Re: Traumatizing – The Interactions Between Clinicians and Therapeutic Helpers and Vicarious Trauma

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Re: Traumatizing – The Interactions Between Clinicians and Therapeutic Helpers and Vicarious Trauma

Capstone Thesis

Lesley University

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Drama Therapy

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Abstract

Vicarious trauma can exist in the therapeutic space shared between the clinician or therapeutic helper and their client. Based on the combined readings of Johnson (2009) and Armstrong et al. (2015), the physical and figurative embodiment of a client’s trauma provides interesting implications for the clinicians and therapeutic helpers involved in the shared therapeutic space. Informed by a drama therapy paradigm, this thesis explores how clinicians and therapeutic helpers have been impacted by their encounters within therapeutic alliances, including how they may have internalized trauma through verbal and physical embodiment in their work. Two 75-minute drama therapy sessions were scheduled with five clinicians and therapeutic helpers working in the areas of community violence and homicide. The results of the intervention indicated that clinicians and therapeutic helpers shift between multiple roles to cope with the vicarious trauma they encounter. The intervention has potential implications regarding the self-awareness of the clinician or therapeutic helper, as well as examining how rates of burn out and compassion fatigue are affected by embodiment of vicarious trauma.
Introduction

Therapy is a process requiring vulnerability from the clients, as histories and biopsychosocial information are shared with the clinician or therapeutic helpers (Younggren et al., 2011). Therapy can be interpreted as a transaction; one of an exchange of services between two or more parties, be it the therapists, the clients, the insurance agencies, and so on. There is both an expectation and understanding that the client is present, whether voluntary or mandated to, to receive some treatment, support, and help from the clinician or therapeutic helper. For that process to happen, there is a core anticipation of sharing. The client’s material is expected, both by therapists, clients themselves, and the general public, to be expressed in the therapeutic space, typically between a solitary clinician/therapeutic helper and the client themselves. Much of the client’s thoughts, emotions, and behaviors across differing locations and time are brought up and examined. Occasionally, traumatic experiences underlie these shared contents in the therapeutic space. The client may also be among other clients and with perhaps more than one clinician/therapeutic helper in a group setting, partaking in a mutual give-and-take process within the group.

The author of this paper professes a curiosity in how traumatic content that emerges in the therapeutic space affects the clinicians or therapeutic helpers present. Younggren et al. (2011) stated that “duty, in the case of a psychotherapeutic relationship, is actually bilateral in nature. Bilateral means not only that the psychologist has duties to the patients, but patients also have duties to the psychologist” (p. 161). Not only are clients’ past, present, and futures potentially
divulged to be contained by the clinician/therapeutic helper, but traumas and transferences; as originated by Freud (1905) to be a process in the unconscious “in which a whole series of psychological experiences are revived, not as belonging to the past, but as applying to the physician at the moment (p. 116)”, are also breathed into a shared atmosphere. With that in mind, and by agreeing with the contract of the therapeutic relationship, clients have a duty to comply with (if not at least communicate their reluctance to comply with) the treatment plans of the clinicians. Ideally, the goal setting process is a collaborative one between the client and their clinician. In return, the clinicians’ and therapeutic helpers’ duties to their clients are to engage in the holding of the therapeutic space. Clarkson and Nuttall (2000) additionally noted that it is in that shared therapeutic space that the clinicians/therapeutic helpers’ unconscious feelings, thoughts, and countertransferences show up in the form of reactions to their clients’ shared material, traumatic histories, and possible transference. Boundaries are pushed, played with and tested as realities interact in the therapeutic space. In response to that process, clinicians and therapeutic helpers should thereby develop a special set of skills in order to hold and process the level of disclosure from clients. The author of this thesis maintains that it is in the sharing of the therapeutic space and in containing both the clients’ and their own feelings, thoughts, and reactions that clinicians and therapeutic helpers start to generate compassion fatigue and secondary traumatic stress. In fact, Ludick and Figley (2016) provided a variety of examples ranging from victim advocates, attorneys, to teachers and students as they widened the net to include not just those who work directly with trauma to be solely partial to compassion fatigue and secondary traumatic stress.

The author of this paper is approaching the topic as a drama therapist-in training, and as such, has applied a drama therapy framework to the development of the method presented. This
author believes that there is an embodiment of the client’s trauma by the clinician/therapeutic helper in the shared therapeutic space. The embodiment is sometimes a literal physical embodiment; the clinician/therapeutic helper takes on the role of the trauma, a piece of the trauma, the perpetrator, and/or the incident, representing a physical being that the client is encouraged to play with and examine, and converse with.

The drama therapist operates in the dramatic realm, combining both drama and therapy in their work with their clients. For example, the drama therapist might take on a different role and pretend in the dramatic realm that they are playing someone who hurt a client and ask the client what responses and words they would like to give to the therapist in-role. The therapist could also suggest that the client write a poem, a letter, or a monologue to address an alternate narrative of the client. For example, the therapist might guide the client who imagines and narrates the year the client chose to take a different job instead of the one they had in reality. The therapist might also prompt the client to consider what the alternate self would say back to them in reply.

There is also a more metaphorical form of embodiment of the client’s trauma shared. For example, a drama therapist may help their client rehearse for conversations and practice assertiveness with the client’s perpetrators present or absent in the client’s life by stepping into the role of said perpetrator. The client is involved in the fine tuning of the role as taken by the drama therapist by directing both physical and metaphorical embodiment of how the drama therapist as perpetrator would hold themselves, move, sound like, respond. An alternate way a drama therapist might approach the same scenario is to utilize the empty chair technique and have the client engage in a conversation with the other person or perpetrator as being projected onto an empty chair. A drama therapist can also en-role as a feeling or an emotion belonging to
the client that they associate with their traumatic experiences, which requires the drama therapist to have a level of faithful rendering (Johnson, 2009). In faithful rendering, the drama therapist is required to honestly embody the emotions and feelings they are en-roling as, thereby possibly evoking within the therapist themselves similar and lingering content. As an example, a drama therapist en-rolled as the feeling of their client’s helplessness may dig deep and invoke similar situations from the therapist’s own life and experiences to be able to accurately and dramatically embody the specific taste of helplessness the client describes. Taking the process a step further, the drama therapist calling upon specific instances of helplessness within themselves in order to locate the best fit and mirror the sense shared by the client may shift their paradigms, their thoughts, emotions, speech patterns, ways of carrying themselves and movements. The faithful rendering aspect of the process may require the drama therapist to delve into their empathy and recount possibly traumatic personal experiences where they have felt the helplessness their client shared. Armstrong et al. (2015) reported that the use and presence of dramatic projection and dramatic embodiment is more likely to result in a higher rate of emotional arousal in participants who witness them. Therefore, not only is the drama therapist holding the space for their client’s pain and emotions, but they themselves are also possibly dredging up hurtful past experiences and holding that as well in the same therapeutic space. These are potential situations that enroll the clinician metaphorically into the client’s trauma story. The embodiment takes the projection availed by the client a step further for both themselves and the clinician.

The author of this paper is curious about what potentially lingers in the systems and bodies of the therapeutic helpers and clinicians once they have exited the embodied roles they chosen to play therapeutically. This author wonders about the remnants of emotional contagion and exercises in empathy and support displayed by this chosen population (possibly otherwise
known as vicarious trauma) – how does it change the clinician/therapeutic helper? Does it intermingle with the clinician/therapeutic helper’s own personal trauma and history? More importantly, how do we as clinicians or therapeutic helpers address these experiences and support ourselves and each other in the process?

Therefore, the author chooses to engage in capstone option 1: Development of a Method. In the literature review, the author will outline vicarious trauma, its effects, vicarious resilience, and the role played by expressive arts therapies in relation to vicarious trauma and vicarious resilience to help support the development of the author’s methodology. Then the methodology and results of the intervention will be presented. Next, the author’s arts-based responses will be shared. Finally, this thesis will end with a discussion of the results and conclude with a summary and potential future implications of the results.

Literature Review

Vicarious Trauma

“...we illustrate how feelings exist in tandem with conceptual information (Barrett, 2017), are sources/locations of dynamic change and structural constraint (Erickson & Stacey, 2013), and cannot be disentangled from the persons who experience them (Cahill, 1998).” (Cottingham & Erickson, 2019, p. 3)

McCann and Pearlman (1990) pioneered the definition and use of the term vicarious trauma as the emotional transformation and cognitive shifts within therapeutic helpers as catalyzed by empathic interactions and engagements with survivors of traumatic experiences. From a sociological perspective, Cottingham and Erickson (2019) used an emotion practice
approach to record and illustrate the complexities of emotional labor and the nuances that underlie the interactions between nurses and the patients they supported. The study emphasizes how emotions in the field of helping others are informed by social contexts as well as the caregiver’s habitus. Habitus, as elaborated by the authors, is “both a product of one’s past and motivates present and future social practice” (p. 7). The authors developed the emotion practice framework: a paradigm that consists of practice theory with Hochschild’s (1979) emotion management framework, to challenge the duality of the aforementioned Hochschild’s framework – the original focus on body versus mind, static versus dynamic states of being, and the individual versus the collective.

Cottingham and Erickson (2019) maintained that “practices are theorized as the “building blocks of social reality” (Feldmand & Orlikowski, 2011, p. 1241) where individuals act as carriers of “patterns of bodily behavior” – routines of knowing, being, and doing (Reckwitz, 2002) (p. 3). Scheer (2012) took this further to argue that “practices not only generate emotions, but that emotions themselves can be viewed as a practical engagement with the world” (p. 193) - engagements that are both embodied and socially structured.” (p. 6). Meaning, the clinician or therapeutic helper both embody and represent their training and routine work.

To sum up Cottingham and Erickson (2019): clinicians and therapeutic helpers come from their trainings (practices), bringing their habitus (internalized schemas used to understand, perceive, discern social realities) shaped under specific feeling rules (i.e. ethics, boundaries, how to best conduct oneself as therapeutic support for a client). Holding all of their own experiences, clinicians and therapeutic helpers still must determine how to build rapport with their clients, design treatment goals and plans, and support their client in the shared space, as well as be prepared to help carry and contain the client’s trauma. Additionally, and possibly, at the same
time, the clinician or therapeutic helper may find themselves carrying their own vicarious trauma, countertransference, and burnout.

Ultimately, Cottingham and Erickson (2019) found that the caregivers’ emotion practice is all at once fulfilling multiple aspects; conscious and embodied, structured dynamically, and individual yet collective. The authors maintained that in caregiving roles, caregivers partake in a conservation of the resource that is emotional capital. In this conservation, caregivers engage in the push and pull of rational and irrational emotional management and feeling affected not just by who is in front of them, but also what is happening within and without them. The authors also noted that even with rationality driving the conservation of emotional capital within the caregiver, the valuable resource can still be used up – occasionally leaving behind psychosomatic reactions within the caregivers’ bodies such as aches, pain, affected sleep, lack of time to eat or urinate, and so on. In other words, the clinician might be able to cognitively understand that their client’s trauma is not their own, but their bodies may still empathetically hold the memory and feel pain in response to what they’ve witnessed in the therapeutic sessions.

**How Vicarious Trauma is Affected and Its Effects**

Craig and Sprang (2010) surveyed and found that “statistically significant decreases in compassion fatigue and burnout and increases in compassion satisfaction” (p. 335) are products of the use of evidence-based practices at the workplace. Regardless, the authors also reported that there is an insufficiency in trauma-specific training amongst the respondents in their findings – something that the authors believe contributed to a higher burnout rate. Adams, Boscarino, and Figley (2006) explained that one of the results of vicarious trauma is secondary traumatic stress (STS). Compounding on that further, Ludick and Figley (2017) compiled a smorgasbord of the
effects of STS. The authors detailed a heightened sense of fear, overaccommodating one’s secondary exposure to trauma and resultant disappointment by generalizing a cynical viewpoint upon all humankind as some of such effects. Additionally, the responders also included experiencing feeling like one’s good internal resources and objects threatened by the secondary trauma exposure to reduce in its finite, already limited amounts. Ludick and Figley (2017) also mentioned possible STS aftereffects in the responders’ reactions in their relationships as shifting to being cold, harsh, punitive, and withdrawing from family members alongside with having increasingly difficult interpersonal relationships. The authors also gathered the psychological and physiological outcomes of STS exposure. These outcomes include physical health complaints such as insomnia and lethargy, psychosomatic issues, anxiety, depression, irritability, substance abuse, and shifts in spiritual and religious beliefs. STS also affects the work productivity of those exposed to it. Ludick (2013) continued to report on an overall reduced sense of satisfaction, ability to assist, and compassion associated with the work of claims workers. The health and wellbeing of the mentioned claims workers were also stated to have been so affected by STS that nearly fifty percent of them reported to taking sick leave to cope. There were also increased levels of absenteeism among them.

**Vicarious Resilience**

Aligning with the definition of vicarious resilience, Michalchuk and Martin (2019) wrote about the potential positive side effects of vicarious trauma such as developing purpose and personal growth, privileging a shared journey, serving humanity, and deriving positive meaning. This in turn provides a much needed and hopeful paradigm on a severely somber topic as a redirect to the results of growth, resilience, and satisfaction. The authors also reported on compassion satisfaction for the clinician as being a possible after effect of working with a
client’s trauma. They elaborated that witnessing and processing a client’s shift to survivor from victim contributes immensely to reduced rates of burnout and vicarious trauma, alongside with increasing the longevity of the clinicians’ jobs and careers. Michalchuk and Martin (2019) also included vicarious posttraumatic growth as a process within clinicians or therapeutic helpers that aligns almost parallely with their clients’ own posttraumatic growth.

Ludick and Figley (2017) maintained that empathy is core to the therapeutic process between client and clinician. The authors also noted that paradoxically, the very same empathy is what causes both vicarious trauma and vicarious resilience within the clinician or therapeutic helper. With that in mind, the authors pointed out that detachment is crucial in the building of both personal resilience and vicarious resilience in clinicians and therapeutic helpers, stating that it is both the process and action of ‘letting go’ and disengaging that helps with personal and vicarious resilience.

In sum, both detachment and processing traumatic content are aspects of a healthy therapeutic skillset that contributes to resilience both personal and vicarious in nature.

**The Role of the Expressive Arts**

Neswald-Potter and Simmons (2016) looked at the interactions between vicarious posttraumatic growth and expressive arts-informed supervision. Through the use of two case studies, the authors noted that the combination of both the regenerative model and the use of self-disclosure and vulnerability by supervisors helped ameliorate the vicarious trauma obtained by the supervised counselors. Huss and Hafford-Letchfield (2019) utilized drawing and writing with their chosen sample of social workers to examine their stressors, reactions, and coping skills
in the workplace, highlighting how social workers in their study were more likely to cite personal mistakes as main causes of stress compared to the ever present overall systemic issues.

Gibson (2018) recorded their internal workings from engaging with clients with trauma in a pediatric hospital in a visual journal. Gibson referred to Moon (2009) as a source of validation of the recorder’s emotions and experiences. Gibson also cited Fish (2012) as an inspiration for the chosen technique – Fish expressed that visual journaling can be utilized as containment, expression and reaction examination, as well as a method to share one’s reflections with other people. Fish (2012) also elaborated that reflecting on response art; that is, art created in reaction to the contents of a therapeutic session, “can draw attention to intense responses to treatment and offer a means to investigate their deeper meaning, which in turn can inform treatment and bring personal insights” (p. 138). Using several case studies, Fish (2012) opined that response art functions as a method to process, contain and explore difficult material and countertransferences rising within the therapist. She also posited that response art helps with the navigation and communication of both interpersonal difficulties and shared empathy between clinician and client. Fish also reasoned that response art plays an important role in supervision and clinical training, both as a redirection of the supervisor’s focus to the present here and now, and as the expression of rich visual material to be availed and examined upon reflection.

**Drama Therapy Concepts Informing the Chosen Intervention**

**Role Theory and De-roling.**

Role Theory is defined by Landy (2009) as containing three important facets. First, humans naturally take on and play roles. Second, human behavior is both highly intricate and paradoxical, needing the context of its opposing counterparts to explain any standalone action or
thought. Regardless, human beings can live with the aforementioned complexities and contradictions. Thirdly, the human personality can be understood as an interacting system of roles (p. 67). Role Theory is useful in understanding a client, but it is also useful for the clinician/therapeutic helper to also consider (alongside the client) which roles also resonate for themselves. As Landy defined, roles contain “patterns of behavior that suggest a particular way of thinking, feeling or acting” (p. 67), and clinicians may discover that a client’s roles may also resonate for them. The use of the skills of empathy, sympathy, compassion, containment, and witnessing by the clinician/therapeutic helper may increase their vulnerabilities to vicarious trauma.

De-roling is also especially important. Landy (2009) elaborated that de-roling is the “shift in realities from the dramatic to that of everyday life” (p. 76). Individuals play with and change roles available in their role repertoires; as explained by Garcia and Buchanan (2009) as the range of available roles within a person (p. 395), as they transition from different circumstances both social, emotional, cognitive, and otherwise. Bringing back to mind Ludick and Figley’s (2017) stance that detachment is important, de-roling is a form of the embodiment of the letting go and disengaging process. Typically, de-roling brings to mind the ‘taking off the skin and feel’ of the character from the actor, but in the case of clinicians and therapeutic helpers, de-roling helps them remove temporarily their social working roles, as to not “take work home”. Additionally, the de-roling of the physical space is also pivotal to the therapeutic process. As Cottingham and Erickson (2019) pointed out, “spaces themselves – as products of past emotional practices – might give off or shape emotions in individuals. Collective moods emerge from intentional and unintentional social practices” (p. 17). This recalls the ‘safety’ and ‘safe and secure place’ element of the therapeutic space and alliance; that is, once a therapeutic alliance is formed
between clinician and client, the therapeutic space may take on the label and “role” of a safe and secure place for the client to engage their material. These two authors highlighted the use, significance, and value of the therapeutically supportive space as a physical entity – an idea that the author of this paper will relate and tie to Feldman, Sussman Jones, and Ward’s (2009) concept of (physical) creative containment.

**Developmental Transformations (DvT).**

According to Johnson (2009), the elements of mutuality, encounter, and playspace are among many core tenets of the drama therapy approach, Developmental Transformations (DvT). Mutuality, otherwise referred to as mutual agreement, is a process agreed upon by the therapist and the client that relies on relational reciprocity in the therapeutic space. Encounter is defined by Johnson as the proximity and phenomenon of the experience between the therapist and the client. The playspace is a drama therapeutic space relying on the previously mentioned concepts of mutuality and encounter, as understood and consented to by therapist and client, to be the place where the therapeutic work occurs and is conducted, often with playfulness and imaginal representation. Relatedly, these elements are usually evident in varying degrees both within the therapy room and metaphorically within the drama therapist, clinician, and therapeutic helper.

**6 Part Story Making (6PSM).**

The 6 Part Story Making (6PSM) by Lahad (1992) is a crucial component in the chosen intervention. The 6PSM is a tool that can be used to creatively assess the levels of stress a client is undergoing. Lahad (1992) maintained that both stressors and coping mechanisms could be illustrated through the 6PSM. Both internal and external resources of the clients were investigated through the lens of the BASIC Ph scale of coping: Belief and Values, Affect, Social,
The author found that different coping styles utilized different combinations of these resources.

Lahad and Dent-Brown (2012) recalled that the initial use of the 6PSM as an assessment tool was to provide clients an opportunity to share with their therapist a map of their projected self coming into contact with reality. The authors also examined the potential varying levels of information that the tool avails to the careful clinician. Access to level 1 (coping style), level 2 (themes/issues), level 3 (here and now questions), level 4 (conflict), level 5 (developmental stage), level 6 (hero’s quest), and level 7 (symbols) were allowed through the six panels. The authors also related the use of the 6PSM with Landy’s (2009) Role Theory, explaining that the systems of roles within clients manifested through the story telling panels of the 6PSM. Following the main characters’ journeys through the six panels illustrated the roles working within each participant as how they had projected to meet the needs of their current reality.

**Aesthetic Distance.**

Halevi and Idisis (2017) utilized Bowen’s family systems theory in an exploration with counselors’ vicarious trauma in Israel. Halevi and Idisis’ use of Bowen’s concept of intrapersonal differentiation of self – similar to the drama therapy concept of aesthetic distancing as elaborated by Landy in Current Approaches in Drama Therapy (2009) – provides particularly useful insight. They discussed the optimal distance of balance befitting an individual on the scale where its polar ends of the spectrum are ‘underdistanced’ (being highly in and within one’s emotions) and ‘overdistanced’ (being highly in and within one’s cognition), spotting similarities in the use of titrating between cognition and emotion as suited in both concepts. The study found that there is a significant negative correlation between differentiation of self and vicarious
traumatization in the sample used, suggesting that individuals with high differentiation of self can maintain flexible personal boundaries that separates effectively their client’s material from their own. It is also stated in Cottingham and Erickson (2019) that the focus of Hochschild’s (1983) original theory on the parallel processes that occur within the organism’s body are laced together with cognitive evaluations (hidden under “symbolic interactionism” (p. 5)), which is reminiscent of the aforementioned concept of aesthetic distancing. Thoits (2004) explained that “symbolic interactionism” is rationalized to be the actions, affect, and behaviors under considerable management by an individual – a display that can be controlled following social conventions and mores.

Methodology

Site of Study

The author of this paper has at their internship site observed, witnessed, and participated in the containment of trauma, and posttraumatic scenarios with clients. The team this author works with serves communities affected by homicide and community violence, and touches on the intricate topics of trauma, grief and loss. One way the team serves these communities is by providing psychoeducation on the above-mentioned topics to teenagers, young people, children, and families. The team’s work also covers funerals, memorials, vigils, and other religious and/or ceremonial cultural rituals surrounding the death and passing of a person due to community violence and homicide. Each event is different. There are no ways to cover beforehand the cultures the team will encounter in the sacred space. There are no methods to prepare any intern or team member for what might be encountered in each area of deep respect. Each member of the team dives right into an atmosphere of varying levels of grief and spectrums of loss.
Occasionally, the team members go into highly tense and pressurized breathing spaces of potent grief, punctuated with wails and songs of loss. Other times, the team enter a space and it was like all the air and noise and sound was sucked out of the room, save for the polite faces slapped on and the rapid pats on the backs. Team members also enter hallowed grounds built on foundations of formalized rituals and religious agreements, sprinkled with holy water, tears, and red nosed snot. Behind each door is a space of the unknown. Every time the team closes the door and leaves, each member carries with them shadows resembling the strength of the emotions tasted. Tears are shared in spaces beyond the poignant and tragic mourning that occurs in the area just before those very doors are closed.

It is similar for vicarious trauma in clinicians and therapeutic helpers. Every clinician or therapeutic helper hold a set of keys to a different door in a client, provided the client meets them halfway and allows the encounter between the two parties to be met in a communicated and slowly evolving (presumably) safe and secure space that usually is the clinician/therapeutic helper’s office. The client, with express permission, consents to sharing their histories and possible traumatic backgrounds with the clinicians/therapeutic helpers, who help hold the space (literally and metaphorically, emotionally, psychically, energetically) and contain the material. Similar to the analogy above, whether clinicians/therapeutic helpers know it or not, shadows of the encounter slip past the physical and metaphorical doors thought to be shut and stays with the clinicians and therapeutic helpers. These shadows linger and sometimes merge with the ones present in the room of the therapeutic alliance. Take the meaning of the word ‘room’ from the sentence before and take it to mean both the physical room set in ‘reality’, and the psychological room(s) of the therapeutic container that is the clinician/therapeutic helper.
The two-part series of workshops were initially planned to be conducted in person. Given the budding circumstances surrounding the COVID-19 around the time of the scheduled intervention, the initial plans shifted to become online remote sessions. This in turn caused some logistical changes such as the inclusion of a directive for the participants to prepare ahead of time: a writing utensil, some paper, space for comfortable movement, access to the Zoom program, and a computer/tablet (as opposed to the cellphone). Use of the remote telehealth option via Zoom also meant a loss of information such as the subtext of the group. The loss of information is further compounded by the amateur capacity of the facilitator to trust their therapeutic instincts when unfamiliar with the use of online therapeutic groups.

**Participant Population.**

The participants of the workshops were voluntary clinicians, therapeutic helpers, and clinicians-in-training at the author’s internship site. The participants consisted of three clinicians, one therapeutic helper, and one clinician-in-training. Four participants identified as female and one participant identified as male. The racial and ethnic identities of the participants are diverse and includes Black – Caribbean, African American, White – Irish and French, African American and Native American and Portuguese, and White – Hispanic. The age range is 23-50 (mean = 32.4, median = 27). As the workshops were only for educational purposes and no formal data was collected, verbal consent was obtained from all participants.

**Workshops**

Two drama therapy workshops providing creative storytelling and embodiment alongside elements of Developmental Transformations (DvT) were developed with the goal of processing and mitigating the impacts of vicarious trauma. The workshops also served as reminders of the
vicarious and personal resilience within the participants as they embodied and shared the characters and guides of their stories. The main activity for both workshops utilized the use of the 6 Part Story Making (6PSM). The use of repeated rituals to de-role is considered in the activity planning and actual sessions. The interplay of rituals and expectations sets up the therapeutic and caregiving relationship between the clinician, therapeutic helper, and caregiver with their clients and patients.

**Workshop 1.**

Warmup: Pass the Stretch, Pass the Sound, Pass the Stretch and Sound

Goal: To get participants comfortable and help them check in with their bodies. As each motion and/or sound is created and shared, the group mirrors it back to the originator. The set-up is developmental, increasing in difficulty to play with the window of tolerance of the participants.

Drama therapy concepts utilized: Developmental Transformations’ (DvT) concepts of mutuality, playspace, and encounter. The warmup establishes that the workshop is starting for everyone and that the space is shifting and being shifted to a therapeutic playspace where the participants will be encountering each other.

Main Activity: 6PSM; First Three Panels (Main Character, Objective, Obstacle)

Embodying and Sharing the Panels

Goal: To introduce storytelling and sharing via projection within the group. The group takes time to create the first three panels before being directed to embody the main characters by taking on the voices and movements of the characters. Each participant then introduces their character’s objective and obstacle to the rest. As the directives surround the work at the site, the panels serve
to illustrate the objectives and obstacles the participants face as their main characters. The embodiment delves into the parts of the body used to represent the characters and the participants’ stories.

Drama therapy concepts utilized: 6PSM and Role Theory. The participants were engaged in the projection and eventual embodiment of different roles within themselves, starting with the main characters of their stories. Aesthetic distance was also utilized as the activity engaged both overdistancing and underdistancing for the participants.

Closing Activity: De-Role, Magic Box

List 2 Positive Traits that Serve the Participants, with Gestures

List 2 Positive Traits that Serve Others, with Gestures

3 Deep Breaths

Goal: De-roling allows the playful separation of the main characters from the participants’ reality. Keeping the ‘suits’ of the main characters in an imagined shared magic box serve as a reminder that the participants can come back to their characters together as a group. The listing of positive traits accompanied with physical gestures is an adapted set of exercises for COVID-19 that function as reminders of positive traits the participants have regardless of the extenuating circumstances and sense of helplessness sourced from social distancing and the inability to go out and do their work physically. The deep breaths activity is also adapted for COVID-19 to ground each participant in their bodies and present reality.

Drama therapy concepts utilized: Role Theory and DvT. Roles are shifted and removed playfully within the playspace. The storing of the characters and roles in the magic box signifies a
(temporary) end to the therapeutic playspace and group. Aesthetic distance was also utilized as the activity engaged both overdistancing and underdistancing for the participants.

**Workshop 2.**

Warmup: Pass the Stretch, Pass the Sound, Pass the Stretch and Sound

Goal: To get participants comfortable and help them check in with their bodies. As each motion and/or sound is created and shared, the group mirrors it back to the originator. The set-up is developmental, increasing in difficulty to play with the window of tolerance of the participants.

Drama therapy concepts utilized: Developmental Transformations’ (DvT) concepts of mutuality, playspace, and encounter. The warmup establishes that the workshop is starting for everyone and that the space is shifting and being shifted to a therapeutic playspace where the participants will be encountering each other.

Main Activity: 6PSM; Second Three Panels (Guide, Climax, Resolution)

**Embodying and Sharing the Panels**

**Pose and Phrase to Represent Resolution**

Goal: To introduce storytelling and sharing via projection within the group. The group takes time to create the second set of three panels. The embodiment delves into the parts of the body used to represent the characters and the participants’ stories. As opposed to embodying the main characters, the participants were directed to embody the guide and helping forces of their stories. This was done to remind the participants of their inner resilience and helpers. The addition of the pose and phrase to represent the resolution of the participants’ stories allows for the physical
embodiment, sharing, and taking away of the possible positive feelings and closures for the participants themselves. The poses and phrases also serve as a physical reminder for the participants of what their main characters (and by extension, the participants themselves) are capable of.

Drama therapy concepts utilized: 6PSM and Role Theory. The participants were engaged in the projection and eventual embodiment of different roles within themselves, starting from the main characters of their stories, then shifting to their guides/helpers/helping forces to the poses and phrases of their resolution. Aesthetic distance was also utilized as the activity engaged both overdistancing and underdistancing for the participants.

Closing Activity: De-Role, Magic Box, Leave and Take Away

- List 3 Positive Traits that Serve Others, with Gestures
- List 3 Positive Traits that Serve The Participants, with Gestures
- 3 Deep Breaths

Goal: De-roling allows the playful separation of the main characters from the participants’ reality. Keeping the ‘suits’ of the main characters in an imagined shared magic box serve as a reminder that the participants can come back to their characters together as a group. The facilitator added the option for the participants to take everything they have experienced and learned in both workshops to be shared and contained in the magic box. The added option of leaving and taking away of the contents allows the participants the choice of what they would like to carry with them into their work beyond the playspace. The listing of positive traits accompanied with physical gestures is an adapted set of exercises for COVID-19 that function as reminders of
positive traits the participants have regardless of the extenuating circumstances and sense of helplessness sourced from social distancing and the inability to go out and do their work physically. The deep breaths activity is also adapted for COVID-19 to ground each participant in their bodies and present reality.

Drama therapy concepts utilized: Role Theory and DvT. Roles are shifted and removed playfully within the playspace. The storing of the characters and roles in the magic box signifies an end to the therapeutic playspace and group. However, the change made to the magic box to allow for the leaving behind and taking away of experiences shared during both workshops allow participants to reflect and play with what was present in the therapeutic playspace. Aesthetic distance was also utilized as the activity engaged both overdistancing and underdistancing for the participants.

**Results**

Inspired by Gibson’s (2018) article in the literature review, the facilitator took notes and made observations by jotting them down on paper the moment they occurred throughout the activities conducted for both workshops. Ideas, sketches, feelings, and inspirations were recorded as quickly as they could be captured within the limited window of time, such as when there was a natural lull and pause in the group. Themes that occurred as the facilitator examined their notes were recorded in Figure 1. Further samples of the processing, writing, and visual art are collected in the appendix of this thesis.

After each workshop ended, the facilitator examined the collected records to further expand on the content. The modality supervisor of the facilitator initiated the discussion surrounding the workshops. The processing of the workshops was further enhanced as the
facilitator replicated the workshops en-roled as a participant under the guidance of their modality supervisor. The parallel process of being both participant and facilitator was enlightening. An example of the author of this thesis’ experience as a participant is included below in Figure 2, followed by a short poem. The poem was a product of rumination by the author of this thesis embodying the role of a participant. Feelings, thoughts, questions, and ideas that arose both during and at the end of the session were recorded. Concepts were immediately and freely written and taken as prompts to be elaborated on structurally. Occasionally, the author of this thesis was also called to move about in specific ways as dictated by the flow of the content – these were illustrated to the best of this author’s abilities with watercolors, markers, and paper, and attached to the appendix of this thesis.

Figure 1.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Elaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>What is the history of the client and clinician?</td>
</tr>
<tr>
<td>Camaraderie</td>
<td>How is the camaraderie between the roles of the clinician?</td>
</tr>
<tr>
<td>Appreciation</td>
<td>What is appreciated?</td>
</tr>
<tr>
<td>Relational Dynamics</td>
<td>What is present and what changes?</td>
</tr>
<tr>
<td>Overlapping Roles and Boundaries</td>
<td>What roles come into play? Whose boundaries?</td>
</tr>
<tr>
<td>Comfort</td>
<td>What is the meaning of comfort for both parties?</td>
</tr>
<tr>
<td>Consideration</td>
<td>Elements of consideration within the therapeutic alliance</td>
</tr>
<tr>
<td>Uncertainty</td>
<td>Change and what is brought into the therapeutic space</td>
</tr>
<tr>
<td>Needs</td>
<td>Whose needs are identified, is there an overlap?</td>
</tr>
<tr>
<td>Locus of Control</td>
<td>Whose locus of control is being played with?</td>
</tr>
<tr>
<td>Topic</td>
<td>Question</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Focus of Control</td>
<td>Where is the focus of control?</td>
</tr>
<tr>
<td>Multiple Relationships; Hierarchies</td>
<td>Which roles take precedent?</td>
</tr>
<tr>
<td>Intentions</td>
<td>What are the intentions of the roles and coping?</td>
</tr>
<tr>
<td>Logistical Complexities</td>
<td>What can a clinician do within limitations?</td>
</tr>
<tr>
<td>Permission</td>
<td>What is allowed and what isn’t, what is in between?</td>
</tr>
<tr>
<td>Taking care of the self and each other</td>
<td>How the clinician take care of themselves and others</td>
</tr>
<tr>
<td>Power Dynamics</td>
<td>Within the organization and the role repertoires</td>
</tr>
<tr>
<td>Discomfort</td>
<td>Limitations and reminders</td>
</tr>
<tr>
<td>Being</td>
<td>Is the clinician present or absent?</td>
</tr>
<tr>
<td>Transitions</td>
<td>Shifts within roles</td>
</tr>
<tr>
<td>Boundaries</td>
<td>Taking care of self and wanting to take care of others</td>
</tr>
<tr>
<td>Caught in between</td>
<td>Too many roles in play</td>
</tr>
<tr>
<td>Push and pull</td>
<td>Something might have to give way?</td>
</tr>
<tr>
<td>Unclear Baselines</td>
<td>What is the initial starting point of health?</td>
</tr>
<tr>
<td>Naming is Difficult</td>
<td>Transference/Countertransference/Biases/Schemas</td>
</tr>
<tr>
<td>What is brought into the space?</td>
<td>Which roles are present in the therapeutic space?</td>
</tr>
</tbody>
</table>
Figure 2. Titled: I am my own Mountain.
Short poem related to Figure 2.

I may be my own mountain
I jumped a little too far ahead
Head first, heart a little laggy behind
As usual
In what I aim and attempt to be
A parallel race
Almost of a
Process.
Not mutual
Not mutually
Excluded-
Exclusive, I mean.

Discussion

The author of this paper found themselves wondering about how the use of dramatic embodiment and dramatic projection resulting in increased rates of emotional arousal in witnesses applies to the chosen population of their thesis; clinicians and therapeutic helpers. This line of thinking arose as a response to how Armstrong et al.’s (2015) article focused on the viewpoints of the clients and their proposed subsequent change. The author of this paper contends that clinicians also share the therapeutic space of which both dramatic projection and dramatic embodiment can be rampantly present in, albeit one might argue that both are supposed to belong strictly to the client. The clinicians and therapeutic helpers also witness and play with and sometimes, play as the object representative of the client’s dramatic projection and dramatic
embodiment, whether in joint or opposing play. Thereby, this author proposes that the multiplicity of roles and sharing of playspaces due to the dramatic projection and dramatic embodiment encourages the interactions of vicarious trauma with personal material for the clinician/therapeutic helper, potentially increasing rates of burnout in the fields of mental health, expressive therapies, and drama therapy.

Clinicians and therapeutic helpers who both knowingly and unknowingly choose to serve populations with trauma are also prone to being exposed to emotional contagion. In the role as “helper” they may find themselves more susceptible to vicarious traumatization. For clinicians and therapeutic helpers who are still new and in training, there might be attempts to better manage their emotional capital as they adjust under the new social rules of the field. How the management is carried out and supervised may inform their future interactions with their clients. Introduce the idea of emergencies, emerging therapeutic alliances, novel administration to the containment of multiple clients’ shared histories and possible traumas back to back and there might be a fair amount of internal conflict within the new clinician or therapeutic helper. The author of this paper also posits that Role Theory-based interventions may help clinicians and therapeutic helpers to understand their experiences in this role as well as define the strengths and vulnerabilities of this role. Perhaps their embrace of the shared or similar roles are almost like a willing unintentional empathetic predisposition to vicarious trauma?

Although the author of this paper acknowledges that boundaries between the clinician/therapeutic helper and clients are pivotal, they also ruminate that detachment reflects the practice of a skill that is much easier said than done. It is also advice often provided to clinicians and therapeutic helpers to not bring work home, but there is no control over if work sneaks home with them without their active knowledge. If work is seeped into the crevices of
their minds, tucked away in the chambers of their hearts, dripping off the feet of their soul, how can the clinician or therapeutic helper safely say that they did not bring them out of the workplace (ethically, in this case) and back into their daily lives? How does the roles clinicians and therapeutic helpers embody at work not merge accidentally with the other roles they take on outside of it? Lines are blurred with and due to vicarious trauma.

This does not take into consideration clinicians and therapeutic workers whose work takes place in nontraditional spaces such as within the therapists’ homes, in their personal cars as they transport their clients, or even in the homes of the clients enlisting the services of in-home therapy. Certain stimuli only need to be similar and reminiscent enough to be considered activating for both client and therapist. Would the color and material – like the leathery smell and feel – of the client’s couch resemble something from the clinician’s or therapeutic helper’s past? These are examples of little bits of embodied memories that could trigger responses deep within the clinician or therapeutic helper. Additionally, the author of this paper wonders – since it is a requirement of their training to bring their therapeutic experiences as a drama therapy intern to supervision classes, peer supervision, personal therapy, consultation with colleagues and supervisors, does this already mean that the work is brought outside of the work space, potentially infringing on the edges of this author’s personal life?

The intervention used in this thesis was informed by all the elements of Lahad’s (1992) BASIC Ph scale. The use of the 6PSM engages the beliefs and values of the participants by opening the space for the sharing of their values and what they considered important in their process. The use of the 6PSM also involves the participants’ affect (as they play out and embody the emotions of their characters and guides), social support (as they delve into what guides and helping forces are needed in their stories), imagination (as they imagined what their stories are
like), and cognition (as they contemplate the arcs of the stories and what elements their main characters faced). The embodiment of the characters and guides, along with the poses and phrases of the resolutions to their stories brings in the physiological element of each participant’s storytelling and coping styles.

Relatedly, in the intervention for this thesis, a multitude of information across the levels were shared with the facilitator. Part of the information communicated in the therapeutic space also displayed the underlying relational dynamics present, as well as the relief experienced by the participants when they focused on the topic of positivity and resilience when presented with the panel that was the guide/helper/helping force. Although there is a focus in Cottingham and Erickson’s (2019) paper on the systemic social contexts that surround their population, the author of this paper is focusing primarily on the individual role. This author will not dismiss the importance of these systemic factors as being less important in the lives and psychological wellbeing of the clinician/therapeutic helpers, however.

**Conclusion**

Vicarious trauma and personal trauma. Vicarious resilience and personal resilience. The starting points of observation and a return to what the author of this paper has determined to be the content of the paper.

The results of the intervention communicated that the areas of vicarious trauma and vicarious resilience within clinicians, therapeutic helpers and clinicians-in-training are intricate and crucial. Multiple layers of information were revealed, reviewed and shared in the therapeutic space of the intervention – illustrating the overlapping aspects of systematic, relational and personal affectations, coping styles, and personal roles in the stories of the chosen main
characters of the participants’ six panels. Still, the author of this thesis mourns the loss of potential data that could have been observed had the circumstances been different. However, it is worthy to state that regardless, the change and uncertainty brought forward by the COVID-19 pandemic were met by the participants with grace, creativity, and flexibility.

There is an abundance of future implications from the educational results of this thesis. The use of the 6PSM interweaved with elements of DvT and Role Theory potentially allows for a high degree of flexibility and playfulness towards further understanding of how vicarious trauma and vicarious resilience affects clinicians and therapeutic helpers. The fact that the intervention was conducted successfully under less than ideal circumstances (COVID-19, sudden shift to remote therapeutic groups etc.) can be attributed to the same flexibility communicated. There is still a richness of resources to be mined and obtained in the area of working with clinicians, therapeutic helpers, and clinicians-in-training. Hopefully as more formal research is conducted in this area, it will mean that more knowledge will be availed to mental health practitioners, especially those working with trauma directly or indirectly. These valuable resources can serve both as enhancers to personal and professional self-awareness as well as being indicative as to how one is possibly reaching their current limits of burnout, compassion fatigue, and secondary traumatic stress. As that improves, there is potential for the combination of personal and professional self-awareness coupled with vicarious resilience and healing from vicarious trauma to contribute to the reduction of burnout and compassion fatigue within the mental health field. The author of this thesis hopes that thereby it will lead to better longevity and wellbeing of the individuals operating and navigating within the areas of psychological health, caretaking, and trauma.
References


Cottingham, M. D., & Erickson, R. J. (2019). The promise of emotion practice: At the bedside and beyond. *Work and Occupation, 0*(0), 1-27.


Ludick, M., & Figley, C. R. (2017). Toward a mechanism for secondary trauma induction and


Appendix

Unfamiliarity and Questions

What am I doing?

What is the value of what I’m doing.

Stop

micromanaging

me (please)

I appreciate your good

Well intentions but

Is that fulfilling your

Need or mine

Then again, I’m not

Good at speaking

Up

And

Clarifying

My own

Boundaries

lol
A Series of Conversations:

I am existent in time; past, present, future.

I am existent in being.

I present myself and represent myself in

The digital presence

And the physical almost un-presence

Of being present in the shared space with

Everyone.
RE: TRAUMATIZING

History
(His-story, her-story, their-story: whose is it?
Your-story, my-story, our-story: told in six parts,
Six participants, a full panel, moderator included!)

Camaraderie
(Camera-there-ie, Camera-fair-ey, camera-cree-py,
Camera-eerie, camera-dear-ie, camera-trippy,
Camera-flipped – reload your images and re-consider how you show up on film!)

Underlying tensions
(There could have been ten, but
Alas, some people went under
And some people might have lied
For attention! -a-tension
Too much and too many to count)

Inside jokes
Playful ribbing
Cracking up
Catching each other
(Body shows up,
Most everybodies showed up)
Embody all the different parts
You keep hidden in your
Close to your
Chest and respiratory systems
Systemic images
Take a picture or two.)

Pre-determined, pre-decided
As informed by
Multiple relationships
(History repeated itself,
I am sure of it,
Patterns of dysfunction
Present in families and groups
Brought into the space,
Lingering hands and remnants of the pre-violent)

In our tracks
In our mistakes
Eyes tracking
Smiles cracking
Humor laden
(Crinkle like the snacks brought and
Gestures shared
Laughter chips
And sown uncertainties
I oat to tell you
Tangling noodles of relations
Twitch
Relation-twitch
‘twhich curves and quirks
We all have a plenty
To cope)
Needs – whose needs are they?
Mine? Yours?
Too many variables all mixed up in this cauldron of soupy
Relationships
With its reflective surfaces of mirrored images
Of past, present
Prior, previous
Future, post-
Shadows of relationships
En-role yourself
Roles and rolls everladden with meaning,
Positives and negatives,
Neutral and void,
A hot pot of mixed blessings,
Everybody brought something for the pot to share, I hope!
How potent (pot-ent)
Ladle yourself a serving
Take a sip of what others have added to the pot
And stir before adding a taste of what is yours
A twitch of a brew.
(Apparently, the longer you brew, and stew
The richer the flavor
Due to its history,
Enhanced; in-hands
We pass bowls around and
To go.
Before sharing cutleries
And silverware.
Cut-leery-ies and
Silver-where?)
If I could have a conversation with whatever-whoever-whichever
Is present in the room – rooms? But we’re on Zoom?
Zoom rooms,
Who-what-which would answer?
The echoes of fragmented digital images
The sentiments lagging just a few seconds late
The dis-connection
(this connection?)
Which being am I talking to
Whose afterimage am I addressing?
Lingering past containing shards
Of encircling, overlapping giant invisible Venn diagrams
We all carry with us,
Informative and informing
Full of intent, whether intentional or unintentional
Sub-intentional?
Let me have a conversation with one of the many rings
A Ring-Leader, if you shall.
One of many, I’m sure.

Ring-Leader, hello.
Or shall I say
Rings-leader?
What should we
What do we-they-I-you-he-she
Brings
Into the Overlap
Let me circle back
And just
Just lap it up
Follow one of the many plagues
The Locuses-
Loci, in other words, of control.
(Loss-I, of control)
Nor-I
Am I-nnocent
And free from the interactions of
Well-timed
And some-times
Unwell-timed
Well-come into
Vicarious trauma
Vicarious resilience
Vicarious despair
How apt
How apropos
How COVID-19.

(What would linger among the lost

The loss of I

The loss of why

I might be a little closer to this topic than I

Had initially

I-initially

Planned.
Is there a process to isolate

(Am I so late?)

And tear between

What is perceived and eaten as

Vicarious trauma and not

Vicarious resilience and not?

It is a spectrum
Of a needle, or set of needles
That depending on how it is gauged
Fluctuate and oscillate
(Buzzing, ever buzzing)
And feed and steam
(Tremors and vibrations)
What is within and then
Permeate (Per-me-ate)
(With wings)
With out.
THESIS APPROVAL FORM

Lesley University
Graduate School of Arts & Social Sciences
Expressive Therapies Division
Master of Arts in Clinical Mental Health Counseling: Drama Therapy, MA

Student’s Name: _____Stephenie Loo_____________________________________________________

Type of Project: Thesis

Title: ___ Re: Traumatizing – The Interactions Between Clinicians and Therapeutic Helpers and Vicarious Trauma

Date of Graduation: ___May 16th 2020________________________________________________________

In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

Thesis Advisor: Laura L. Wood, Ph.D.
5.4.2020 Electronic Signature generated 4:01pmEST