Spring 5-18-2019

The Benefits of Art Therapy for Mental Health Clinicians Who Have Experienced Vicarious Trauma

Monique Downs
Lesley University, mdowns@lesley.edu

The Benefits of Art Therapy for Mental Health Clinicians Who Have Experienced Vicarious Trauma

Capstone Thesis: Literature Review

Lesley University

Date: May 2019

Student's Name: Monique S. Downs

Specialization: Expressive Therapies/Art Therapy

Thesis Instructor: Sarah Hamil, Ph.D., LCSW, RPT-S, ATR-BC

Abstract

The American Counseling Association (ACA) Code of Ethics (2014) stresses that the most important aspect of counseling is to promote the welfare of client and to respect their dignity. This literature review demonstrated that clinicians' engagement with traumatized clients could influence the ongoing and cumulative effects of their exposure to clients' stories and emotional expression of their traumatic experiences. When a clinician is impacted by vicarious trauma (VT) symptomatology, the relationship with their clients may suffer, putting both at risk for ongoing and unintended harm. One method of enhancing a holistic, healing sense of self is to utilize art therapy as a treatment modality not only to mitigate the impact of VT but also to enhance the clinicians' ability to experience vicarious posttraumatic growth (VPTG) and resiliency. The literature further indicated that gathering data through visual imagery allowed for opportunities to explore data with a different lens, which was not readily available through quantitative or qualitative research. By combining arts-based research (ABR), along with quantitative and qualitative research of the literature, this critical inquiry explored the benefits of utilizing art therapy with clinicians who have experienced VT.

Keywords: vicarious trauma, risk factors, vicarious posttraumatic growth, resiliency, art therapy.

"I found I could say things with color and shapes that I could not say any other way- things I had no words for."

- Georgia O'Keeffe

The Benefits of Art Therapy for Mental Health Clinicians Who Have Experienced Vicarious Trauma

Introduction

Working as a health professional has its rewards and also has challenges. For instance, in a recent study, Baciu & Vîrgă (2018) suggested that social workers displayed symptoms that met the diagnostic criteria of posttraumatic stress disorder (PTSD) as defined in the *Diagnostic and Statistical Manual of Mental Illness 5th Ed* (DSM-5) (American Psychological Association, 2013, p. 271-274). The authors asserted that trauma reactions in social workers included: 63.8 % have had intrusive thoughts about clients; 43% experienced exaggerated startle reflex; 39.8% reported emotional numbing; 29.4% experienced a sense of reliving clients' trauma, and 14.5% had disturbing dreams about their clients (p. 158). These statistics pose a distinct professional dilemma for clinicians who have engaged in therapeutic work with survivors of trauma causing them to be exposed to the effects of Vicarious Trauma (VT).

Branson (2018) defined VT as "the unique, negative, and accumulative changes that can occur to clinicians who engage in an empathetic relationship with clients" (p. 1). In more severe cases the risks involved in working directly with traumatized clients created significant distress and clinicians experienced "physical, emotional, and cognitive symptoms similar to those of their

traumatized clients" (Harrison & Westwood, 2009, p. 203) and developed symptomology similar to PTSD. Branson stated that PTSD "symptoms could develop in the absence of the kind of traumatic event required for a PTSD diagnosis" (p. 79). Whether clinicians' present with symptoms related to PTSD, or they develop an actual PTSD diagnosis, they deserve opportunities to heal and develop a sense of resiliency and growth in the same holding environment they offer those they have worked with in a session. Art therapy may be a useful form of engaging clinicians through a means of creativity and personal and interpersonal resources.

This thesis will include a review of the historical development of research to define vicarious trauma, secondary traumatic stress, compassion fatigue, cumulative trauma, and burnout. Also, the literature review will illuminate the neurobiological impact of VT and the utilization of art therapy as a treatment modality by ameliorating the devastating impact of VT. Exploration of the efficacy of art therapy in treating VT will be reviewed to identify risk factors and protective factors that may determine the potential for developing VT or posttraumatic growth (PTG) (Hyatt-Burkhart 2014, p. 453). By examining and identifying the components of PTG and resiliency, this thesis will illuminate art therapy interventions shown to be efficacious in developing and identifying treatment goals and treatment plans that were beneficial for clinicians as a strengths-based therapeutic approach.

Identifying symptomology and the "process of neuro-reciprocity" (Isobel & Angus-Leppan, 2018, p. 388) of clinicians who have experienced VT is vital in developing art therapy interventions to meet their individual needs best. This review will offer opportunities to understand further if art therapy will have added value to clinical professionals who treat trauma survivors. Although research has evolved in recognizing VT "it is equally important to

understand what protects and sustains clinicians in their work with traumatized individuals" (Harrison & Westwood, 2009 p. 204). By understanding clinicians' strengths and awareness of positive, healthy qualities one can embrace a means of mitigating the impact VT has amongst those clinicians.

This critical inquiry of literature will illuminate qualitative, quantitative, arts-based, and mixed methods research, and will examine the unique, creative qualities, and therapeutic aspects in art therapy that are found to be a beneficial tool for ameliorating VT symptomology and enhancing PTG and resiliency. Identifying core concepts through a thorough review of the literature will provide insight into how clinicians can heal vicarious wounds and develop a strengths-based approach to enhance the likelihood of PTG and resiliency. As clinicians, we are ethically obligated to maintain our biopsychosocial and interpersonal well-being which will allow for clinicians to be in the best possible position to effectively and ethically care for themselves and, in turn, their clients.

Literature Review

Trauma refers to physical, emotional, mental, spiritual, and psychological wounds inflicted on an individual. A traumatic event or a history of trauma can leave psychological symptoms long after any physical injuries have healed. The Diagnostic Statistical Manual-5th Edition (DSM-5), (2013) provides the diagnostic term that was established to help understand the psychological reaction to emotional trauma as post-traumatic stress disorder (PTSD) which can occur after an extremely stressful event, such as military combat, a natural disaster, or physical, emotional, mental, sexual, and spiritual abuse. PTSD symptoms can include but are not limited to intrusive memories, somatic complaints, prolonged psychological distress, negative beliefs about oneself, problems in concentration, sleep disturbances which causes clinically significant distress (DSM-5). VT meets the diagnostic criteria for PTSD: under DSM-5 diagnostic criteria A. 4., a diagnosis of PTSD can apply to adults (or children over the age of 6) who have been "experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse)" (p. 271). One can argue that clinicians who are repeatedly exposed to their client's frequent disclosure of significant, detailed, and excruciating traumatic experiences and the effects on their clients, would fit appropriately into the diagnostic criteria examples.

Two articles by Newell, Nelson-Gardell & MacNeil (2016) & Branson (2015) reflected common themes and timeframes relevant to the current understanding of VT. These themes will help clarify and understand the terminology and historical factors related to defining VT. They have identified some of the downfalls of not having clear terminology and its impact on future

research, as well as the inconsistencies that impact can have when using the term VT in an inappropriate context.

Newell et al. (2016) created a historical timeline which identified the common terms associated with VT and their historical impact. Newell et al. suggested that the first recognized conversations in the professional literature where the process in which emotions of clients can be mentally occupied or “transferred to the therapist,” was introduced in the early 1900s as part of the dawn of Freud's psychoanalytic practice and theory (p. 308). In 1916 Freud coined the term "countertransference," and historically the term was viewed in a negative light. Newell et al. (2016) cited Clarkson and Nuttall (2000) who stated that “it was potentially harmful or even destructive to the analyst’s ability to objectively analyze and interpret client’s information and situations” (p. 308). From Freud’s interpretation of countertransference to defining VT, other terms have impacted the therapeutic field, such as "burnout," "empathetic attunement," "emotional contagion," and "vicarious trauma" (p. 307).

Newell et al. (2016) identified that “vicarious” was a term first utilized by Laurie Ann Pearlman who worked with survivors of incest and sexual abuse. They stated that Pearlman “describes the effects of trauma as “vicarious.” Meaning clinicians treating trauma victims could actually, indirectly, experience clients’ emotional traumatic reactions (or other psychological reactions) themselves in the process of sustained empathy engagement” (p. 308). To engage empathetically with clients is a unique form of expression. Clinicians are trained to be a holding space or container for their clients’ biopsychosocial and spiritual expression.

Branson (2015) attributed the term “vicarious trauma” to Pearlman and McCann; however, he defined VT as:

> a specific and limited term used to describe the unique, negative, and accumulative changes that can occur to clinicians who engage in an empathetic relationship with clients" and that there is a direct correlation between a client's often graphic disclosure of traumatic events that "occur during the therapeutic relationship. (p. 1)

The four commonalities in both assertions are trauma, clients, empathy, and clinicians. To further these commonalities, they both described related terms such as secondary traumatic stress (STS), compassion fatigue (CF), and burnout. These terms through research have been used interchangeably, creating a challenge for researchers who often have different perspectives of each of these terms. When looking for risk and protective factors, connecting the appropriate terminology to the risk and protective factors will provide for opportunities to establish valid and reliable research. This thesis will utilize the language Branson (2018) developed in his review of the literature on VT, themes in research, and vocabulary (p.2). After a thorough review of the literature on terminology, Branson clearly defined and articulated the most recent and thorough use of distinct and salient terminology, therefore creating a clear and succinct use of language for VT. This perspective suggested that the use of clearly defined terminology by Branson be used moving forward with future research.

Branson (2018) identified the following list of terms commonly used and often confused with VT. The first term STS applied to "professions such as first responders, medical personnel, members of a legal/correctional community, and other professionals" who engaged with those who have experienced traumatic events; however, there was no ongoing relationship between the trauma survivor and their professional agent. The second term often confused with VT is CF which referred to "family members, loved ones, laypersons, and other professionals" who

become overwhelmed by observing a traumatic event. The third term, burnout, was the product of a “poor working environment" which included high turnover, improper compensation, environmental conditions, workload, increased hours, and additional responsibilities. (p. 2-3). By establishing standards in which consistent terminology is used will allow future research to be more consistent, valid, and reliable and will allow for a more cohesive way to communicate common conditions for ongoing research on vicarious trauma.

In addition to standard terminology, compassion satisfaction (CS), PTG, vicarious posttraumatic growth (VPTG), and resiliency are also terms that identified ways in which VT positively impacted clinicians and allowed for healing and restoration of the clinicians’ well-being. Stamm (2010) developed the *Professional Quality of Life: Version 5 (ProQOL)* (see Appendix), a questionnaire that identified CS and CF for professionals in the field. Craig and Sprang (2010) described how some clinicians “report growth and feelings of well-being associated with their practice” (p. 319-320). They credited Figley (1995) who coined the term “compassion fatigue” which Craig and Sprang described as “the cognitive-emotional-behavioral changes that caregivers experience from indirect exposure to trauma survivors” (p. 320). Having clear terminology impacts how we approach and identify potential risk factors associated with each term. Clarity will enrich a clinicians’ understanding of risks associated with VT in the world of traumatology.

There has been sufficient research which has identified risk factors and the effects of trauma on clinicians working with trauma survivors. A study by Adams, Matto, & Harrington (2001) identified contributing factors of VT utilizing *The Traumatic Stress Institute Belief Scale (TSI)-Revision L* (Traumatic Stress Institute, 1994), which was based on a constructivist self-development theory, psychoanalytic, and cognitive theories, and was designed to measure

disruptions in cognitive beliefs (p. 365). TSI is a 49-item, 6-point Likert scale that identified concepts such as self-safety, self-trust, other-safety, other-esteem, and other-intimacy. The TSI scale placed an emphasis on "inner experiences" versus the "full range of potential effects of traumatic stress" (p. 365). Items studied were sex, age, race, trauma history, years in practice, client-contact hours, salary, training, seeking a job, somatic complaints, alcohol or drug use, and intrusion of thoughts. The clinical implication of the outcome suggested that young, inexperienced social workers experienced more somatic complaints, more disturbance in their self-identity, and difficulty in relationships with others. They experienced more depersonalization as well as feeling a lack of personal accomplishments. The results of the study also indicated that younger, less experienced social workers who had a personal history with trauma were at a higher risk of VT impacting their lives, whereas older social workers who may have done their personal work surrounding their own traumatic experiences increased the likelihood of a positive correlation between VT and PTG surrounding healing past traumas. Perceived social support played a role in being sensitive to the impacts of VT, and those with more social supports received higher ratings than those who had not. Additionally, building a strong sense of community, such as those with other social workers, was essential in dealing with the isolation and loneliness that often-impacted clinicians and their work (p. 336-370).

Pearlman and Ian (1995), described their work as "conceptualized within constructivist, self-development theory (CSDT)"; (McCann & Pearlman, 1990s, Pearlman & Saakvitne, 1995a, 1995b), (p.558). According to Pearlman and Ian (1995), CSDT identified a blend of psychology, object relations theory, and contemporary psychoanalytic theory. (p. 558). They further stated that VT could impact the clinicians' internal world, creating changes in their perspective and are "cumulative across time" (p. 558). They completed their research utilizing the *Traumatic Stress*

Institute Belief Scale-Revision F (TSI) (1995). The TSI was a 6 point-Likert scale with one being "disagree strongly," and six being "agree strongly" (p. 559) The TSI, according to Pearlman and Ian measured “disruptions in safety, trust, intimacy, esteem, and power” (2015, p. 559). Pearlman and Ian identified that there were statistically significant differences between therapists with a personal trauma history and those without a trauma history. They noted two variables that impacted clinicians included the length of time doing their work and percentage of survivors on a clinicians’ caseload. The longer clinicians worked with survivors, the less likely VT would impact them and the more likely they were to experience PTG and VR. Additionally, the longer clinicians worked with survivors allowed them to develop a sense of self-trust and increased the likelihood of PTG and vicarious resilience VR (p. 559).

Regarding burnout, Pearlman and Ian (1995) addressed variables such as age, gender, personal trauma history, therapy, length of time doing the work, wages, education, and work setting (p. 560-561) concerning VT and its impact on clinicians. When discussing clinicians with a personal history of trauma, they indicated a correlation between the length of time doing the work, being new to the field, and symptomology as relevant factors. They noted that those who have had more training, who worked in a clinical setting, and have addressed their personal trauma history had a higher rate of success in not developing symptoms of VT (p. 562). On the other hand, clinicians can experience resiliency which explores how "trauma survivors access adaptive processes and coping mechanisms to survive and even thrive in the face of adversity” (Hernandez, Gangsei & Engstrom; Masten & Coatsworth, 1998; Walsh, 2003).

In recent years, the field of psychology had taken a turn and began looking through a different lens when treating trauma survivors. Positive psychology reflected on how to build strengths, assets, qualities, and positive traits of an individual and how trauma survivors learned

to thrive in life. As clinicians immersed themselves with their clients and engaged in an empathetic relationship in their work with survivors of trauma, a contrary effect of VT can be "vicarious resilience" (VR). VR is a "transformation in the clinicians (or other trauma worker's) inner experience resulting in empathetic engagement with the client's trauma material" (Hernandez 2007, p. 230; Gangsei & Engstrom; Pearlman & Saakvitne, 1995). VR reflects how clinicians take on the positive aspects of their clients' healing process.

In a strengths-based approach for clinicians, Hernandez et al. (2014) put this into the following context: both VT and resiliency "are a natural human experience"; therefore "it is reasonable to propose that the psychotherapeutic environment also creates opportunities for a vicarious resiliency process" to begin (p. 232). There are typical strengths of clinicians that impacted how Hernandez et al. identified their world view of VT. They asserted that clinicians who tend to seek healing from pain, draw lessons from experience, are open and spontaneous, utilize humor, access and express creativity, show initiative, and pose a compassionate heart (p. 232) can build upon these strengths by utilizing strengths-based, art therapy in psychotherapy when their lives become challenging due to their kind-hearted, compassionate, and caring personas.

The peer-reviewed article by Harrison & Westwood (2009) identified protective factors that some mental health professionals aspire to in order to prevent the possibility of developing VT symptoms which included experiencing "physical, emotional, and cognitive symptoms similar to those of their traumatized clients" (p. 203). A sample study of six "peer-nominated master therapists" (p. 203) were interviewed and asked a prominent question, "how do you manage to sustain your personal and professional well-being, given the challenges of your work with seriously traumatized clients?" (p. 203). The analysis of the data was retrieved utilizing

“typology of narrative analysis" developed by Lieblich, Tuval, Mashiach, and Zilber (1998), according to Harrison & Westwood (p. 203). The methodology of the study was a sampling recruited through flyers of their peers and other therapists nominated by organizations, with a minimum of 10-years years' experience working with traumatized clients, between the ages of 49-59, who identified themselves as “managing well” (p. 207). Results identified nine key themes amongst the sample: “countering isolation (in professional, personal, and spiritual realms); developing mindful self-awareness; consciously expanding perspective to embrace complexity; active optimism; holistic self-care; maintaining clear boundaries and honoring limits; exquisite empathy; professional satisfaction; and creating meaning” (p. 207). These nine themes represented core values and beliefs of clinicians that had successfully navigated when working with trauma survivors. Incorporating these themes into a core belief system may strengthen the likelihood of mitigating the effects of vicarious trauma.

VT exposure can impact a clinicians’ changes in world views. According to Molnar, Killian, Emery, Sprang, & Gottfried, (2017), VT resides on a “spectrum of affective and behavioral responses” resulting in outcomes that are: “negative” bringing about vicarious traumatization, secondary traumatic stress, burnout, PTSD, unhealthy behaviors, and compassion fatigue; “neutral” which creates resilient and healthy workers; or “positive” resulting vicarious resilience, posttraumatic growth, vicarious transformation, and compassion satisfaction (p. 132).

An examination of the literature regarding the impact of VT on clinicians and the correlation between VT and VPTG indicated trauma work could potentially "increase short- and long-term levels of distress" (Cohen & Collens, 2013, p. 570). However, it "can be managed through personal and organizational coping strategies" (p. 570). Organizational supports were imperative to identifying and creating a structured healing environment to allow clinicians to

explore and understand the impact their essential work has on them. Sansbury, Graves, & Scott (2014) identified key concepts individuals who may be adversely impacted by the challenging and dynamic work they do. In interviews with trauma clinicians, there were several life areas impacted by vicarious traumatization such as "seeing the world in a negative way, feeling unsafe, reduced sense-of-self, reduced connection to work, less interest in others, and increased negative affect" (p. 115). These prominent life areas can be addressed utilizing art therapy techniques to offer a healing and thriving community.

In research done by Sansbury et al., (2014) it was recommended that organizations assist in the development of therapeutic healing environments and aid to their clinical and non-clinical staff by maintaining a therapeutic workspace and a sense of well-being and resiliency. "Organizations must have a solid infrastructure and system within which trauma caregivers and providers can work, and they must consider where group differences make a caregiver more vulnerable" (p. 118). When hiring staff, organizations should ensure their employees have had "experience or training in providing trauma-specific services, are open to receiving ongoing additional training, and subscribe to the philosophy of trauma recovery concepts" (p. 118). Recognizing the value and efficacy of art therapy as a "trauma recovery concept" for individuals and organizations would allow for organizational enhancements in the healing and recovery of VT and build resiliency in the workplace.

It has been documented that at an organizational level that "when people perceive their organizations to be supportive, they experience lower levels of vicarious trauma" (Sansbury et al., 2014, p. 112); Hodges, & Wegner, 1997). Therefore, it is imperative that an organization's environment exemplify the type of support network clinicians provide to their clients. Sansbury et al. (2014) indicated that when staff are asked what changes are needed to support an

environment that address the needs of clinicians, “trauma recovery concepts such as safety, empowerment, collaboration, choice, and trust” are named. If this practice is not addressed a “filtering down” (p. 119) of the adverse effects on clinicians may occur which will impact the clients that they serve, potentially creating the unintended consequences of re-traumatization for their clients.

Education about the signs and symptoms of VT are indicated for organizations wanting to provide a supportive, learning structure to help clinicians identify risk factors related to VT. It is "essential that regular communication occurs. Either in individual clinical supervision or larger staff meetings (or both)” stated Sansbury et al., (p. 119, 2014). Providing resources on VT for their staff will aid clinicians in identifying positive self-care practices and strategies for managing VT. Also, organizations should "provide opportunities for continued growth of their clinicians, particularly if the organization purports to deliver evidenced-based practices" which will allow clinicians to develop their understanding of the changes and development of the most current assessments, research, and evidence-based treatments on trauma and recovery. Staff training should be implemented to allow for clinicians to “feel empowered and well-equipped” to manage complex trauma cases that they become exposed to on an ongoing basis (p. 119). Sansbury et al. (2014) also suggested that organizations provide opportunities for voluntary assessments to "monitor compassion fatigue, vicarious traumatization, or burnout" and have the opportunity to process verbally and non-verbally to "develop strategies to offer an environment of support and self-care” (p. 119). Art therapy assessments such as Diagnostic Drawing Series (DDS), Person Picking an Apple from a Tree (PPAT), and the Formal Elements Art Therapy Scale (FEATS) may be beneficial assessment tools in identifying clinicians’ symptomology and to recognize the healing and recovery processes by providing insight into art therapy

interventions for an organization's employee. "The most effective approach to assessment in the field of art therapy appears to incorporate objective measures such as standardized evaluation procedures (formal assessments; behavioral checklists; portfolio evaluation), and subjective approaches such as the client's interpretation of his or her artwork" (Betts, 2006, p. 402).

There have been numerous empirical studies done that demonstrated the correlation of the number and severity of trauma survivors on a clinicians' case-load with either positive or negative correlations. According to Sansbury et al. (2014) "a full case-load of multiple complex, trauma cases is not recommended," and instead clinicians should be offered a "diversified portfolio" of clients within their care which will enhance the clinicians "sense of balance" (p. 119). Art therapy can provide clinicians' opportunities to explore the impact their case-loads have on them. This information will help explore the influence their case-loads have on them with their supervisors and other organizational structures. Organizations can be proactive in offering balanced case-loads and when challenges arise, offer individual and group art therapy to reinstate a sense of well-being for their employees and provide opportunities for them to advocate with their employers their need for adjustments including a diversified client base and the number of clients on their case-loads.

According to Bird (2018), "visual imagery within qualitative research is an established method of gathering data that has parallels to how images are used within art therapy." (p.14). Gathering data through imagery allowed for opportunities to explore data with a different lens which were not readily available to quantitative or qualitative research. Mohr (2014) stated that arts-based research "proposes to *do something* with the lived experience, to grant it significance and value through transformative act of poetic imagination" (p. 157). Arts-based research showed a dialogue within the art process and product. It gathered insight into the underpinnings

of value, truth, identity, and understanding. The following arts-based research articles identified the impact of art therapy research done in a domestic violence program and post-traumatic growth amongst teenagers who survived an earthquake in Peru.

Bird's (2017) arts-based research was conducted with a group of women who experienced domestic violence, stated, "through the use of collage, participants created visual representations of their responses to experiences of domestic violence and abuse" (p. 14) along with "collective visual storytelling" (p. 23). The study consisted of a pilot phase which involved a single group meeting for six weeks and the main phase which involved three group meetings for 10 weeks. The study included 20 women "who attended at various points, and I was able to collect eight completed stories from seven women" (p. 18). There was no evidence of the age range of the women or how many participated in each group. The study consisted of only women from white, British descent indicating a probable bias from a cultural perspective. The data collected were from Bird's interpretations as well as participatory methods from the women in the study. Findings from the study indicated three strong themes: escape and harmony; relationships and social support; and agency and resistance. Bird found that being sympathetic to these themes when creating art therapy interventions, an art therapist may insightfully create treatment goals and interventions to address these themes and how they impacted survivors of domestic violence.

Mohr (2014) conducted arts-based research on 11 children between the ages of 11–19 who attended a nine-month art therapy intervention following an earthquake in Peru in 2017. The children experienced acute psychological trauma following the event. Mohr returned to the site three years after to "utilize art as a lens for seeing experiences of growth and understanding

through the participants' eyes" (p.155). Participants were encouraged to "take photographs of themselves or their surroundings in response to specific themes or questions and later used the visual imagery of the photography as a point of departure in non-structured interviews" (p. 157).

The results of the arts-based research indicated that there were distinct themes that evolved from participants "exploration of post-traumatic growth" (Mohr, 2014 p. 158). Key elements included honoring and holding, relatedness to the community, family and friends, finding balance amid darkness and light, and freedom to move forward (p. 158-160). These themes translated into many similar traumatic experiences and how they achieved post-traumatic growth when engaged in art therapy programs, the healing and discovery that can result, and to everlasting change in the face of traumatic events. Because Mohr's research was over a period of time following the event, the growth could not only be seen in their photography but could also be seen with other art-based activities within the community.

The article by Schouten, de Niet, Knipscheer, Kleber, & Hutschemaekers entitled *The Effectiveness of Art Therapy in the Treatment of Traumatized Adults* (2015) based its research on a systematic review of the literature to "identify literature concerned with research on art therapy with traumatized adults…to review the results of this research…and to draw conclusions on the effectiveness of art therapy in the treatment of trauma" (p. 221). When considering the inclusion and exclusion criteria, search outcomes identified six research studies were utilized. The "Delphi list for quality assessment of randomized control trials" (p. 222) were employed to assess the quality of the studies which included "randomization of allocation, group comparison and presentation of estimates" (p. 222).

The interventions assessed involved a mandala coloring group, group art therapy, trauma-focused drawing, trauma-focused mandala drawing, art therapy with psychotherapy, and a 10-session group of art therapy which included cognitive-behavioral therapy (CBT). Control conditions involved art control, treatment as usual, and wait-list conditions. Type of design, population/types of trauma, mean age, and gender were also established characteristics of the studies. Some results included decreased anxiety, decreased trauma symptoms, and increased severity in the art therapy control condition, as well as a significant decrease in arousal, re-experiencing, avoidance, and decreased depression. The group art therapy was the only assessment which showed no significant decrease in the severity of trauma symptoms (Schouten, 2015, p. 224).

Establishing whether art therapy is an effective modality for treating traumatized individuals had mixed reviews. In their article, Baker, Metcalf, Varker, & O'Donnell (2017) completed a systematic review of the literature; they delved into how effective creative arts therapies had in the treatment of adults with PTSD. As with other research, they also established that for some survivors, "the memory of the traumatic event may be stored in the memory system in a nonverbal manner and accessing the trauma memory, as is required by verbal therapies, is difficult (Baker et al., p. 2; Talwar, 2007)." Therefore, accessing these memories would require accessing thoughts, feelings, and emotions with verbal and non-verbal means, alternatives to treatments such as the hybrid field of art therapy can benefit clinicians' VT symptomology.

Baker et al. (2017) indicated that:

> researchers have proposed the following mechanisms by which creative arts therapies may improve PTSD symptoms: r*elaxation* experienced during creative art therapy could

> reduce hyperarousal; n*onverbal expression* facilitates the expression of memories and emotions that are difficult to put into words, as both art and trauma are sensory mediated; c*ontainment* of traumatic material within a creative art product provides a sense of control, empowerment, agency, and accomplishment; s*ymbolic expression* makes progressive exposure tolerable and helps overcome avoidance; *the pleasure* of creation builds self-esteem, helps rekindle responsiveness to rewards, and reduces emotional numbness; the activation of *emotional behavior* and *sensory-emotional processing* through creative engagement leads to stress and directly the areas of the brain associated with posttraumatic expression" (Baker et al.,, p. 2; Bensimon, Amir & Wolf, 2012; Car et al., 2012; Spiegel et al., 2006).

Although this list discussed the various benefits associated with creative arts interventions, it is essential to note that in the Baker et al. article (2017) their goal was to identify the correlation related to the "level of therapist involvement…i.e.: ongoing, limited, or unknown level of involvement" (p. 2). With this in mind, they determined that creative arts therapies indicated "low" levels of benefit in the use of expressive therapies (p. 2). This assertion is relevant in as much as it related only to the amount of the therapists' involvement in treatment when engaged in creative arts and evaluated against individuals diagnosed with PTSD. It does not gauge the effectiveness of the therapeutic interventions involved. Although the premise of the article was to identify the effectiveness of creative arts therapies, it fell short in its reliability of their assertion. However, one benefit of the article is that it identified the correlation between a clinicians' amount of involvement with their clients. It is essential to understand that therapists engaged with their clients will impact the effectiveness of art therapy treatment and the quality of

a therapeutic relationship. Building a strong therapeutic alliance is the cornerstone to any treatment modalities, including art therapy.

Perryman, Blisard, & Moss (2019) offered “guidelines for selecting creative arts activities to assist clients in processing and thus diminishing the effects of trauma” (p. 81). They asserted that "creative arts therapies allow for repressed memories and feelings to surface and be processing a way that is less threatening and at the client's own pace" (p.84), which created opportunities for the brain to find balance. They stated that clients might be overwhelmed with their experiences and have a difficult time with the ability to express themselves verbally which creates a "lack of a coherent narrative" without a beginning, middle, and end (p. 84). Therefore, their stories would get fragmented.

Emotions are stored in the right hemisphere of the brain, “presiding over autobiographical memory and the processing of negative unconscious emotions…and the left brain is verbal, analytical, and rational" (Perryman et al. 2019, Cozolino, 2010; Schore, 2009). The authors asserted that repressed memories and feelings become activated through art therapy. When a client gets overwhelmed with emotions, they are "lacking the verbal capacity to process, again lacking a coherent narrative” (Perryman et al.; Chong, 2015; van der Kolk, 2014). They noted that:

> “Counselors working with clients who have experienced trauma can find themselves feeling overwhelmed as they attempt to help regulate intense emotions or reach the extremely withdrawn client. Creative arts techniques offer both client and counselor a mechanism to remain within the window of tolerance for a more extended period, allowing the integration necessary for healing (p. 85).”

Perryman et al. (2019) proposed four essential factors needed when implementing creative techniques. First, develop a therapeutic alliance with the client. If a client does not feel safe, cannot trust, and is unable to experience an attachment to the therapist, the right hemisphere of the brain can shut down and stop the verbal process from occurring or it "minimizes the rational left brain" (p. 86). Second, the therapist must be clear with the art intervention. "Creative techniques that offer empowerment or an opportunity to change the client's narrative prior to reconsolidation provide a sense of regained control over the event." The importance for clinicians to assess the clients and where they are at in the fight, flight, freeze, or faint responses needs to be taken into consideration "as it guides how to provide sound therapeutic intervention" (p. 86). Third, it is crucial to address the clients' traumatic experience through the right hemisphere, where their stories are "stored in fragmented emotional states" according to Perryman et al., (p. 86). After engaging in art therapy, clients may have internalized the experience. Fourth, be aware that processing a traumatic event can elicit other traumatic experiences for the client.

Perryman et al. (2019) indicated that utilizing the left hemisphere in writing about their traumatic experience can integrate both the left and right hemispheres of the brain in order to "clarify their stories" (p. 86). Perryman et al. cited Eckert (2015) and stated that "once the traumatic memory is recalled, the therapist has a window of time in which to provide an emotionally corrective experience through creative activity, facilitating the healing process" (p. 87). According to Perryman et al., "this awareness offers clients a more comprehensive understanding of their lives, empowering them to have more control over their reactions to future life events" (p.87). Moving through these traumatic experiences with a client is a delicate balance of knowing not only what activated clients' traumatic reactions and the various regions

activated in the brain, but also what interventions best address their needs in a safe, engaging, and therapeutic way; when clinicians get exposed to their clients' ongoing, devastating, and fragmented stories, they too may become affected negatively and express reactions similar to that of their clients. Perryman et al. concluded:

> Creative arts offer a unique benefit in promoting communication between the right hemisphere, where images and negative unconscious emotions are stored, and the left hemisphere, which houses logic and language. Creative arts therapies allow for repressed memories and feelings to surface and for them to be processed and reconsolidated in a less threatening way and at the client's own pace. The left hemisphere can then logically produce a verbal, coherent story (p. 92).

Support for the neurobiological view of trauma with implications for art therapy was addressed by Gantt and Tinnin (2009). They identified that posttraumatic stress disorders "involve nonverbal mental activity that escapes or overrides verbal thinking" (p. 148). Recent research on evolutionary survival strategies, the advancement of neuroimaging of the psychological responses to trauma, and the psychological constructs of trauma supported the perspective that psychological trauma is benefited by the use of a non-verbal treatment such as trauma-informed art therapy which can enrich the healing aspects art therapy has to offer (p. 148).

Gantt and Tinnin (2009) supported the hypothesis made by several researchers: Hass-Cohen (2003) "regards the image-making in therapy as a concrete sensorimotor activity that can safely modulate traumatic affect and provide specific feedback in the form of art therapy directives and interpretations"; Ogden and Minton (2000) indicated that "this process quiets the amygdala…and promotes more effective coping responses"; in addition, Malchiodi (2003)

contended that “as additional research on neuropsychological and mind-body paradigms emerge we will learn why images and image-making are central to enhance health and well-being”; while McNamee (2005) described “a neurologically based art therapy modality – bilateral art - that activates both the right- and left-brains in the process of creating images” was beneficial in devising non-verbal art therapy treatment protocols and interventions (p. 149).

Utilizing the Expressive Therapies Continuum (ETC) (Hinz, 2009), Burau & Downs (2019) suggested that the ETC helped inform clinicians on what type of material to use, when, and how to use them in order to engage clients in a meaningful way. It can also be used to help determine preferred ways of relating to people and materials in the environment and aligns with various neuropsychological functions by addressing kinesthetic and sensory integration, perceptual and affective components, cognitive and symbolic processing, evolved and included in the creative realm of non-verbal expression (2019, p. 8-15). Clinicians can move through the ETC to help navigate their reactions to VT and improve, enhance, and integrate PTG and VR.

In an interview with Bessel van der Kolk and Shannon Straus ATR-BC, Horsley & Horsley (2017) explored current research on trauma and implications for art therapy. In their interview, van der Kolk asserted that “people who don't deal with the trauma have a much better chance of becoming ill or being addicted, or on long-term medication, they die earlier.” He stated that with trauma “getting your body to be present is very important” and we need to imagine “other ways of being in the body.” van der Kolk continued “you need to expand your mind and expand the parts of your brain that have to do with imagination and possibilities” and that “we need to open up to the possibility to see other things.” He asserted that “people don’t remember these tragedies in words, the memory is in terms of body sensations and, in terms of images.”

In Horsley & Horsley's (2017) interview, "the second piece is opening up your imagination…there are many ways of opening up the imagination…we live by our imagination" suggested van der Kolk. Board Certified Art Therapist Straus stated to van der Kolk as she presented and discussed artwork she had created in response to the untimely death of her son "I really felt like there was something missing in my healing process, and it wasn't until one evening a little voice said, 'why don't you make a collage'…and I listened." She wondered to herself as she reflected on the moment when she created her collage, "can I be in the moment?"

Continuing with the Horsley & Horsley (2017) interview, Straus declared to van der Kolk "you said imagination is such an important piece…it was the beginning of a wonderful investigation. I could see that over time I could see that that was healing." van der Kolk responded "you see something emerge and it's a surprise…a part of that too is a surprise…a part of being alive is a surprise…that is what it means to me… surprised by my internal world."

In response to Straus' artwork "This is severe trauma, and you have to work through those fragmented pieces" informed van der Kolk during the Horsley & Horsley (2017) interview. Fragmentation comes from the traumatic experiences being interrupted by the timing delay of the trauma experience moving from the non-verbal to the verbal aspects of brain functions. Straus indicated "that's part of the creative process; because the trauma sits side by side with the formal elements of creativity." van der Kolk responded by affirming that you need to "let your body guide you." "I knew that I was also in my body…I was in it" declared Straus.

Horsley & Horsley (2017) suggested to both van der Kolk and Straus that "we have to find a way to release them, we carry them inside our bodies" when referring to the cognitive and somatic trauma experiences. As Straus searched her imagery, she expressed energetically "there it is! It's not all inside me." She moved her from internal world through her cognitive

restructuring, emotions, and bodily sensations, to her external world and created a separation between herself and her experience. Being able to remove herself from the traumatic experience, placed it in a creative visual medium, and explored her traumatic experience with distance and insight which allowed her to integrate the experience and connect the fragmented pieces of the trauma she suffered as a result of her son's untimely death.

Although Straus was not working with an art therapist, she was aware of the implications that creating artwork alone is not the same as creating art in session or groups. During the Horsley & Horsley (2017) discussion, Straus reflected that she got "a good sense of I am not alone in this" then indicated that "yes, you can do this by yourself, but being with other people helps." When those who have experienced VT create artwork in isolation there can be a benefit, however, it is limited in scope to the therapeutic aspects of sharing and exploring with skilled art therapy experts and in group art therapy sessions. "Being able to feel safe with other people is probably the single most important aspect of mental health; safe connections are fundamental to meaningful and satisfying lives." declared van der Kolk, 2014, (p. 79).

Isolation can be a vast barrier in healing VT. Being in relations with others, be it a trained art therapist or in an art therapy group with other professionals allows for evolving recognition of the emotional, physical, sensory, and spiritual pain and suffering that is all consuming. Having others witness the suffering and the growth validates the experience and offers opportunities for different perspectives to enter the imagination. Retraining the brain's neuropathways, in addition to exploring the sensory components of the traumatic experiences, offers opportunities to evolve through the pain and suffering and bring about a healing environment where PTG and VR can exist and thrive. Clinicians can gain insight into their internal and external worlds and express themselves in a safe, therapeutic environment that is guided by the hands of a compassionate,

caring, and a skillfully trained art therapist by creating a holding environment to meet individual and group needs. Clinicians give so often of themselves, taking time to receive from others creates a therapeutic alliance where healing and trust will evolve and help ameliorate the effects of VT, enhance opportunities for vicarious joy to exist, and become the norm for such deserving professionals.

Discussion

Traumatized clients have unique needs that require a significant amount of a clinicians' expertise, wisdom, compassion, and energy. They traverse the peaks and valley of the emotional, physical, and psychological underpinnings by empathetically working with their clients. They put themselves out there to help their clients navigate the pain, suffering, and damage caused by traumatic experiences while serving as a holding container and a guiding force for their suffering. By no fault of their own, they get exposed to fragmented souls that require healing and unwittingly place themselves at risk of absorbing the psychological trauma of their clients' ongoing suffering. Compassion and empathy opens the gateway for VT to enter into even the most unsuspecting and well-trained clinicians, and in many cases, without them even being aware it is happening. As clients progress through the various stages of recovery and healing, there is an innate experience that happens within clinicians as well. They take pride in their abilities to bring clients out of suffering and into wholeness. However, there is no one there to help clinicians emerge through their own private experiences when they are working with so many individuals who are suffering.

Some organizations have taken precautions to support their clinicians by offering individual supervision, group supervision, peer supervision, and in some instances, employee assistance programs. Due to the culture of the health and human services field and the rising

costs of medical management, clinicians face an onslaught of having too many clients in their case-load. At times, clinicians work more hours than is allotted by their agencies, while other times clinicians are required to bring their work home with them in order to get done all that is required of them. These extended hours impact the quality and effectiveness of the clinicians' ability to revitalize and recuperate from their clinical work placing them more at risk of job burnout, job dissatisfaction, compassion fatigue, and complete emotional, mental, and spiritual exhaustion.

The notion of "self-care" enters into the equation as though that is all that is required to manage the impact of working in the mental health field. Self-care looks different for everyone and has many components. Individuals, groups, and organizations can become proactive by advocating for their needs to be met and offer specific supports to help alleviate the repercussions of the impact of VT. Art therapy is one tool that can allow for clinicians a safe space to navigate the impact their work has on them and allow them to heal their trauma and VT. Building a resilient community of clinicians who grow through their experiences, creatively exploring through the kinesthetic level of the ETC through movement and the sensory level, and by exploring bodily sensations and sensory integration will allow them to integrate their experience through physiological means. By being engaged in the perceptual level of the ETC by exploring forms and individual images allows for healing by how things are seen and experienced and offering relief from their suffering. The affective level of the ETC allows for identifying emotional experiences and builds emotional intelligence. Healing the negative impacts of the emotions involved in working with clients who are suffering will allow clinicians to be more present for their clients and will offer opportunities for emotional regulation. Integrating the cognitive level of the ETC through various mediums which are well structured

allow opportunities for the brain to heal itself by creating new neuropathways and deadening neuropathways that are destructive to their well-being. Working on a symbolic level can provide opportunities for language development and identifying common structures where traumatic stories can be explored and integrated into a cohesive narrative with a beginning, middle, and end to give meaning to their experiences and storytelling.

Art therapy helps clinicians integrate all their experiences by building an active community through groups and individual sessions. Healing alone may not be the best option, although being alone is necessary to rejuvenate the mind, body, and spirit; however, isolation may be an enemy of VT by creating a downward spiral into a depressive state. Healing within a community allows clinicians to be offered what they so freely give to their clients, a space to connect with another and share their suffering with others in a similar situation. When we connect with others, we connect with ourselves and our place in the world. Picking up the fragmented pieces of the impact of VT will only enhance the ability to experience PTG and resiliency.

The fundamental nature of this thesis intentionally omitted what appropriate “protocols” should be undertaken as well as specific art therapy interventions due to the complexities of individualistic, didactic, and communal experiences. A trained art therapist must always keep in mind the specific needs of the individual, of a group, and the dynamics of the therapeutic alliance that is required to create a healing space. Pooling from the strengths and needs of clinicians allows for an organic and naturalistic healing environment to evolve. VR and PTG must be nurtured and will evolve as clinicians embark on their journey of healing from the trauma created through empathetic attunement. Clinicians deserve the same healing opportunities to help maintain a sense of authenticity in their work and within themselves. The gift of healing through

art therapy will allow for the exploration for vicarious joy and resilience to enter into their world both personally and professionally. It will bring them closer to their clients and the life-altering and evolutionary work they provide for those in their care.

References

Adams, B., Matto, C., & Harrington, D. (2001). *The Traumatic Stress Institute Belief Scale as a measure of vicarious trauma in a national sample of clinical social workers*. Families in Society, 82(4), 363–371. Retrieved from: https://doi-org.ezproxyles.flo.org/10.1606/1044-3894.178

American Counseling Association (2014). *Code of ethics*. (p.4). Alexandria, VA: Retrieved from: 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: American Psychiatric Publishing.

Baciu, L., & Vîrgă, D. (2018). The prevalence of secondary traumatic stress among Romanian social workers: A replication study. *Social Work Review / Revista de Asistenta Sociala*, 17(3), 151–164. Retrieved from: http://ezproxyles.flo.org/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=131871200&site=eds-live&scope=site

Baker, F., Metcalf, O., Varker, T., & O'Donnell, M. (2017). A systematic review of the efficacy of creative arts therapies in the treatment of adults with PTSD. *Psychological Trauma: Theory, Research, Practice, and Policy*. 10(6) 643–651. doi: 10.1037/tra0000353

Bensimon, M., Amir, D., & Wolf, Y. (2012). A pendulum between trauma and life: Group music therapy with post-traumatized soldiers. *The Arts in Psychotherapy*, 39, 223–233. Retrieved from: http://dx.doi.org/10.1016/j.aip.2012.03 .005

Betts, D. (2006). Art therapy assessments and rating instruments: Do they measure up? *The Arts in Psychotherapy*, 33(5) 422–434. Retrieved from: https://doi.org/10.1016/j.aip.2006.08.001

Bird, J. (2018). Art therapy, arts-based research and transitional stories of domestic violence and abuse. *International Journal of Art Therapy,* 23(1) 14–24. Retrieved from: https://doi.org/10.1080/17454832.2017.1317004

Branson, D. (2018). Vicarious trauma, themes in research, and terminology: A review of the literature. *Traumatology.* Retrieved from: http://dx.doi.org/10.1037/trm0000161

Burau, D., & Downs, M. S., (2019, February). *Connection to Self and Others Through Art.* [PowerPoint].

Carr, C., d'Ardenne, P., Sloboda, A., Scott, C., Wang, D., & Priebe, S. (2012). Group music therapy for patients with persistent post-traumatic stress disorder: An exploratory randomized controlled trial with mixed methods evaluation*. Psychology and Psychotherapy: Theory, Research and Practice,* 85, 179–202. Retrieved from: http://dx.doi.org/10.1111/j.2044-8341.2011.02026.x

Chong, C. Y. J. (2015). Why art psychotherapy? Through the lens of interpersonal neurobiology: The distinctive role of art psychotherapy intervention for clients with early relational trauma. *International Journal of Art Therapy*, 20, 118–126. Retrieved from: https://doi.org/10.1080/17454832.2015.1079727

Clarkson, P., & Nuttall, J. (2000). Working with countertransference. *Psychodynamic Counseling*, 6, 359–379. Retrieved from: https://doi-org.ezproxyles.flo.org/10.1080/13533330050132125

Cohen, K., Collens, P. (2012). The impact of trauma work on trauma workers: A metasynthesis on vicarious trauma and vicarious posttraumatic growth. *American Psychological Association*, 5(6), 570-580. Retrieved from http://dx.doi.org/10.1037/a0030388

Cozolino, L. (2010). *The neuroscience of psychotherapy: Healing the social brain* (2nd ed.). New York, NY: Norton.

Craig, C. D., & Sprang, G. (2010). Compassion satisfaction, compassion fatigue, and burnout in a national sample of trauma treatment therapists. *Anxiety, Stress & Coping*, 23(3), 319–339. doi: 10.1080/10615800903085818

Eckert, B. (2015). Memory reconsolidation understood and misunderstood. *International Journal of Neuropsychotherapy,* 3, 2–46. Retrieved from: https://doi.org/10.12744/ijnpt.2015.0002-0046

Figley, C. R. (1993). Compassion stress: Toward its measurement and management. *Family Therapy News,* 1–2.

Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In C. R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized,* 1–20. New York: Brunner/Mazel.

Figley, C. R. (1996). Review of the compassion fatigue self-test. In B.H. Stamm (Ed.), M*easurement of stress, trauma, and adaptation*. Baltimore, MD: Sidran Press.

Figley, C. R. (2002a). Compassion fatigue: Psychotherapists' chronic lack of self-care*. Journal of Clinical Psychology,* 58, 1433–1441. Retrieved from: https://doi.org/10.1002/jclp.10090

Figley, C.R. (2002b). *Treating compassion fatigue.* New York: Brunner/Routledge.

Gantt, L., & Tinnin, L. W. (2009). Support for a neurobiological view of trauma with implications for art therapy. *The Arts in Psychotherapy*, *36*, 148–153. Retrieved from: https://doi.org/10.1016/j.aip.2008.12.005

Harrison, R., & Westwood, M. (2009). Preventing vicarious traumatization of mental health therapists: Identifying protective practices. *Psychotherapy: Theory, Research, Practice, Training, 46*(2), 203–219. doi: 10.1037/a0016081

Hass-Cohen, N. (2003). Art therapy mind body approaches. *Progress in Family Systems Research and Therapy*, 12, 24–38.

Hernandez, P., Gangsei, D., & Engstron, D. (2007). *Vicarious resilience: A new concept in work with those who survive trauma.* Family Process, 46(2), 229–241. Retrieved from: https://doi-org.ezproxyles.flo.org/10.1111/j.1545-5300.2007.00206.x

Hinz, L. D. (2009). *Expressive therapies continuum: A framework for using art in therapy*. New York, NY: Routledge.

Horsley, H. & Horsley, G. (2017, May). Episode 47: Healing Trauma/Creative Activities [Video file]. Retrieved from: https://www.youtube.com/watch?v=3x-n4lyzfd4

Hyatt-Burkhart, D. (2014). The experience of vicarious posttraumatic growth in mental health workers. *Journal of Loss & Trauma,* 19(5), 452–461. Retrieved from: https://doi-org.ezproxyles.flo.org/10.1080/15325024.2013.797268

Isobel S. & Angus-Leppan G. (2018*).* Neuro-reciprocity and vicarious trauma in psychiatrists. *Australasian Psychiatry,* 26(4) 388 –390. Retrieved from: https://doi.org/10.1177/1039856218772223

Jordan, K. (2010). Vicarious trauma: Proposed factors that impact clinicians. *Journal of Family Psychotherapy*. 21, 225-237. Retrieved from: http://dx.doi.org.ezproxyles.flo.org/10.1080/08975353.2010.529003

Lieblich, A., Tuval-Mashiach, R., & Zilber, T. B. (1998). *Narrative research: Reading, analysis and interpretation*. Thousand Oaks Calif: Sage Publications.

Malchiodi, C. (2003). Art therapy and the brain. In C. Malchiodi (Ed*.), Handbook of art therapy.* New York: Guilford.

Masten, A. S., & Coatsworth, J. D. (1998). The development of competence in favorable and unfavorable environments: lessons from research on successful children. *The American Psychologist*, (2), 205. Retrieved from: http://ezproxyles.flo.org/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=edsgao&AN=edsgcl.20583391&site=eds-live&scope=site

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. Retrieved from: https://doi-org.ezproxyles.flo.org/10.1007/BF00975140

McNamee, C. M. (2005). *Bilateral art: Integrating art therapy, family therapy, and neuroscience*. Contemporary Family Therapy, 27(4). Retrieved from: https://doi.org/10.1007/s10591-005-8241-y

Mohr, E. (2014). Posttraumatic growth in youth survivors of a disaster: An arts-based research project. *Art Therapy: Journal of the American Art Therapy Association*, *31*(4), 155–162. Retrieved from: http://dx.doi.org.ezproxyles.flo.org/10.1080/07421656.2015.963487

Molnar B., Killian, K., Emery, V., Sprang, G. & Gottfried, R. (2017). *Advancing science and practice for vicarious traumatization/secondary traumatic stress: A research agenda.* Traumatology, 23(2), 129–142. Retrieved from: https://psycnet.apa.org/doi/10.1037/trm0000122

Newell, J. M., Nelson-Gardell, D., & MacNeil, G. (2016). Clinicians responses to client traumas: A chronological review of constructs and terminology. *Trauma, Violence, & Abuse*, 17(3), 306–313. Retrieved from: https://doi-org.ezproxyles.flo.org/10.1177/1524838015584365

Ogden, P., & Minton, K. (2000). *Sensorimotor psychotherapy: One method for processing traumatic memory.* Traumatology, 4(3).

Pearlman, L. A., & Mac Ian, P. S. (1995). *Vicarious traumatization: an empirical study of the effects of trauma work on trauma therapists.* Professional Psychology, Research and Practice, (6), 558. Retrieved from: http://ezproxyles.flo.org/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=edsgao&AN=edsgcl.17981827&site=eds-live&scope=site

Pearlman, L.A., & Saakvitne, K.W. (1995). Treating therapists with vicarious traumatization and secondary traumatic stress disorders. In C.R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*, 150–177. New York: Brunner/Mazel.

Perryman, K., Blisard, P., & Moss, R. (2019). Using creative arts in trauma therapy: The neuroscience of healing. *Journal of Mental Health Counseling*, *41*(1), 80–94. Retrieved from: https://doi-org.ezproxyles.flo.org/10.17744/mehc.41.1.07

Schore, A. N. (2009). Relational trauma and the developing right brain. *Annals of the New York*

Academy of Sciences, 1159, 189–203. Retrieved from: https://doi.Org/10.llll/j.1749-6632.2009.04474.x

Schouten, K. A., de Niet, G. J., Knipscheer J. W., Kleber, R. J., & Hutschemaekers, G. J. M. (2015). The effectiveness of Art therapy in the treatment of traumatized adults: A systematic review of art therapy and trauma*. Trauma, Violence and Abuse*, 16(2) 220–228. doi: 10.1177/1524838014555032

Spiegel, D., Malchiodi, C., Backos, A., & Collie, K. (2006). Art therapy for combat-related PTSD: Recommendations for research and practice. *Art Therapy: Journal of the American Art Therapy Association*, 23, 157–164. Retrieved from: http://dx.doi.org/10.1080/07421656.2006.10129335

Stamm, B. H. (2010). *The ProQOL: Professional Quality of Life Scale: Compassion Satisfaction and Compassion Fatigue*. Pocatello, ID: ProQOL.org. Retrieved April, 2019 from: www.proqol.org

Talwar, S. (2007). Accessing traumatic memory through art making: An art therapy trauma protocol (ATTP). *The Arts in Psychotherapy*, 34, 22–35. Retrieved from: http://dx.doi.org/10.1016/j.aip.2006.09.001

van der Kolk, B. (2014*). The body keeps the score: Brain, mind, and body in the healing of trauma*. New York, NY: Penguin Books.

Walsh, F. (2002). A Family Resilience Framework: Innovative Practice Applications. *Family Relations,* 51(2), 130. Retrieved from: http://ezproxyles.flo.org/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=edsjsr&AN=edsjsr.3700198&site=eds-live&scope=site

Appendix

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE (PROQOL) VERSION 5 (2009)

When you *help* people you have direct contact with their lives. As you may have found, your compassion for those you help can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a clinician. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often

_____ 1. I am happy.
_____ 2. I am preoccupied with more than one person I help.
_____ 3. I get satisfaction from being able to help people.
_____ 4. I feel connected to others.
_____ 5. I jump or am startled by unexpected sounds.
_____ 6. I feel invigorated after working with those I help.
_____ 7. I find it difficult to separate my personal life from my life as a clinician.
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I help.
_____ 9. I think that I might have been affected by the traumatic stress of those I help.
_____ 10. I feel trapped by my job as a clinician.
_____ 11. Because of my clinical work, I have felt "on edge" about various things.
_____ 12. I like my work as a clinician.
_____ 13. I feel depressed because of the traumatic experiences of the people I help.
_____ 14. I feel as though I am experiencing the trauma of someone I have helped.
_____ 15. I have beliefs that sustain me.
_____ 16. I am pleased with how I am able to keep up with therapeutic techniques and protocols.
_____ 17. I am the person I always wanted to be.
_____ 18. My work makes me feel satisfied.
_____ 19. I feel worn out because of my work as a clinician.
_____ 20. I have happy thoughts and feelings about those I help and how I could help them.
_____ 21. I feel overwhelmed because my case-load seems endless.
_____ 22. I believe I can make a difference through my work.
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I help.
_____ 24. I am proud of what I can do to help.
_____ 25. As a result of my clinical work, I have intrusive, frightening thoughts.
_____ 26. I feel "bogged down" by the system.
_____ 27. I have thoughts that I am a "success" as a clinician.
_____ 28. I can't recall important parts of my work with trauma victims.
_____ 29. I am a very caring person.
_____ 30. I am happy that I chose to do this work.

YOUR SCORES ON THE PROQOL: PROFESSIONAL QUALITY OF LIFE SCREENING

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental health care professional.

Compassion Satisfaction _____

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout_____

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Secondary Traumatic Stress_____

The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.

WHAT IS MY SCORE AND WHAT DOES IT MEAN?

In this section, you will score your test so you understand the interpretation for you. To find your score on **each section,** total the questions listed on the left and then find your score in the table on the right of the section.

Compassion Satisfaction Scale

Copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

3. _____
6. _____
12. _____
16. _____
18. _____
20. _____
22. _____
24. _____
27. _____
30. _____

Total: _____

The sum of my Compassion Satisfaction questions is	So My Score Equals	And my Compassion Satisfaction level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about the effects of helping when you are *not* happy, so you reverse the score

You Wrote	Change to
	5
2	4
3	3
4	2
5	1

*1._____= _____
*4._____= _____
8. _____
10. _____
*15._____= _____
*17._____= _____
19. _____
21. _____
26. _____
*29._____= _____

Totals: _____

The sum of my Burnout Questions is	So my score equals	And my Burnout level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Secondary Traumatic Stress Scale

Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

2. _____
5. _____
7. _____
9. _____
11. _____
13. _____
14. _____
23. _____
25. _____
28. _____

Total: _____

Total: _____

The sum of my Secondary Trauma questions is	So My Score Equals	And my Secondary Traumatic Stress level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High