. Without such awareness, they may inadvertently restrict opportunities for growth within their supervisees (Splevins et al., 2010).

All trauma workers have an ethical responsibility to pay attention to their well-being and to utilise organisational or individual processes of meaning making to enhance their clinical effectiveness and improve therapeutic outcomes (Sexton, 1999). The inherent stressors of trauma work can be minimised when clinicians make sense of their experience and the traumatic stories they hear. Making sense of their experience helps clinicians to feel capable, satisfied and fulfilled in their work, and in turn, promotes the possibility of growth within themselves and their clients.

There was one inconsistency between the results of our study and other studies of meaning making that necessitates further discussion. Changes to religious or spiritual beliefs have been supported as a mechanism through which people can make meaning of extreme situations (e.g. Park, 2010). Moreover, this change is typically reported as being *positive* in nature because trauma workers are seen as increasing in faith or connecting more deeply with their religion. Within our sample, there was no mention of relying on religious or spiritual faith to make sense of the traumatic stories. Although not utilised as a method of meaning making, spiritual change was reported as an outcome of working with refugee survivors. A notable portion of the sample discussed changes in their spirituality as a result of their work. However, these changes were not all about a deepening of faith as previous research would suggest (e.g. Tedeschi & Calhoun, 2006). A number of clinicians reported questioning their beliefs or abandoning their faith because of their work with refugees. Nevertheless, this decrease in religiosity was *perceived* as a positive type of change by the clinicians. Therefore, in the future, researchers need to approach with

caution the notion of spiritual change and its purpose with respect to meaning making. Our findings suggest that trauma workers might not rely on their faith to make sense of their experience; neither is positive spiritual change limited to a deepening of faith or increase in religiosity. Although our sample was comprised of people from varied counties of origin, our results are consistent with much of the previous PTG research conducted in Australia (Shakespeare-Finch & Morris, 2010).

Strengths, limitations and future directions

Few studies have explored the potential consequences for clinicians working with survivors of refugee-related trauma. With the number of refugees rising and awareness of the impact of trauma work increasing, the importance of conducting such research is high. Existing VT and VPTG studies are neither restricted to working with refugee populations (e.g. Ben-Porat & Itzhaky, 2009; Iliffe & Steed, 2000; Linnerooth et al., 2011; Moulden & Firestone, 2007; Sabin-Farrell & Turpin, 2003; Schauben & Frazier, 1995; Steed & Downing, 1998; Voss Horrell et al., 2011), nor do these studies always examine VT and VPTG explicitly. A number of researchers have explored related phenomena such as burnout, secondary traumatic stress, or well-being and life satisfaction (e.g. Century, Leavey, & Payne, 2007; Eleftheriadou, 1999). Our study was one of the first to explore VT and VPTG amongst a sample of clinicians who work solely with refugees. Our findings add to the existing literature by presenting qualitative data that provides a comprehensive and richly detailed view of the ways in which this group of clinicians are affected by their work (Sabin-Farrell & Turpin, 2003).

The primary limitation of our study is its cross-sectional design, further complicated by the fact that most of the clinicians reported previous work experience in a trauma-related field. As such, disentangling the effects of current versus previous work is difficult. To limit the likelihood of clinicians reporting on changes associated with previous work, particular caution was taken to ask questions in relation to their work at QPASTT. However, there is no way to be sure clinicians were reporting only on their current experience and were not influenced by past work. As well, clinicians commonly discussed work-related stressors outside of hearing traumatic stories (e.g. working with interpreters and dealing with government bodies). The impact of these stressors on VT and VPTG remains unknown. Therefore, we recommended that, in the future, researchers investigate whether such stressors can influence levels of traumatisation or growth reported by clinicians.

Another limitation was that clinicians were sampled from only one organisation, which impacts the generalisability of our findings. We recommend that our study be replicated across a number of agencies, with a particular focus on sampling from several countries. Differences in the impact of trauma work might arise when the treating clinician is from the same cultural background as the refugee (see Miller, Martell, Pazdirek, Caruth, & Lopez, 2005).

Summary

Working with those recovering from refugee-related trauma seems to be distressing and shocking, but equally rewarding and transforming for the clinician. Bearing witness to client trauma and experiencing a sense of secondary or VT causes

clinicians to question their basic beliefs and engage in conscious meaning-making processes. As a result, clinicians might experience PTG similar to many survivors of direct trauma. However, care must be taken to ensure that the risks of trauma work are minimised. Organisations are responsible for providing adequate supervision and training for their clinicians, as well as a cohesive and supportive team environment. In addition, trauma workers are encouraged to develop effective self-care strategies that will help promote positive outcomes for themselves and their clients. Although inherently difficult, trauma work can provide an opportunity to flourish and grow in ways that few other professions allow.

Notes on contributors

Allysa J. Barrington is currently undertaking a Doctorate of Clinical Psychology at Queensland University of Technology. Although a relatively new contributor to the trauma field, her research has been dedicated to posttraumatic growth and associated phenomena.

Jane Shakespeare-Finch is Associate Professor in Psychology and Counselling at Queensland University of Technology, Brisbane, Australia. Jane teaches Health Psychology, Individual Differences and Assessment and her research focus is on the promotion of resilience and posttraumatic growth.

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